Avera Health Plans

HIPAA 837 Professional Transaction Companion Guide
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Disclosure Statement

The information in this document is intended only for the trading partners and business associates of Avera Health Plans, Inc. Periodically, changes may be made to the information in this document, which will be incorporated in new editions of this publication. Avera Health Plans may make improvements and/or changes in the product and/or program described in this publication at any time.

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Introduction

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the secretary to adopt standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

Purpose of the Companion Guide

The HIPAA EDI Transaction Standard Companion Guide explains the procedures necessary for Business Associates and Trading Partners of Avera Health Plans to transmit Electronic Data Interchange (EDI) transactions.

This Companion Guide is not intended to replace the X12N Implementation Guides; rather it's intended to be used in conjunction with them. Additionally, the Companion Guide is intended to convey information that is within the framework and structure of the X12N Implementation Guides and not to contradict or exceed them.

Additional Information

The Avera Health Plans Companion Guide provides information primarily for a provider or facility, electronic claims clearinghouse vendor and/or business associate.

The advantage of utilizing EDI Claims transactions is a more timely turn around process for claims submission, processing and reimbursement.

- Avera Health Plans will receive the files from eProvider Solutions through a transmission upload process.

- Uploaded files will be verified against a member match program.

- Claims not meeting the data matching process against member records will reject and be returned to the originating provider via eProvider Solutions.

- Claims meeting the data match process are loaded into our system for adjudication.

- An acknowledgement file 997/TA1 is sent to eProvider Solutions listing pertinent file information. TA1 communicates the successful acceptance or rejection, including reasons for rejection. The 997 file informs submitters that the transmission arrived and of any syntactical errors in the transmission. The 997 files are created for every inbound transaction set during the load process.

Customer/Provider Service

Contact the Avera Health Plans Service Center at (605) 322-4545 or toll-free at 1 (888) 322-2115.

Avera Health Plans Service Center representatives will gladly assist you with EDI transaction needs. The Service Center representatives will enlist the help of the Avera Health Plans Applications Staff with EDI transaction inquiries when necessary.

Control Segments/Envelopes

Not yet defined.

Payor Specific Business Rules

- Claim will reject when no Group Number is passed.
  Subscriber loop 2000B, SBR.

- Claim will reject if no Insured ID Number is passed.
  Subscriber Name loop 2010BA, NM1.

- Claim will reject if no Insured Name is passed.
  Subscriber loop 2010BA, NM1.

- Claim will reject if no Patient Name is passed.
  Patient Name loop 2010CA, NM1 when relationship to insured is not self.

- Claim will reject if no Patient Member ID number is passed.
  Patient Name loop 2010CA, NM1.

- Claim will reject if no Patient Date of Birth is passed.
  Patient Demographic loop, 2010CA, DMG.

- Claim will reject if no Patient Address is passed.
  Patient Address loop 2010CA, N3 and N4.

- Claim will reject if the Patient Relationship to Insured is not passed.
  Patient loop 2000C, PAT.

- Claim will reject if Patient Condition Related information is not passed.
  Claim Info loop 2300, CLM11 – 1, 2, or 3 when accident or employment related.

- Claim will reject when a Diagnosis Code is not passed.
  Diagnosis Code loop 2300, HI.

- Claim will reject when Date of Service is not passed in loop 2300, DTP segments.

- Claim will reject when Place of Service is not passed.
  Claim Info loop 2300, CLM.

- Claim will reject when Procedure Code is not passed.
  Professional loop 2400, SV1.

- Claim will reject when Days/Units are not passed.
  Professional loop 2400, SV1.

- Claim will reject when NPI is not passed.
  Rendering Provider loop 2310B, NM1.

- Claim will reject when Federal Tax ID Number is not passed.
  Rendering Provider loop 2310B, REF.

- Claim will reject when Patient Account Number is not passed.
  Claim information loop 2300, CLM.

- Claim will reject when Total Charge Amount is not passed.
  Claim information loop 2300, CLM.

- Claim will reject when Name of Physician is not passed.
  Rendering Provider loop 2310B, NM1.

- Claim will reject when Service Facility Address in not passed except when the Billing Address is the same as the Service Facility Address.
  Service Facility Location loop 2420C, NM1.

- Claim will reject when Billing Provider Information is not passed.
  Billing Provider loop 2010AA, NM1.

- Claim Notes must be passed in loop 2300, NTE.
  We do not map notes from Loop 2400, NTE.