



WELLCARE EDI TRANSACTION SET

837I X12N HEALTH CARE CLAIM INSTITUTIONAL ASC X12N (004010X096A1) Companion Guide

Inbound 837Institutional Claims Submission

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REVISION HISTORY

Date	Rev #	Author	Description
04/10/2006	DRAFT	G. Webb	Initial draft
	Final	"	Final Review)cosmetic updates
04/18/2006		"	Added NPI statement (2010AA)

CONTACT ROSTER

Trading Partners and Providers ; Questions, Concerns, Testing information please email the following	
EDI Coordinator	
EDICoordinator@wellcare.com	Multi group supported email distribution
EDI Testing	
EDITesting@wellcare.com	Multi group supported email distribution

INTRODUCTION

WellCare Health Plans, Inc. ("WellCare") used the standard format for Claims Data reporting from Providers and Trading Partners (TPs). WellCare X12N 837 Institutional Claim submission companion guide is intended for use by WellCare Providers and TPs in conjunction with ANSI ASC X12N National Implementation Guide. It has been written to assist those Submitters who will be implementing the ASC X12N 837I Healthcare Claim Institutional transaction. This WellCare Companion Guide clarifies the HIPAA-designated standard usage and must be used in conjunction with the following document:

The 837I Healthcare Claim Institutional Implementation Guides (IG)

To purchase a download IG contact the Washington Publishing company at http://www.wpc-edi.com/hipaa/HIPAA_40.asp. or call (425) 831-4999.

This WellCare Companion Guide contains data clarifications derived from specific business rules that apply exclusively to claims processing for WellCare Health Plans. Field requirements are located in the ASC X12N 837I (004010X096A1) Implementation Guide.

Submitters are advised that updates will be made to the Companion Guides on a continual basis to include new revisions to the web sites below. Submitters are encouraged to check our website at periodically for updates to the Companion Guides.

Georgia Submitter <http://georgia.wellcare.com> (both guides)

All Other states;

http://www.wellcare.com/Resources/Documents/837P_Claims_Sub_Comp_Guide.pdf
(professional guide)

http://www.wellcare.com/Resources/Documents/837I_Claims_Sub_Comp_Guide.pdf
(institutional guide)

Reporting States

This Guide covers further clarification to Providers and TPs submitting Institutional Claims to WellCare and providing services in the following states;

- Connecticut
- Florida
- Georgia
- Illinois
- Indiana
- Louisiana
- New York

GENERAL INFORMATION

Valid Provider Identifiers

Submitters should use the Medicaid/Medicare Provider Number assigned to all providers who have signed Core Provider Agreements with States to provide healthcare services to Medicaid/Medicare for capitated, no-fee and fee-for-service clients. Until the National Provider Identification (NPI) number is implemented, the ANSI ASC X12N 837I format requires the use of the State Medicaid/Medicare Provider Number with the “1D” or “1C” qualifier in the REF01 Segments.

Alternate Provider IDs are only accepted per the contract agreements with WellCare.

Electronic Submission

Institutional service claims submitted using the ANSI ASC X12N 837 format should be separated from Encounter reporting. When sending Institutional service claims WellCare expects the BHT06, Claims Identifier to be set to “CH”. When reporting Encounters WellCare expects the BHT06 to be set to “RP”.

File Upload

EDT files for production should be submitted to the following Secure FTP site <https://edi.wellcare.com/human.aspx>, using secure File Transfer Protocol; See section FTP Process

Submission Frequency

WellCare processes claims on a daily basis.

File Size Requirements

The following list outlines the file sizes by transaction type:

Transaction Type	Testing Purposes	Production Purposes
837 formats – claims	50 -100 claims	< 5000 claims

FTP PROCESS

Secure File Transfer Protocol

MOVEit® is WellCare’s preferred file transfer method of transfer electronic transactions over the Internet. It has the FTP option or online web interface.

Secure File Transfer Protocol (SFTP) is specifically designed to handle large files and sensitive data. WellCare’s utilizes Secure Sockets Layer (SSL) technology, the standard internet security and SFTP ensures unreadable data transmissions over the Internet without a proper digital certificate.

- Registered users are assigned a secure mailbox where all reports are posted. Upon enrollment, they will receive a login and password.

In order to send files to WellCare submitters need to have an FTP client that supports AUTH SSL encryption. The AUTH command allows WellCare to specify the authentication mechanism name to be used for securing the FTP session. Sample FTP client examples are:

- WS_FTP PRO[®] (The commercial version supports automation and scripting)
 - WS_FTP PRO[®] has instructions on how to connect to a WS_FTP Server using SSL.
- Core FTP Lite[®] (The free version supports manual transfers)
 - Core FTP Lite[®] has instructions on how to connect to a WS_FTP Server. Additionally, WellCare can provide setup assistance.

FILE TEST PROCESS

WellCare will accept test files on a case-by-case basis. Notify the Testing Coordinator of your intent to test and to schedule accordingly.



IF YOU DO NOT NOTIFY WELLCARE OF YOUR INTENT TO TEST, YOUR CLAIM SUBMISSION MAY BE OVERLOOKED.

Testing

1. Create test files in the ANSI ASC X12N 837I format.
 - Files should include all types of provider claims. (i.e. **837I** for Inpatient Hospital, Outpatient Services, Home Health, Hospice, etc.)
 - Batch files by 837I type of claim and group by month.
 - Set Header Loops for Test:
 - Header ISA15 to ' T '
 - Header REF02 to ' **004010X096DA1** ' (837I)
 - Header use ' **CH** ' in Header BHT06 for claims
2. Name each batch file according to the File Naming Standards listed below:
 - Company Identifier short name(CMPNM)
 - 837TST
 - Date test file is submitted to WellCare (CCYYMMDDHHMM) with last byte equaling file type I = institutional services
 - **Example:** CMPNM_837TST_200509011525
3. Transmit your **TEST** files to the WellCare SFTP site: <https://edi.wellcare.com>
4. Email a copy of the file Upload Response and your file name to the EDI Coordinator

Production

After the Provider or TPs are production ready WellCare will accept ANSI ASC X12N 837I format and process batch files daily. Files must have the appropriate PRODUCTION identifiers as listed in the 837I Mapping Documents.

Naming Standards: WellCare uses the file name to help track each batch file from the drop off site through the end processing into WellCare's data warehouse.

- 1- Create test files in the ANSI ASC X12N 837I format.
 - Set Header Loops for Production:
 - Header ISA15 to ' **P** '
 - Header REF02 to ' **004010X096A1** ' (837I)
 - Header use ' **CH** ' in Header BHT06 for claims
- 2- Name each batch file according to the File Naming Standards listed below:
 - Company Identifier Short Name(CMPNM)
 - 837PROD
 - Date production file is submitted to WellCare (CCYYMMDDHHMM) with last byte equaling file type **I** = institutional services
 - **Example:** CMPNM_837PROD_200509011525**I**
- 3- WellCare recommends the use of EDIFECS or CLAREDI for minimum Level integrity testing prior to uploading your production files.
- 4- Transmit your Production files to WellCare through the SFTP site. See FTP Process section
- 5- File Upload Acceptance/Response will be immediate after upload has completed.
- 6- After the file has passed through WellCare's Enterprise Systems validation process, (includes business edits). The electronic ANSI ASC X12N 997 (Functional Acknowledgement) outlining file rejects will be posted to the SFTP site.
- 7- If the file is unreadable then a TA1 will be posted to the pickup location.

WELLCARE VALIDATION PROCESS

When 8371 Claim files are accepted by the WellCare processing system the Edit program will:

- Process all Claims 8371 files
- Edit the transactions for content against X12 Standards, WellCare's eligibility history, Medicaid/Medicare id's, valid dates, valid standard transaction code sets:
 - Current Procedural Terminology (CPT);
 - Standard Edition International Classification of Diseases (ICD.9.CM);
 - Health Care Financing Administration Comprehensive Procedure Coding System (HCPCS);
- The 997 is generated when the file header and trailer check and passes through the EDI edits. The 997 accepts / rejects each file transmission.
See the 837 IG for additional information about the response coding and Addendum C in this Guide.



FURTHER CLAIM FIELD DESCRIPTION

Refer to the IG for the initial mapping information the grid below further clarifies additional information WellCare requires. For Situational fields that WellCare requires, will be specified as S - R.

Interchange Control Header:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
	ISA06	Interchange Sender ID	M	1		Unique ID assigned by WellCare. Example: WC123456 followed by spaces to complete the 15-digit element
	ISA08	Interchange Receiver ID	M	1		Use 'WELLCARE' Note: Please make sure the Receiver ID is left justified with trailing spaces for a total of 15 characters. Do not use leading ZEROS.

Functional Group Header:

	GS02	Senders Code	M	1		Use your existing WellCare Submitter ID or the trading partner ID provided during the enrollment process.
	GS03	Receivers Code	M	1		Use WC ID "WELLCARE"

Transaction Set Header:

05	ST02	Transaction set Control Number	M	1		Submitters can send transactions using the number 0001 in this element and increment from there. ST02 must be unique and identical to SE02.
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Header:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
010	BHT03	Originator Application Transaction Identifier	R	1		Unique Transaction ID # assigned by the Submitters System
010	BHT06	Claim/Encounter Identifier	R			Use value "CH"
015	REF02	Transmission Type Identification	R	1		REF02 Reference ID "004010X096A1"

LOOP ID - 1000A – Submitter Name

020	NM109	Submitter Identifier	S-R		<u>1</u>	Submitter's "ETIN" i.e., Use the WellCare Submitter ID or 6-digit trading partner ID assigned during the EDI enrollment process.
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LOOP ID - 1000B – Receiver Name

020	NM103	Receiver Name	R	1	<u>1</u>	Use value "WELLCARE HEALTH PLANS, INC" (I.e., WellCare Health Plans of Georgia,
	NM109	Receiver Primary ID	S-R			WellCare Health Plans of New York) Use value "WELLCARE"



Detail:						
Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
LOOP ID - 2000A – Billing/Pay-To Provider Hierarchical Level					≥1	
003	PRV01	Billing/Pay-To Provider Specialty Information	S-R	1		Required for submitters in IL, NY Use value “ BI ” = Billing or “ PT ” Pay-To Provider
LOOP ID - 2010AA – Billing Provider Name					1	
015	NM109	Billing Provider ID	R	1		If No Pay-To Loop (2010AB) submitted (Pay-to Provider is the same entity as the Billing Provider), the loop 2010AA must have Tax ID in it. Meaning that NM108 must have value “ 24 ” and NM109 = Provider Tax ID.
035	REF01	Reference Identification Qualifier	R	8		All States Use value “ 1D ” in at least one iteration. Note: NY submitters send second REF loop use value “ 0B ”, IN submitters send second REF loop use value “ B3 ”.
035	REF02	Billing Provider Additional Identifier	R			Sent to state for submitters reporting in NY , Provider License number
LOOP ID - 2010AB – Pay to Provider’s Name					1	
NM109	NM109	Pay-To Provider Identifier	R	1		If Pay-To Loop (2010AB) exists and the (Pay-to Provider is a different entity than the Billing Provider), the loop 2010AB must have Tax ID in it. Meaning that NM108 must have value “ 24 ” and NM109 = Provider Tax ID. Note: Please send NPI when available, If “ XX - NPI ” is used, then either the Employer’s Identification Number or the Social Security Number of the provider must be carried in the REF in this loop.
035	REF01	Reference Identification Qualifier	R	5		Use value “ 1D ” for all States submitting 2010 loop
LOOP ID - 2000B – Subscriber Hierarchical Level					≥1	
005	SBR01	Payer Responsibility Sequence Number Code	R	1		Use value ‘ P ’ if <u>WellCare</u> is the primary payer.
005	SBR09	Claim Filing Indicator Code	S	1		Value equal to Medicaid or Medicare filing
LOOP ID - 2010BA – Subscriber Name					1	
015	NM108	Subscriber Primary Identification code Qualifier	S-R	1		Use value “ MI ”
015	NM109	Subscriber Primary Identifier	S-R	1		Subscriber Medicaid/Medicare ID
032	DMG01	Subscriber Demographic Information	S-R	1		Required when Loop ID-2000B, SBR02 = 18 (self)
035	REF01	Reference Identification Qualifier	S			Use value “ IG ” (Insurance policy #)



LOOP ID - 2010BC – Payer Name					1
015	NM108	Identification code Qualifier			Use value "PI"
015	NM109	Identification code			Use value "WELLCARE"
LOOP ID - 2300 – Claim Information					100
130	CLM02	Total claim charge amount	S	1	For claims transmissions, zero (0) may be a valid amount.
130	CLM05	Place of Service Code	S	1	CLM05 applies to all service lines unless it is over written at the line level.
130	CLM05-3	Claim Frequency Code	R	1	Use value "1" for original claims record " Use value "7" when submitting corrections and replacing previously submitted claim records. Use value "8" to void the claim
135	DTP	Discharge Hour	S-R	1	Required on all final inpatient claims.
135	DTP	Statement Dates	R	1	Required
135	DTP	Admission Date/Hour	S-R	1	Required on all Inpatient claims.
140	CL1	Institutional Claim Code	S		Required when patient was admitted to the hospital for inpatient services.
155	PWK	Claim Supplemental Information	S	10	Required if there is paper documentation to support the electronic claim
180	REF	Claim Identification Number for Clearinghouses and other Transmission Intermediaries	S	1	Used only by transmission intermediaries Value "D9" = for Clearinghouses
180	REF	Service Authorization Exception Code	S	1	Sent to state for submitters reporting in LA
180	REF	Prior Authorization or Referral Number	S	2	Sent to state for submitters reporting in LA
180	REF	Medical Record Number	S	1	Sent to state for submitters reporting in CT, IN, IL, LA, NY,
231	HI	Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information	S	1	At least one Diagnosis Code (Primary) must exist to accept an claim
231	HI01-1	Code List Qualifier Code	S	1	Use value = BK, & BR
231	HI01-2	ICD-9 Principal Diagnosis Code	R	1	Required on all Inpatient and Outpatient claims records
231	HI	Diagnosis Related Group DRG Information	S	2	DRG Information is required when an inpatient hospital is under DRG contract with a payer
LOOP ID - 2310A – Attending Physician Name					1
250	NM1	Attending Physician Name	S	1	Required on all inpatient claims; Sent to state for submitters reporting in NY and CT
LOOP ID - 2310B – Operating Physician Name					S
250	NM1	Operating Physician Name	S	1	Sent to state for submitters reporting in IL
LOOP ID - 2310C – Other Provider Name					S
250	NM1	Other Provider Name	S	1	Sent to state for submitters reporting in IN
271	REF	Other Provider Secondary Identification	S	5	Valid Value in REF02 is "0B" Sent to state for submitters reporting in IN
LOOP ID - 2320 – Other Subscriber Information (COB)					10
290	SBR	Other Subscriber Information	S	1	Sent when applicable Sent to state for submitters reporting in GA, IN, NY and CT

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295	CAS	Claim Level Adjustment	S	5		Sent to state for submitters reporting in GA, IN, NY and CT
300	AMT	Actual Prior Payment Amount	S	1		Sent to state for submitters reporting in GA, IN
305	DMG	Other Subscriber Date of Birth	S	1		Sent to state for submitters reporting in GA, IN
LOOP ID – 2330A – Other Subscriber Name						
250	NM1	Other Subscriber Name	S	1		Required if 2320 COB loop is used
332	N3	Other Subscriber Address	S	1		Sent to state for submitters reporting in GA, IN
340	N4	Other Subscriber City, State, Zip	S	1		Sent to state for submitters reporting in GA, IN
LOOP ID - 2330B – Other Payer Name						
					1	
325	NM1	Other Payer Name	S-R	1		Sent to state for submitters reporting in GA, IN
332	N3	Other Payer Address	S	1		Sent to state for submitters reporting in GA
340	N4	Other Payer City, State, Zip	S	1		Sent to state for submitters reporting in GA
350	DTP	Claim Adjudication Date	S-R	1		Sent to state for submitters reporting in CT, IN
LOOP ID - 2400						
					999	
365	LX	Line Number	R	1		Required for all states
350	DTP	Claims Payment Date	S-R	1		Required for all states
555	SE	Transaction Set Trailer	M	1		SE02 must be unique and identical to ST02.

ATTACHMENT A

Glossary

Term	Definition
HIPAA	In 1996, Congress passed into federal law the Health Insurance Portability and Accountability Act (HIPAA) in order to improve the efficiency and effectiveness of the entire health care system. The provisions of HIPAA, which apply to health plans, healthcare providers, and healthcare clearinghouses, cover many areas of concern including, preventing fraud and abuse, preventing pre-existing condition exclusions in health care coverage, protecting patients' rights through privacy and security guidelines and mandating the use of a national standard for EDI transactions and codesets.
SSL (Secure Sockets Layer)	SSL is a commonly used protocol for managing the security of a message transmission through the Internet. SSL uses a program layer located between the HTTP and TCP layers. The "sockets" part of the term refers to the sockets method of passing data back and forth between a client and a server program in a network or between program layers in the same computer. SSL uses the public-and-private key encryption system from RSA, which also includes the use of a digital certificate.
Secure FTP	Secure FTP, as the name suggests, involves a number of optional security enhancements such as encrypting the payload or including message digests to validate the integrity of the transported files to name two examples. Secure FTP uses Port 21 and other Ports, including SSL.
AUTH SSL	AUTH SSL is the explicit means of implementing secure communications as defined in RFC 2228. AUTH SSL provides a secure means of transmitting files when used in conjunction with an FTP server and client that both support AUTH SSL.
Required Segment	A required segment is a segment mandated by HIPAA as mandatory for exchange between trading partners.
Situational Segment	A situational segment is a segment mandated by HIPAA as optional for exchange between trading partners.
Required Data Element	A mandatory data element is one that must be transmitted between trading partners with valid data.
Situational Data Element	A situational data element may be transmitted if data is available. If another data element in the same segment exists and follows the current element the character used for missing data should be entered.
N/U (Not Used)	An N/U (Not Used) data element included in the shaded areas if the Implementation Guide is NOT USED according to the standard and no attempt should be made to include these in transmissions.
ATTENDING PROVIDER	The primary individual provider who attended to the client/member during an in-patient hospital stay. Must be identified in 8371, Loop 2310A, REF02 Segment, by their assigned Medicaid/Medicare ID number assigned by State to the individual provider while the client was in-patient.
BILLING PROVIDER	The Billing Provider entity may be a health care provider, a billing service, or some other representative of the provider. For claims reporting, the Billing Provider identified in Loop 2010AA, REF02 segment is the State Medicaid/Medicare ID number assigned by

Term	Definition								
	State. This is the primary identifier to distinguish all Lines of business								
IMPLEMENTATION GUIDE (IG)	Instructions for developing the standard ANSI ASC X12N Health Care Claim 837 transaction sets. The Implementation Guides are available from the Washington Publishing Company.								
PAY-TO-PROVIDER	The Pay-to-Provider in Loop 2010AB, REF02 Segment is the State assigned Medicaid/Medicare ID number of the healthcare provider that was paid by WellCare. This could be a medical group, clinic, hospital, other institution, or the individual provider who rendered the service.								
REFERRING PROVIDER	Identifies the individual provider who referred the client or prescribed Ancillary services/items such as Lab, Radiology and Durable Medical Equipment (DME). Report this provider in Loop 2310A, REF02 Segment using the Medicaid/Medicare ID number assigned by State to the referring provider.								
RENDERING PROVIDER	The primary individual provider who attended to the client/member. They must be identified in 83P, Loop 2310B, REF02 Segment, use the Medicaid/Medicare ID number assigned by State to the individual provider while the client was in active status.								
TRADING PARTNERS (TPs)	Includes all of the following; payers, switch vendors, software vendors, providers, billing agents, clearinghouses								
DATE FORMAT	All dates are eight (8) character dates in the format CCYYMMDD. The only date data element that varies from the above standard is the Interchange Date data element located in the ISA segment. The Interchange Date date element is a six (6) character date in the YYMMDD format.								
DELIMITERS	<p>A delimiter is a character used to separate two (2) data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction. The following characters are used as data delimiters for all transaction segments:</p> <table border="1" data-bbox="586 1461 1365 1585"> <thead> <tr> <th data-bbox="586 1461 979 1493">CHARACTER</th> <th data-bbox="979 1461 1365 1493">PURPOSE</th> </tr> </thead> <tbody> <tr> <td data-bbox="586 1493 979 1524">* Asterisk</td> <td data-bbox="979 1493 1365 1524">Data Element Separator</td> </tr> <tr> <td data-bbox="586 1524 979 1556">: COLON</td> <td data-bbox="979 1524 1365 1556">Sub-Element Separator</td> </tr> <tr> <td data-bbox="586 1556 979 1585">~ Tilde</td> <td data-bbox="979 1556 1365 1585">Segment Terminator</td> </tr> </tbody> </table>	CHARACTER	PURPOSE	* Asterisk	Data Element Separator	: COLON	Sub-Element Separator	~ Tilde	Segment Terminator
CHARACTER	PURPOSE								
* Asterisk	Data Element Separator								
: COLON	Sub-Element Separator								
~ Tilde	Segment Terminator								



ATTACHMENT B

File Example

ST*837*987654~
BHT*0019*00*0123*20041218*0932*CH~
REF*87*004010X096A1~
NM1*41*2*JONES HOSPITAL *****46*00120~
PER*IC*JANE DOE*TE*9005555555~
NM1*40*2*MEDICAID*****46*12345~
HL*1**20*1~
PRV*BI*ZZ*280000000X~
NM1*85*2*JONES HOSPITAL *****24*808403012~
N3*225 MAIN STREET BARKLEY BUILDING~
N4*CENTERVILLE*PA*17111~
REF*1D*987654080A~
REF*B3*549302200~
HL*2*1*22*0~
SBR*P*18*****MC~
NM1*IL*1*DOE*JOHN*T***MI*030005074A~
N3*125 CITY AVENUE~
N4*CENTERVILLE*PA*17111~
DMG*D8*19750513*M~
NM1*PR*2*MEDICAID*****PI*00435~
CLM*756048Q*2683.38***13:A:1*Y*A*Y*O*****N~
DTP*434*RD8*20041120-20041123~
DTP*435*DT*200409110000~
CL1*1*7*01~
AMT*C5*2683.38~
HI*BK:2765*BJ:2765~
HI*BH:51:D8:20041123~
HI*BE:Z1:::1451.36~
HI*BG:09~
QTY*CA*3*DA~
NM1*71*1*JONES*JOHN*J***24*999370125~
PRV*AT*ZZ*207RG0300X~
SBR*S*01*351630*STATE TEACHERS*****MC~
CAS*PR*1*0.00~
AMT*C4*2683.38~
DMG*D8*20000125*F~
OI***Y***Y~
NM1*IL*1*DOE*JANE*S***MI*222004433~
N3*125 CITY AVENUE~
N4*CENTERVILLE*PA*17111~
NM1*PR*2*STATE TEACHERS*****PI*1135~
DTP*573*D8*20040911~
LX*1~
SV2*0305*HC:85025*2003*UN*1~
DTP*472*D8*20040911~
LX*2~
SV2*0730*HC:93005*680.38*UN*3~
DTP*472*D8*20040911~
SE*49*987654~



ATTACHMENT C

997 Interpretations

The examples below show an accepted and a rejected X12 N 997. On the WellCare sftp site in the respective Provider directory the X12N 997 files, when opened, will display as one complete string without carriage returns or line feeds.

Accepted 997

```
ISA*00*00*5265*ZZ*100000*ZZ*100008  
*050923*1126*U*00401*000000166*1*T*~GS*FA*77046*100008*20031023*112600*1660001  
*X*004010X096A1~ST*997*0001~AK1*HC*756048Q~AK2*837*TEST~AK5*A~AK9*A*1*1*1~  
SE*6*0001~GE*1*1660001~IEA*1*000000166~
```

Rejected 997

```
ISA*00*00*5264*ZZ*100000*ZZ*100008  
*050923*1124*U*00401*000000165*1*T*~GS*FA*77046*100008*20031023*112400*1650001  
*X*004010X096A1~ST*997*0001~AK1*HC*19990000~AK2*837*TEST~AK5*R*7~AK9*R*1*1*  
0~SE*6*0001~GE*1*1650001~IEA*1*000000165~
```