5010 837 Companion Guide

Refers to the Implementation Guides Based on X12 version 005010

Companion Guide Version Number: 1.6

Revision Date: August 30, 2023

INTRODUCTION

The objective of the guide is not to report all of the required data in the implementation guide. The HIPAA implementation guide contains many optional data specifications. This companion guide will indicate what optional data requirements must be met to quickly adjudicate the claim. The companion guide will also describe additional data information clarifications that will assist in adjudicating the claim upon receipt.

Note: Loops supplied within the 837 file are required to be in the sequence as defined in the HIPAA implementation guide. Segments within the loops are expected to follow the sequence in which the HIPAA implementation guide defines the segments within each loop.

Note: The HIPAA implementation guide recommends a limit of 5000 CLM segments. AultCare adheres to this limit and cannot accept file that exceed this transmission size.

The following sections are contained within the guide.

1. **Envelope Data Requirements –** This chapter explains how to fill out the ISA and GS segment. (Page 3)

2. **Professional Claim Data Requirements –** The data requirements for Professional Claims are explained. (Page 6)

3. **Institutional Claim Data Requirements –** The data requirements for Institutional Claims are explained. (Page 25)

4. **Dental Claim Data Requirements** – The data requirements for Dental Claims are explained. (Page 40)

5. **Trading Partner Requirements** – This chapter defines the following items:

    a. Electronic Claim Procedures. (Page 52)

    b. Testing procedure. (Page 53)

    c. Production procedure (Page 54)

    d. Response/Acknowledgements (Page 55)

    e. File Transfer Process (Page 67)

6. **Appendix A** – This chapter lists changes made to the companion guide. (Page 73)

    Appendix B – Product Lines for Electronic Claims (Page 75)

If there are additional questions, please contact our HIPAA 837 Transaction Coordinator by emailing edisupport@aultcare.com .

1. ENVELOPE DATA REQUIREMENTS

The ISA and GS segments make up the header information for the 837 transaction . The information in the tables in this chapter show what information is expected.

Within the ISA is the Test/Production indicator. This indicator must be filled in properly. Test files must be sent with the "T" for test. After testing is successfully completed, the indicator changes to "P" for production processing.

ISA – Interchange Control Header

Location	Data Element Description	Expected Value
ISA01	**Authorization Information Qualifier**	00
ISA02	**Authorization Information**	Blank
ISA03	**Security Information Qualifier**	00
ISA04	**Security Information**	Blank
ISA05	**Interchange ID Qualifier**	ZZ
ISA06	**Interchange Sender ID**	Client Federal Tax ID
ISA07	**Interchange ID Qualifier**	ZZ
ISA08	**Interchange Receiver ID**	AultCare Federal Tax ID: 341488123 OR Aultra Federal Tax ID: 204951704
ISA09	**Interchange Date**	YYMMDD
ISA10	**Interchange Time**	HHMM
ISA11	**Repetition Separator**	Recommend carat (^)

ISA12	**Interchange Control Version Number**	00501
ISA13	**Interchange Control Number**	Increment by 1 with each submission
ISA14	**Acknowledgment Requested**	0 or 1
ISA15	**Usage Indicator**	T or P
ISA16	**Component Element Separator**	Recommend colon (:)

Note: An asterisk (*) is recommended as the data element separator.

A tilde (~) is recommended as the segment terminator.

GS – Functional Group Header

Location	Data Element Description	Expected Value
GS01	**Functional Identifier Code**	HC
GS02	**Application Sender's Code**	Client Federal Tax ID
GS03	**Application Receiver's Code**	AultCare Federal Tax ID: 341488123 OR Aultra Federal Tax ID: 204951704
GS04	**Date**	CCYYMMDD
GS05	**Time**	HHMM
GS06	**Group Control Number**	Provider Assigned
GS07	**Responsible Agency Code**	X
GS08	**Version / Release / Industry Identifier Code**	Varies depending on file type being sent: 005010X222 or 005010X223 or 005010X224

2. Professional Claim Data Requirements

The tables in this chapter cover the data that is required for a professional claim. The data presented is not all of the data required for a claim, **only** the data that needs clarification or further description of the expected data.

For more information about each piece of data and the different locations, please refer to the HIPAA Implementation Guide for the 837 Health Care Claim: Professional.

Headers

Transaction Set Header: Consistent with the HIPAA implementation Guide.

Beginning of Hierarchical Transaction: Consistent with the HIPAA implementation Guide.

Submitter/Receiver Header Information:

Loop Id	Data Element	Data Element Description	Data Requirements
1000A	NM108	**Identification Code Qualifier**	46 – Electronic Transmitter Identification Number
1000A	NM109	**Identification Code**	Provider Federal Tax ID Number
1000B	NM108	**Identification Code Qualifier**	46 – Electronic Transmitter Identification Number
1000B	NM109	**Identification Code**	AultCare Federal Tax ID Number: 341488123 OR Aultra Federal Tax ID Number: 204951704

Billing Provider

Note: Tax ID should be supplied in the associated secondary identification REF segment whenever NPI is supplied for a provider or service facility/location.

Loop Id	Data Element	Data Element Description	Data Requirements
2000A	PRV02	**Reference Identification Qualifier**	PXC
2000A	PRV03	**Reference Identification**	If the rendering provider is the same as the bill-to and pay-to provider is not supplied, the taxonomy code is required in this loop.
2010AA	NM101	**Entity Identifier Code**	85 – Billing Provider
2010AA	NM103	**Name Last or Organization Name**	Provider Name or Group Name
2010AA	NM108	**Identification Code Qualifier**	XX – National Provider Identifier
2010AA	NM109	**Identification Code**	Billing Provider National Provider Identifier **Note:** Billing Provider Tax Identification Number is required in the 2010AA REF Segment.
2010AA	N3	**Billing Provider Address**	Billing Provider Address information required when rendering provider/facility is the same as the

			Bill-to provider.
2010AA	N4	**Billing Provider Location City/State/Zip**	Billing Provider location information required when rendering provider/facility is the same as the Bill-to provider.
2010AA	REF01	**Reference Identification Qualifier**	EI – Employer's Identification Number
2010AA	REF02	**Reference Identification**	Billing Provider Federal Tax ID Number
2010AB	NM101	**Entity Identifier Code**	87 – Pay-to Provider
2010AB	N3	**Pay-To Provider Address**	Pay-to Provider Address information required when rendering provider/facility is the same as the Pay-to provider.
2010AB	N4	**Pay-to Provider Location City/State/Zip**	Pay-to Provider location information required when rendering provider/facility is the same as the Pay-to provider.

Subscriber

Loop Id	Data Element	Data Element Description	Data Requirements
2000B	SBR03	**Reference Identification**	The Group number is not required, but is recommended and will facilitate claim processing.
2000B	SBR04	**Name**	The Group Name is not required, but is recommended.
2000B	SBR09	**Claim Filing Indicator Code**	AultCare and Aultra accept codes: **CI**: Commercial **16**: HMO Medicare Risk
2010BA	NM103	**Name Last or Organization Name**	Subscriber Last Name
2010BA	NM104	**Name First**	Subscriber First Name
2010BA	NM108	**Identification Code Qualifier**	MI – Member Identifier
2010BA	NM109	**Identification Code**	Provide the subscriber's Member ID.
2010BA	N301	**Address Information**	Subscriber's Street Address Required only when the subscriber is the patient. If the subscriber is not the patient then do not send.

2010BA	N401	**City Name**	Subscriber's City Required only when the subscriber is the patient. If the subscriber is not the patient then do not send.
2010BA	N402	**State or Province Code**	Subscriber's Postal State Code Required only when the subscriber is the patient. If the subscriber is not the patient then do not send.
2010BA	N403	**Postal Code**	Subscriber's Postal Code Required only when the subscriber is the patient. If the subscriber is not the patient then do not send.
2010BA	DMG02	**Date Time Period**	Subscriber's Date of Birth. Required when patient is the same as the subscriber.
2010BA	DMG03	**Gender Code**	Subscriber's Gender Code. Required when patient is the same as the subscriber.

2010BA	REF01	**Reference Identification Qualifier**	SY – Social Security Number
2010BA	REF02	**Reference Identification**	Social Security Number
2010BB	NM103	**Name Last or Organization Name**	Populate the field with the payer name. Populate this field with AULTCARE OR Populate this field with AULTRA.
2010BB	NM108	**Identification Code Qualifier**	PI – Payer Identifier
2010BB	NM109	**Identification Code**	Populate the field with the AultCare federal tax id: 341488123 OR Populate the field with the Aultra federal tax id: 204951704.
2010BB	N3 & N4	**Address Information**	Populate the N3 and N4 segments with AultCare address information. AultCare address: 2600 Sixth St SW. Canton, OH 44710 OR Aultra address: PO Box 6060

			Canton, OH 44706

Patient (Dependent)

The patient information should be provided when the subscriber is not the patient.

Loop Id	Data Element	Data Element Description	Data Requirements
2010CA	NM103	**Name Last or Organization Name**	Patient Last Name
2010CA	NM104	**Name First**	Patient First Name
2010CA	N301	**Address Information**	Patient's Street Address
2010CA	N401	**City Name**	Patient's City
2010CA	N402	**State or Province Code**	Patient's Postal State Code
2010CA	N403	**Postal Code**	Patient's Postal Code
2010CA	DMG02	**Date Time Period**	Patient's Date of Birth
2010CA	DMG03	**Gender Code**	Patient's Gender Code

Claim Information

Loop Id	Data Element	Data Element Description	Data Requirements
2300	CLM01	**Claim Submitter's Identifier**	The provider should attempt to make this number unique. This number will be echoed back in the

			835. A unique number will make it easier to identify the claim.
2300	CLM06	**Yes/No Condition or Response Code**	Supplying provider signature on file information may facilitate claim adjudication.
2300	CLM07	**Provider Accept Assignment Code**	Supplying the Medicare assignment code may facilitate claim adjudication.
2300	CLM08	**Yes/No Condition or Response Code**	Supplying benefits assignment information may facilitate claim adjudication.
2300	DTP01	**Date/Time Qualifier**	431 – Onset of current illness or symptom
2300	DTP03	**Date Time Period**	The date of the illness or incident that caused the illness may speed up the processing of the claim for certain types of claims.
2300	DTP01	**Date/Time Qualifier**	454 – Initial Treatment
2300	DTP03	**Date Time Period**	The date of the initial treatment may speed up the processing of the claim for certain types of claims.
2300	DTP01	**Date/Time Qualifier**	439 – Accident

2300	DTP03	**Date Time Period**	If the claim is for an accident, then the accident date is required.
2300	DTP01	**Date/Time Qualifier**	484 – Last Menstrual Period
2300	DTP03	**Date Time Period**	Required when claim involves pregnancy.
2300	DTP01	**Date/Time Qualifier**	455- Last X-Ray
2300	DTP03	**Date Time Period**	Required for chiropractor claims; and claims involving spinal manipulation.
2300	DTP01	**Date/Time Qualifier**	471- Prescription
2300	DTP03	**Date Time Period**	Required when a prescription has been written for hearing devices or vision frames and lenses and is included with this claim.
2300	DTP01	**Date/Time Qualifier**	360- Disability Begin
2300	DTP03	**Date Time Period**	The disability begin date may speed up the processing of the claim for certain types of claims.
2300	DTP01	**Date/Time Qualifier**	361- Disability End
2300	DTP03	**Date Time Period**	The disability end date may speed up the processing of the claim for

			certain types of claims.
2300	DTP01	**Date/Time Qualifier**	297- Date Last Worked
2300	DTP03	**Date Time Period**	The last work date may speed up the processing of the claim for certain types of claims.
2300	DTP01	**Date/Time Qualifier**	296- Return to Work Date
2300	DTP03	**Date Time Period**	The return to work date may speed up the processing of the claim for certain types of claims.
2300	DTP01	**Date/Time Qualifier**	435- Admission Date
2300	DTP03	**Date Time Period**	Required on all claims/encounters that involve a patient hospital admission.
2300	DTP01	**Date/Time Qualifier**	096- Discharge Date
2300	DTP03	**Date Time Period**	Required for inpatient claims; this field indicates when a patient is discharged from a facility.
2300	DTP01	**Date/Time Qualifier**	090-Assumed Care Date
2300	DTP03	**Date Time Period**	Required for Medicare claims.

2300	DTP01	**Date/Time Qualifier**	091-Relinquished Care Date
2300	DTP03	**Date Time Period**	Required for Medicare claims.
2300	AMT01	**Amount Qualifier Code**	F5 – Patient Amount Paid
2300	AMT02	**Monetary Amount**	For correct payment, please indicate any amounts the patient paid toward the service.
2300	REF01	**Reference Identification Qualifier**	G1 – Prior Authorization Number
2300	REF02	**Reference Identification**	If the service had prior authorization, then include the authorization number for faster processing.
2300	REF01	**Reference Identification Qualifier**	4N – Service authorization exception code
2300	REF02	**Reference Identification**	Required when providers are required by state law. (e.g. Medicaid in some states)
2300	REF01	**Reference Identification Qualifier**	F5 – Mandatory Medicare Crossover indicator
2300	REF02	**Reference Identification**	Required only for Medicare Crossover claims.
2300	NTE02	**Description**	Note: Text should not be sent unless absolutely

			necessary to explain the claim. Note: Injury details should be supplied when applicable (e.g. when, where, how, etc.) AultCare and Aultra highly recommend accident detail in the NTE segment to expedite claim consideration for accident related claims.
2300	HI01-1	**Code List Qualifier Code**	ABK – Principle Diagnosis
2300	HI01-2	**Industry Code**	ICD-10 Primary Diagnosis required; additional diagnosis codes supplied as needed. Note: Codes beginning with an E (E-codes) can be provided to supply accident information.
2300	HCP	**Claim Pricing / Repricing Information**	Supply when applicable.
2310A	NM101	**Entity Identifier Code**	DN – Referring Provider
2310A	NM103	**Name Last or Organization Name**	Referring Provider Last Name
2310A	NM104	**Name First**	Referring Provider First Name

2310A	NM108	**Identification Code Qualifier**	XX – National Provider Identifier
2310A	NM109	**Identification Code**	Referring Provider National Provider Identifier **Note:** Referring Provider Tax Identification Number is required in the 2310A REF Segment.
2310A	REF01	**Reference Identification Qualifier**	G2 – Provider Commercial Number which is the Provider Federal Tax ID Number
2310A	REF02	**Reference Identification**	Referring Provider Federal Tax ID Number
2310B	NM101	**Entity Identifier Code**	82 – Rendering Provider
2310B	NM103	**Name Last or Organization Name**	Rendering Provider Last Name
2310B	NM104	**Name First**	Rendering Provider First Name
2310B	NM108	**Identification Code Qualifier**	XX – National Provider Identifier
2310B	NM109	**Identification Code**	Rendering Provider National Provider Identifier **Note:** Rendering Provider Tax Identification Number is required in the 2310B REF Segment.

2310B	PRV01	**Provider Code**	PE – Performing
2310B	PRV02	**Reference Identification Qualifier**	PXC – Health Care Provider Taxonomy Code
2310B	PRV03	**Reference Identification**	PRV- Billing Provider Specialty
2310B	REF01	**Reference Identification Qualifier**	G2 – Provider Commercial Number which is the Rendering Provider Federal Tax ID Number
2310B	REF02	**Reference Identification**	Rendering Provider Federal Tax ID Number
2310C	NM101	**Entity Identifier Code**	77 - Facility
2310C	NM103	**Name Last or Organization Name**	Laboratory or Service Facility Name
2310C	NM108	**Identification Code Qualifier**	XX – National Provider Identifier
2310C	NM109	**Identification Code**	Laboratory or Service Facility National Provider Identifier
2310C	N3	**Service Facility Address**	Service Facility address information required for claim adjudication.
2310C	N4	**Service Facility Location City/State/Zip**	Service Facility location information required for claim adjudication.

2310C	REF01	Reference Identification Qualifier	G2 – Provider Commercial Number which is the Service Facility Tax ID Number.
2310C	REF02	Reference Identification	Service Facility Tax ID Number.
2310D	NM101	**Entity Identifier Code**	DQ – Supervising Provider
2310D	NM103	**Name Last or Organization Name**	Supervising Provider Last Name
2310D	NM104	**Name First**	Supervising Provider First Name
2310D	NM108	**Identification Code Qualifier**	XX – National Provider Identifier
2310D	NM109	**Identification Code**	Supervising Provider National Provider Identifier
2310D	REF01	**Reference Identification Qualifier**	G2 – Provider Commercial Number which is the Supervising Provider Federal Tax ID Number.
2310D	REF02	**Reference Identification**	Supervising Provider Secondary Identifier
2320	CAS	**Claim Level Adjustments:** **Claim Adjustment Group Code** **Adjustment Reason Code** **Adjustment Amount** **Adjustment Quantity**	Supply when applicable to the claim.
2320	AMT	**Coordination of Benefits:** **Payer Paid Amount** **Remaining Patient Liability** **Total Non-Covered Amount**	Provide COB and Medicare amounts when applicable to the claim.

		Medicare Inpatient Adjudication **Medicare Outpatient Adjudication**	

Other Subscriber Information

Supply other subscriber information when pertinent to the claim.

Service Line Information

Loop Id	Data Element	Data Element Description	Data Requirements
2400	SV101-1	**Product/Service ID Qualifier**	HC – CPT or HCPCS codes **Note:** A maximum of 50 lines can be accepted by AultCare and Aultra.
2400	SV101-2	**Product/Service ID**	Procedure code
2400	SV101-3 SV101-4 SV101-5 SV101-6	**Procedure Modifier**	Procedure Modifiers 1 – 4 are required when the reporting accuracy of the associated procedure code is improved.
2400	SV102	**Monetary Amount**	Line item charge amount. Note: Positive values only.

2400	SV103	**Unit or Basis for Measurement Code**	UN – Units, used for most cases. MJ – Minutes for Anesthesia claims.
2400	SV104	**Quantity**	Units or Minutes for this claim line.
2400	SV105	**Facility Code Value**	The place of service is required, unless presented at the claim level.
2400	SV107 – 1	**Diagnosis Code Pointer**	The first diagnosis code is required. Use remaining diagnosis pointers if needed to substantiate medical treatment.
2400	SV109	**Yes/No Condition or Response Code**	Emergency indicator is required when service is known to be an emergency by the provider.
2400	SV111	**Yes/No Condition or Response Code**	EPSDT indicator is required if Medicaid services are result of a screening referral.
2400	SV112	**Yes/No Condition or Response Code**	Family Planning indicator is required for Medicaid claims.
2400	SV5	**Durable Medical Equipment Service**	Required when reporting rental/purchase price information for DME.
2400	DTP01	**Date/ Time Qualifier**	472 – Service Date

2400	DTP02	**Date Time Period Format Qualifier**	The service date for the procedure.
2400	HCP	**Line Pricing / Repricing Information**	Supply when applicable.
2400	NTE02	**Description**	AultCare highly recommends supplying additional information regarding service rendered detail (e.g. for unlisted procedures, dosage, etc.)
2430	SVD	**Line Adjudication Information**	Supply this information when applicable.
2430	CAS	**Line Adjustment** **Claim Adjustment Group Code** **Claim Adjustment Reason Code** **Adjustment Amount** **Adjustment Quantity**	Supply this information when applicable.

Service Line Segments

Information provided within the service line 2400 loop that overrides information provided within the claim level 2300 loop should follow the same guidelines defined at the claim loop level. **Note:** Different providers for the same claim cannot be sent at the service line segment level. Only one rendering provider can be associated with each claim.

Trailers

Transaction Set Trailer: These segments are consistent with the HIPAA implementation Guide.

3. Institutional Claim Data Requirements

The tables in this chapter cover the data that is required for an institutional or hospital claim. The data presented is not all of the data required for a claim, only the data that needs clarification or further description of the expected data. Institutional claims cover both inpatient and outpatient services.

Headers

Transaction Set Header: Consistent with the HIPAA implementation Guide.

Beginning of Hierarchical Transaction: Consistent with the HIPAA implementation Guide.

Submitter/Receiver Header Information:

Loop Id	Data Element	Data Element Description	Data Requirements
1000A	NM108	**Identification Code Qualifier**	46 – Electronic Transmitter Identification Number
1000A	NM109	**Identification Code**	Provider Federal Tax ID Number
1000B	NM108	**Identification Code Qualifier**	46 – Electronic Transmitter Identification Number
1000B	NM109	**Identification Code**	AultCare Federal Tax ID Number: 341488123 OR Aultra Federal Tax ID Number: 204951704

Billing Provider

Note: Tax ID should be supplied in the associated secondary identification REF segment whenever NPI is supplied for a provider or service facility/location.

Loop Id	Data Element	Data Element Description	Data Requirements
2000A	PRV02	**Reference Identification Qualifier**	PXC
2000A	PRV03	**Reference Identification**	PRV- Billing Provider Specialty
2010AA	NM101	**Entity Identifier Code**	85 – Billing Provider
2010AA	NM103	**Name Last or Organization Name**	Provider Name or Group Name
2010AA	NM108	**Identification Code Qualifier**	XX – National Provider Identifier
2010AA	NM109	**Identification Code**	Billing Provider National Provider Identifier **Note:** Billing Provider Tax Identification Number is required in the 2010AA REF Segment.
2010AA	N3	**Billing Provider Address**	Billing Provider Address information required when service facility provider is the same as the Bill-to provider.
2010AA	N4	**Billing Provider Location City/State/Zip**	Billing Provider location

			information required when service facility provider is the same as the Bill-to provider.
2010AA	REF01	**Reference Identification Qualifier**	EI – Employer's Identification Number
2010AA	REF02	**Reference Identification**	Billing Provider Federal Tax ID Number
2010AB	NM101	**Entity Identifier Code**	87 – Pay-to Provider
2010AB	N3	**Pay-To Provider Address**	Pay-to Provider Address information required when service facility provider is the same as the Pay-to provider.
2010AB	N4	**Pay-to Provider Location City/State/Zip**	Pay-to Provider location information required when service facility provider is the same as the Pay-to provider.

Subscriber

Loop Id	Data Element	Data Element Description	Data Requirements
2000B	SBR03	**Reference Identification**	The Group number is not required, but is recommended and will facilitate claim processing.
2000B	SBR04	**Name**	The Group Name is not required, but is recommended.
2000B	SBR09	**Claim Filing Indicator Code**	AultCare and Aultra accept codes: **CI**: Commercial Insurance **16**: HMO Medicare Risk
2010BA	NM103	**Name Last or Organization Name**	Subscriber Last Name
2010BA	NM104	**Name First**	Subscriber First Name
2010BA	NM108	**Identification Code Qualifier**	MI – Member Identifier
2010BA	NM109	**Identification Code**	Provide the subscriber's Member ID.
2010BA	N301	**Address Information**	Subscriber's Street Address Required only when the subscriber is the patient. If the subscriber is not the patient then do not send.
2010BA	N401	**City Name**	Subscriber's City

			Required only when the subscriber is the patient. If the subscriber is not the patient then do not send. .
2010BA	N402	**State or Province Code**	Subscriber's Postal State Code Required only when the subscriber is the patient. If the subscriber is not the patient then do not send.
2010BA	N403	**Postal Code**	Subscriber's Postal Code Required only when the subscriber is the patient. If the subscriber is not the patient then do not send.
2010BA	DMG02	**Date Time Period**	Subscriber's Date of Birth. Required when patient is the same as the subscriber.
2010BA	DMG03	**Gender Code**	Subscriber's Gender Code. Required if the subscriber is the patient.
2010BA	REF01	**Reference Identification Qualifier**	SY – Social Security Number

2010BA	REF02	**Reference Identification**	Social Security Number
2010BB	NM103	**Name Last or Organization Name**	Populate the field with the payer name. Populate this field with AULTCARE. OR Populate this field with AULTRA.
2010BB	NM108	**Identification Code Qualifier**	PI – Payer Identifier
2010BB	NM109	**Identification Code**	Populate the field with the AultCare federal tax id: 341488123 OR Populate the field with the Aultra federal tax id: 204951704.
2010BB	N3 & N4	**Address Information**	Populate the N3 and N4 segments with AultCare address information. AultCare address: 2600 Sixth St SW. Canton, OH 44710 OR Aultra address: PO Box 6060 Canton, OH 44706

Patient (Dependent)

The patient information should be provided when the subscriber is not the patient.

Loop Id	Data Element	Data Element Description	Data Requirements
2010CA	NM103	**Name Last or Organization Name**	Patient Last Name
2010CA	NM104	**Name First**	Patient First Name
2010CA	N301	**Address Information**	Patient's Street Address
2010CA	N401	**City Name**	Patient's City
2010CA	N402	**State or Province Code**	Patient's Postal State Code
2010CA	N403	**Postal Code**	Patient's Postal Code
2010CA	DMG02	**Date Time Period**	Patient's Date of Birth
2010CA	DMG03	**Gender Code**	Patient's Gender Code

Claim Information

Loop Id	Data Element	Data Element Description	Data Requirements
2300	CLM01	**Claim Submitter's Identifier**	The provider should attempt to make this number unique. This number will be echoed back in the 835. A unique number will make it easier to identify the claim.
2300	CLM06	**Yes/No Condition or Response Code**	Supplying provider signature on file information may facilitate claim

			adjudication.
2300	CLM07	**Provider Accept Assignment Code**	Supplying the Medicare assignment code may facilitate claim adjudication.
2300	CLM08	**Yes/No Condition or Response Code**	Supplying benefits assignment information may facilitate claim adjudication.
2300	DTP01	**Date/Time Qualifier**	050 – Repricer Received Date
2300	DTP03	**Date Time Period**	Required when a repricer is passing the claim onto the payer.
2300	DTP01	**Date/Time Qualifier**	096 – Discharge
2300	DTP03	**Date Time Period**	Discharge Hour required for final inpatient claims/encounters.
2300	DTP01	**Date/Time Qualifier**	434 – Statement
2300	DTP03	**Date Time Period**	Required statement from or to date.
2300	DTP01	**Date/Time Qualifier**	435 – Date of Admission
2300	DTP03	**Date Time Period**	Admission date required for all inpatient claims.
2300	CL1	**Institutional Claim Code Segment**	Required when reporting hospital based admissions and Medicare outpatient registrations on claims/encounters.
2300	AMT01	**Amount Qualifier Code**	F3 – Patient Responsibility Amount
2300	AMT02	**Monetary Amount**	For correct payment, please indicate any amounts the patient is responsible for

			toward this service.
2300	REF01	**Reference Identification Qualifier**	G1 – Prior Authorization
2300	REF02	**Reference Identification**	If the service had prior authorization, then include the authorization number for faster processing.
2300	REF01	**Reference Identification Qualifier**	4N – Service authorization code
2300	REF02	**Reference Identification**	Required when providers are required by state law (e.g. Medicaid in some states)
2300	REF01	**Reference Identification Qualifier**	9F – Referral Number
2300	REF02	**Reference Identification**	If the service had a referral, then include the referral number for faster processing.
2300	NTE02	**Description**	Note: Text should not be sent unless absolutely necessary to explain the claim. Note: Injury details should be supplied when applicable (e.g. when, where, how, etc.) AultCare highly recommends accident detail in the NTE segment to expedite claim consideration for accident related claims.
2300	HI	**Principal, Admitting, E-Code and Patient Reason, for Visit Diagnosis Information**	Required except as noted in HIPAA implementation guide.

2300	HI	**Diagnosis Related Group Information**	Required when inpatient is under DRG contract.
2300	HI	**Principal Procedure Information**	Required on inpatient claims or encounters when a procedure was performed.
2300	HCP	**Claim Pricing / Repricing Information**	Supply when applicable.
2310A	NM101	**Entity Identifier Code**	71 – Attending Physician
2310A	NM103	**Name Last or Organization Name**	Attending Physician Last Name
2310A	NM104	**Name First**	Attending Physician First Name
2310A	NM108	**Identification Code Qualifier**	XX – National Provider Identifier
2310A	NM109	**Identification Code**	Attending Physician National Provider Identifier **Note:** Attending Physician Tax Identification Number is required in the 2310A REF Segment.
2310A	REF01	**Reference Identification Qualifier**	G2 – Provider Commercial Number which is the Attending Physician Federal Tax ID Number
2310A	REF02	**Reference Identification**	Attending Physician Federal Tax ID Number
2310B	NM101	**Entity Identifier Code**	72 – Operating Physician
2310B	NM103	**Name Last or Organization Name**	Operating Physician Last Name
2310B	NM104	**Name First**	Operating Physician First Name
2310B	NM108	**Identification Code Qualifier**	XX – National Provider Identifier

2310B	NM109	**Identification Code**	Operating Physician National Provider Identifier **Note:** Operating Physician Tax Identification Number is required in the 2310B REF Segment.
2310B	REF01	**Reference Identification Qualifier**	G2 – Provider Commercial Number which is the Operating Physician Federal Tax ID Number
2310B	REF02	**Reference Identification**	Operating Physician Federal Tax ID Number **Note:** The Operating Physician will be accepted when supplied, but is not required.
2310C	NM101	**Entity Identifier Code**	ZZ – Other Operating Physician
2310C	NM103	**Name Last or Organization Name**	Other Operating Physician Last Name
2310C	NM104	**Name First**	Other Operating Physician First Name
2310C	NM108	**Identification Code Qualifier**	XX – National Provider Identifier
2310C	NM109	**Identification Code**	Other Operating Physician National Provider Identifier **Note:** Other Operating Physician Tax Identification Number is required in the 2310C REF Segment.
2310C	REF01	**Reference Identification Qualifier**	G2 – Provider Commercial

			Number which is the Other Operating Physician Federal Tax ID Number
2310C	REF02	**Reference Identification**	Other Operating Physician Federal Tax ID Number **Note:** The Other Operating Physician will be accepted when supplied, but is not required.
2310E	NM101	**Entity Identifier Code**	77 – Facility
2310E	NM103	**Name Last or Organization Name**	Service Facility Name
2310E	NM108	**Identification Code Qualifier**	XX – National Provider Identifier
2310E	NM109	**Identification Code**	Service Facility National Provider Identifier **Note:** Service Facility Tax Identification Number is required in the 2310E REF Segment.
2310E	N3	**Service Facility Address**	Service facility address information required for claim adjudication.
2310E	N4	**Service Facility Location City/State/Zip**	Service Facility location information required for claim adjudication.
2310E	REF01	**Reference Identification Qualifier**	G2 – Provider Commercial Number which is the Service Facility Federal Tax ID Number
2310E	REF02	**Reference Identification**	Service Facility Federal Tax ID Number

2320	CAS	**Claim level Adjustments:** **Claim Adjustment Group Code** **Adjustment Reason Code** **Adjustment Amount** **Adjustment Quantity**	Supply when applicable to the claim.
2320	AMT	**Coordination of Benefits :** **Payer Paid Amount** **Remaining Patient Liability** **COB Non Covered Amount** **Medicare Inpatient Adjudication** **Medicare Outpatient Adjudication**	Provide COB and Medicare amounts when applicable to the claim

Other Subscriber Information

Supply other subscriber information when pertinent to the claim.

Service Line Information

Loop Id	Data Element	Data Element Description	Data Requirements
2400	SV201-1	**Product/Service ID Qualifier**	Revenue Code Note: A maximum of 999 lines can be accepted by AultCare and Aultra.
2400	SV202	**Composite Medical Procedure Identifier**	Required when an appropriate HCPCS code and modifiers exist for this service line item.
2400	SV203	**Monetary Amount**	Line item charge amount.
2400	SV204	**Unit or Basis for Measurement Code**	Specify the way units will be supplied.
2400	SV205	**Quantity**	Supply quantity of units.
2400	SV207	**Monetary Amount**	Supply non-covered money amount when line

			item is not covered.
2400	DTP	**Service Line Date**	Supply when required by revenue, procedure, drug codes, or HIEC code.
2400	HCP	**Line Pricing / Repricing Information**	Supply when applicable.
2410	LIN	**Drug Identification**	Supply drug information as needed for claim adjudication.
2430	SVD	**Line Adjudication Information**	Supply this information when applicable.
2430	CAS	**Line Adjustment** **Claim Adjustment Group Code** **Claim Adjustment Reason Code** **Adjustment Amount** **Adjustment Quantity**	Supply this information when applicable.

Service Line Segments

Information provided within the service line 2420 loop that overrides information provided within the claim level 2300 loop should follow the same guidelines defined at the claim loop level. **Note:** Different providers for the same claim cannot be sent at the service line segment level. Only one rendering provider can be associated with each claim.

Trailers

Transaction Set Trailer: These segments are consistent with the HIPAA implementation Guide.

4. Dental Claim Data Requirements

The tables in this chapter cover the data that is required for dental claims. .

Headers

Transaction Set Header: Consistent with the HIPAA implementation Guide.

Beginning of Hierarchical Transaction: Consistent with the HIPAA implementation Guide.

Submitter/Receiver Header Information:

Loop Id	Data Element	Data Element Description	Data Requirements
1000A	NM108	**Identification Code Qualifier**	46 – Electronic Transmitter Identification Number
1000A	NM109	**Identification Code**	Provider Federal Tax ID Number
1000B	NM108	**Identification Code Qualifier**	46 – Electronic Transmitter Identification Number
1000B	NM109	**Identification Code**	AultCare Federal Tax ID Number: 341488123 OR Aultra Federal Tax ID Number: 204951704

Billing Provider

Note: Tax ID should be supplied in the associated secondary identification REF segment whenever NPI is supplied for a provider or service facility/location.

Loop Id	Data Element	Data Element Description	Data Requirements
2000A	PRV02	**Reference Identification Qualifier**	PXC
2000A	PRV03	**Reference Identification**	If the rendering provider is the same as the bill-to and pay-to provider and is not supplied, the taxonomy code is required in this loop.
2010AA	NM101	**Entity Identifier Code**	85 – Billing Provider
2010AA	NM103	**Name Last or Organization Name**	Provider Name or Group Name
2010AA	NM108	**Identification Code Qualifier**	XX – National Provider Identifier
2010AA	NM109	**Identification Code**	Billing Provider National Provider Identifier **Note:** Billing Provider Tax Identification Number is required in the 2010AA REF Segment.
2010AA	N3	**Billing Provider Address**	Billing Provider Address information required when rendering provider/facility is

			the same as the Bill-to provider.
2010AA	N4	**Billing Provider Location City/State/Zip**	Billing Provider location information required when rendering provider/facility is the same as the Bill-to provider.
2010AA	REF01	**Reference Identification Qualifier**	EI – Employer's Identification Number
2010AA	REF02	**Reference Identification**	Billing Provider Federal Tax ID Number
2010AB	NM101	**Entity Identifier Code**	87 – Pay-to Provider
2010AB	N3	**Pay-To Provider Address**	Pay-to Provider Address information required when rendering provider/facility is the same as the Pay-to provider.
2010AB	N4	**Pay-to Provider Location City/State/Zip**	Pay-to Provider location information required when rendering provider/facility is the same as the Pay-to provider.

Subscriber

Loop Id	Data Element	Data Element Description	Data Requirements
2000B	SBR03	**Reference Identification**	The Group number is not required, but is recommended and will facilitate claim processing.
2000B	SBR04	**Name**	The Group Name is not required, but is recommended.
2010BA	NM103	**Name Last or Organization Name**	Subscriber Last Name
2010BA	NM104	**Name First**	Subscriber First Name
2010BA	NM108	**Identification Code Qualifier**	MI – Member Identifier
2010BA	NM109	**Identification Code**	Provide the subscriber's Member ID.
2010BA	N301	**Address Information**	Subscriber's Street Address Required only when the subscriber is the patient. If the subscriber is not the patient then do not send.
2010BA	N401	**City Name**	Subscriber's City Required only when the subscriber is the patient. If the subscriber is not

			the patient then do not send.
2010BA	N402	**State or Province Code**	Subscriber's Postal State Code Required only when the subscriber is the patient. If the subscriber is not the patient then do not send.
2010BA	N403	**Postal Code**	Subscriber's Postal Code Required only when the subscriber is the patient. If the subscriber is not the patient then do not send.
2010BA	DMG02	**Date Time Period**	Subscriber's Date of Birth. Required when patient is the same as the subscriber.
2010BA	DMG03	**Gender Code**	Subscriber's Gender Code. Required when patient is the same as the subscriber.
2010BA	REF01	**Reference Identification Qualifier**	SY – Social Security Number
2010BA	REF02	**Reference Identification**	Social Security Number
2010BB	NM103	**Name Last or Organization Name**	Populate the field with the payer name.

			Populate this field with AULTCARE OR Populate this field with AULTRA.
2010BB	NM108	**Identification Code Qualifier**	PI – Payer Identifier
2010BB	NM109	**Identification Code**	Populate the field with the AultCare federal tax id: 341488123 OR Populate the field with the Aultra federal tax id: 204951704.
2010BB	N3	**Address Information**	Populate the N3 segment with AultCare address information. AultCare address: 2600 Sixth St SW. Canton, OH 44710 OR Aultra address: PO Box 6060 Canton, OH 44706

Patient (Dependent)

The patient information should only be provided if the subscriber is not the patient.

Loop Id	Data Element	Data Element Description	Data Requirements
2010CA	NM103	**Name Last or Organization Name**	Patient Last Name
2010CA	NM104	**Name First**	Patient First Name
2010CA	N301	**Address Information**	Patient's Street Address
2010CA	N401	**City Name**	Patient's City
2010CA	N402	**State or Province Code**	Patient's Postal State Code
2010CA	N403	**Postal Code**	Patient's Postal Code
2010CA	DMG02	**Date Time Period**	Patient's Date of Birth
2010CA	DMG03	**Gender Code**	Patient's Gender Code

Claim Information

Loop Id	Data Element	Data Element Description	Data Requirements
2300	CLM01	**Claim Submitter's Identifier**	The provider should attempt to make this number unique. This number will be echoed back in the 835. A unique number will make it easier to identify the claim.

2300	DTP01	**Date/Time Qualifier**	439 – Accident
2300	DTP03	**Date Time Period**	If the claim is for an accident, then the accident date is required.
2300	DTP01	**Date/Time Qualifier**	452 – Appliance Placement
2300	DTP03	**Date Time Period**	Supply appliance placement date.
2300	DTP01	**Date/Time Qualifier**	050 – Repricer received date
2300	DTP03	**Date Time Period**	Required when a repricer is passing the claim onto the payer.
2300	DN1	**Quantity**	Indicate the number of months of orthodontic treatment.
2300	DN2	**Reference Identification**	Tooth number needed for services other than preventative care.
2300	DN2	**Tooth Status Code**	Required for services other preventative care.
2300	REF01	**Reference Identification Qualifier**	G3 – Predetermination of Benefits Identification Number
2300	REF02	**Reference Identification**	If the request is for predetermination of benefits, then enter the code here.

2300	REF01	**Reference Identification Qualifier**	9F- Referral Number
2300	REF02	**Reference Identification**	If the service was the result of a referral, please enter the referral number.
2300	NTE02	**Description**	Note: Text should not be sent unless absolutely necessary to explain the claim. Note: Injury details should be supplied when applicable (e.g. when, where, how, etc.) AultCare and Aultra highly recommend accident detail in the NTE segment to expedite claim consideration for accident related claims.
2310B	NM101	**Entity Identifier Code**	82 – Rendering Provider
2310B	NM103	**Name Last or Organization Name**	Rendering Provider Last Name
2310B	NM104	**Name First**	Rendering Provider First Name
2310B	NM108	**Identification Code Qualifier**	XX – National Provider Identifier

2310B	NM109	**Identification Code**	Rendering Provider National Provider Identifier **Note:** Rendering Provider Tax Identification Number is required in the 2310B REF Segment.
2310B	PRV01	**Provider Code**	PE – Performing
2310B	PRV02	**Reference Identification Qualifier**	PXC – Health Care Provider Taxonomy Code
2310B	PRV03	**Reference Identification**	The taxonomy code is required in this loop.
2310B	REF01	**Reference Identification Qualifier**	G2 – Provider Commercial Number which is the Provider Federal Tax ID Number
2310B	REF02	**Reference Identification**	Rendering Provider Federal Tax ID Number
2310B	REF01	**Reference Identification Qualifier**	0B – State License Number
2310B	REF02	**Reference Identification**	The state license number of the rendering dentist should be supplied.
2310C	NM101	**Entity Identifier Code**	77 – Facility
2310C	NM103	**Name Last or Organization Name**	Facility Name

2310C	NM108	**Identification Code Qualifier**	XX – National Provider Identifier
2310C	NM109	**Identification Code**	Facility Name National Provider Identifier **Note:** Facility Name Tax Identification Number is required in the 2310C REF Segment.
2310C	N3	**Service Facility Address**	Service Facility address information required for claim adjudication.
2310C	N4	**Service Facility Location City/State/Zip**	Service Facility location information required for claim adjudication.
2310C	REF01	**Reference Identification Qualifier**	G2 – Provider Commercial Number which is the Provider Federal Tax ID Number
2310C	REF02	**Reference Identification**	Service Facility Federal Tax ID Number
2310C	REF01	**Reference Identification Qualifier**	0B – State License Number
2310C	REF02	**Reference Identification**	The state license number of the rendering dentist should be supplied.

Other Subscriber Information

Supply other subscriber information when pertinent to the claim.

Service Line Information

Service line information is consistent with the HIPAA implementation guide. **Note:** Different providers for the same claim cannot be sent at the service line segment level. Only one rendering provider can be associated with each claim.

Trailers

Transaction Set Trailer: These segments are consistent with the HIPAA implementation Guide.

5. Trading Partner Requirements

The information in this chapter explains the procedures a provider or vendor follows to establish electronic file transmission with AultCare and/or Aultra.

837 Electronic Claims Procedures for Providers and/or Vendors:

AultCare and Aultra have established the following procedures for the implementation of the 837 electronic claims file for HIPAA compliance.

Providers and vendors that follow these 837 guidelines will benefit by smooth transition to HIPAA electronic claims submission with minimal interruption of claims processing.

Guidelines:

- Each Provider/Vendor must create a login on AultCare or Aultra website.

  AultCare's website:
  https://www.aultcare.com

  Aultra's website:
  https://www.aultragroup.com

  A Trading Partner Agreement (TPA) is included in this login process. Login instructions are located within "Website How To Guides" on the following website:
  https://www.aultcare.com/hipaa

  Once this is completed, AultCare will provide logins and passwords to the Payor Connectivity Services (PCS) System that is utilized for HIPAA Transactions.

- An 837 Companion Guide is located under Forms on AultCare or Aultra's website.

- Successful 837 testing should be completed and approved by AultCare and/or Aultra prior to submitting a production file.

Please forward questions to edisupport@aultcare.com

Testing Procedure:

The following testing procedure must be completed by providers and/or vendors prior to receiving authorization to submit production 837 HIPAA Transactions.

- A test file will need to be submitted utilizing Secure File Transfer Protocol (SFTP) or by manually uploading files directly into the test PCS system.
- Usage Indicator (ISA15) must be a "T".
- Test files should contain only twenty records.
- Test file naming convention.
    - For professional – HCFA.
        - "H837P(-company name-)MMDDYYYY(-month, day, year-).txt"
    - For Institutional – (UB92).
        - "H837I (-company name-)MMDDYYYY(-month, day, year-).txt"
    - For Dental.
        - "H837D (-company name-)MMDDYYYY(-month, day, year-).txt"
- Submit Test 837 files to the following website: https://aultcaretest.payorconnectivity.com or the SFTP Site at https://infoexchange.changehealthcare.com if access has been setup.
- It is the submitter's responsibility to retrieve response/acknowledgements (TA1, 999, 277CA) from the PCS system. Refer to the Response/Acknowledgement section of this document for additional details. Submitter's utilizing SFTP to submit files will receive acknowledgements utilizing this process.
- AultCare will provide approval to begin submitting production 837 HIPAA Transactions. They will provide a production login and password to utilize for these transactions.
- Prior to making modifications to production files, a test file containing the modifications should be submitted to AultCare for review prior to making changes in production.

Please contact edisupport@aultcare.com with any questions.

Production Submission Procedures:

- Utilize the production Login and Password to submit Production files.
- Change Usage Indicator (ISA15) from T to P.
- Production files are distinguished from test files by the file name. Use the following naming convention when submitting production files:

  PH837fxxxxxxxxxMMDDCCYYX.txt

  PH837 Production file name prefix

  F Indicates file type I, P, or D (Institutional, Professional, or Dental)

  xxxxx Company name

  MMDD Month and Day

  CCYY Century and Year

  X This suffix value is required only when multiple files are transmitted for the same day. The value begins with A and increments with each file. A date and time stamp may be used as well, as long as the file names are unique.

  Single File Example: PH837PCOMPANYX10272011.txt

  Multiple Files Example: PH837PCOMPANYX10272011A.txt
  PH837PCOMPANYX10272011B.txt

- Submit production files using the following website: https://aultcare.payorconnectivity.com or the SFTP Site at https://infoexchange.changehealthcare.com if access has been setup.

Remember to inform AultCare and Aultra regarding changes that affect submission. Some examples would be change in vendor, software version, submission method, and tax id changes

RESPONSE/ACKNOWLEDGEMENTS

- Files received prior to 21:30 CST will be acknowledged the same day. Files received between 21:30 CST and 1:30 CST will be acknowledged after 1:30 CST.

- The following Acknowledgements will be available once the file is reviewed for syntax requirements:

    a. TA1 – Interchange Acknowledgement
        i. Produced when an Interchange is rejected. All claims within the Interchange will need to be resubmitted.
    b. 999 – Implementation Acknowledgement
        i. Produced when the file passes the Interchange validation.
        ii. The 999 file produced for 837 files containing more than one Functional Group will provide detail on each Functional Group. Each Functional Group will be reviewed and accepted/rejected separately. Claims within a rejected Functional Group will need to be resubmitted.
        iii. A HIPAA 837 file will be generated containing claims rejected within the Functional Group. This file can be identified by the file extension (.badedi)

- The following Acknowledgment will be available once the file is reviewed for eligibility requirements:
    a. 277CA – Claim Level Acknowledgement
        i. The 277CA will reflect the status of all claims. Claims that are accepted will reflect a 20 "Accepted for processing" in segment STC01-1 and claims that are rejected will reflect a 33 "Subscriber and subscriber id not found" in segment STC01-1.
            1. The 33 status code will be produced when the Member Identification Number (ID) submitted in the 837 file does not match eligibility contained in the Payer Connectivity Services (PCS) System. The eligibility contained in this system is as follows:
                a. Two years plus current for all product lines with the exception of Primetime Health Plan which contains 3 years plus current. Claims incurred prior to this time will need to be submitted on paper with documentation supporting the reason the claim should be considered.
        ii. A HIPAA 837 file will be generated containing claims that rejected at the claim level. This file can be identified by the file extension (EligFail.edi)
        iii. Claims submitted with the incorrect member ID will need to be resubmitted with the accurate information.

- It is the submitter's responsibility to retrieve acknowledgments and determine the action that needs taken to correct rejected files, transactions and/or claims.

TA1 Interchange Acknowledgement

A TA1 interchange acknowledgement to verify the syntactical accuracy of the envelope of the X12 interchange. A TA1 response message will always contain the ISA and IEA segments. If the EDI document contains an error at the interchange level, such as in the Interchange Control Header (ISA) segment or the Interchange control trailer (IEA), then the interchange acknowledgement will also only contain the ISA, TA1, and IEA segments.

ISA*00* *00* *ZZ*888888888 *ZZ*999999999 *101220*1801*U*00401*000002848*0*T*:~TA1*010001728*101208*0701*R*006~IEA*0*000002848~

PCS ISA-IEA Validation

Syntax validation is performed on all inbound 837 files. Validation failures are rejected at the ISA-IEA level with a TA1. The invalid data is returned to the Submitter along with the TA1 report indicating the reason for rejection.

Element	Purpose
Interchange control number	This number uniquely identifies the interchange. The sender assigns the interchange control number and this together with the sender ID uniquely identifies the interchange data to the recipient.
Interchange Date	This mandatory element indicates the date that the interchange was prepared. This information is in the *YYMMDD* format.
Interchange Time	This mandatory element indicates the time that the interchange was prepared. This information is in the 24-hour clock format.
Interchange Acknowledgement Code	This code is mutually agreed between the trading partners such as: • A= Accepted • R= Rejected • E= Accepted, but the file contains errors and must not be resubmitted
Interchange Note	This is a three-digit number that corresponds to one of the following note

Code	codes: • 000 No Errors • 001 The Interchange Control Number in the Header and Trailer do not match. The value in the header is used as an acknowledgement. • 002 The Standard as noted in the Control Standards Identifier is not supported. • 003 The version of the controls is not supported. • 004 The segment terminator is not valid. • 005 Invalid interchange ID qualifier for sender. • 006 Invalid interchange ID for sender. • 007 Invalid interchange ID qualifier for recipient. • 008 Invalid interchange ID for recipient. • 009 Unknown interchange receiver ID. • 010 Invalid Authorization Information Qualifier Value. • 011 Invalid Authorization Information Value. • 012 Invalid Security Information Qualifier Value. • 013 Invalid Security Information Value. • 014 Invalid Interchange Date Value. • 015 Invalid Interchange Time Value. • 016 Invalid Interchange Standards ID Value. • 017 Invalid Interchange Version ID number. • 018 Invalid Interchange Control Number. • 019 Invalid Acknowledgement Request Value. • 020 Invalid Test Indicator value. • 021 Invalid Number of Included Group Value. • 022 Invalid control structure. • 023 Improper end of file. • 024 Invalid Interchange content.

	• 025 Duplicate Interchange Control Number. • 026 Invalid Data Element Separator. • 027 Invalid Component element Separator. • 028 Invalid Delivery date in the Deferred Delivery Request. • 029 Invalid Delivery time in the Deferred Delivery Request. • 030 Invalid Delivery time code in the Deferred Delivery Request. • 031 Invalid grade of service code.

999 Implementation Acknowledgements

The 999 functional acknowledgements indicate the results of analysis of the syntax of the functional groups and documents in an X12 interchange. When an error occurs in a document receiving a functional acknowledgement, the sender can reformat the document according to the correct syntax, and then resubmit the document.

ISA*00* *00* *ZZ*888888888 *ZZ*999999999
*110930*1255*^*00501*000000001*0*P*:~
GS*FA*888888888*999999999*20110930*125504*1*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HC*367350075*005010X222A1~
AK2*837*0001*005010X222A1~
IK5*A~
AK2*837*0002*005010X222A1~
IK5*A~
AK2*837*0003*005010X222A1~
IK5*A~
AK2*837*0004*005010X222A1~
IK5*A~
AK2*837*0005*005010X222A1~
IK5*A~
AK2*837*0006*005010X222A1~
IK5*A~
AK9*A*6*6*6~
SE*16*0001~
GE*1*1~
IEA*1*000000001~

PCS ST-SE Validation

Files that passed the syntax validation are forwarded on for claim level processing. Claims are validated against the HIPAA SNIP 1-3 guidelines. Claim validation failures are rejected at the transaction set level ST-SE, meaning that if a transaction set has multiple claims and one claim is found to be invalid the entire transaction set is rejected at the ST-SE level. All claims within that transaction set will be returned to the submitter along with the 999 indicating the reason for the rejection. If any of the transaction set is rejected, the 999 will return an AK5*R~ for that particular ST-SE. The AK9* is used to report on the status of all transaction sets within the file.

ST Segment

The ST segment acts as the Transaction Set Header segment of an X12 document (transaction set). The ST segment indicates the start of a transaction set in an interchange, and contains the following mandatory elements. The elements in the ST segment identify the identifier code for the transaction set and the identifying control number.

Element	Purpose
Transaction Set Identifier Code	This element contains the identifier code for the transaction set, for example 837.
Transaction Set Control Number	This element contains the identifying control number assigned by the sender of the transaction set.

AK1 Segment

The AK1 segment is mandatory in a 999 acknowledgement. The purpose of this segment is to start the acknowledgement of a functional group. The elements in the AK1 segment provide information about the functional groups being acknowledged.
The AK1 segment consists of the following mandatory elements.

Element	Purpose
Functional Identifier Code	This code identifies a group of application-related transaction sets.
Group Control Number	The original sender of the transaction set assigns this control number; this number refers to the functional groups being acknowledged.

ISA*00* *00* *ZZ*888888888 *ZZ*999999999
*110930*1148*^*00501*000000001*0*T*:~
GS*FA*888888888*999999999*20110930*114844*1*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HC*38*005010X222A1~
AK2*837*38001*005010X222A1~
IK3*CLM*22*2300*8~
IK4*1*1028*7* ~
IK5*R*5~
AK9*R*1*1*0~
SE*8*0001~
GE*1*1~
IEA*1*000000001~

AK2 Segment

The AK2 segment is an optional segment in the 999 response file. The function of the AK2 segment is to indicate the start of a single transaction set. The elements in the AK2 segment identify the transaction set.
The following table lists the elements that the AK2 segment contains.

Element	Purpose
Transaction Set Identifier Code	The sender assigns this code. This code identifies the transaction set.
Transaction Set Control	The control number is unique in the transactional set functional group.

Number	The original sender of the data assigns this control number.

ISA*00* *00* *ZZ*888888888 *ZZ*999999999
*110930*1148*^*00501*000000001*0*T*:~
GS*FA*888888888*999999999*20110930*114844*1*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HC*38*005010X222A1~
AK2*837*38001*005010X222A1~
IK3*CLM*22*2300*8~
IK4*1*1028*7* ~
IK5*R*5~
AK9*R*1*1*0~
SE*8*0001~
GE*1*1~
IEA*1*000000001~

IK3 Segment

The IK3 segment is an optional segment in a 999 functional acknowledgement. The function of this segment is to report errors in, and the location of, a data segment. The elements in the IK3 segment identify the location of the segment containing syntactical errors.
The following table lists the elements that the IK3 segment contains.

Element	Purpose
Segment Id Code	This code identifies the code ID of the data segment containing the error.
Segment position in transaction set	This element counts the location of the segment containing syntactical errors from the start of the transaction set.
Segment Syntax Error Code	This optional element indicates the syntactical error found in the segment.

ISA*00* *00* *ZZ*888888888 *ZZ*999999999
*110930*1148*^*00501*000000001*0*T*:~
GS*FA*888888888*999999999*20110930*114844*1*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HC*38*005010X222A1~
AK2*837*38001*005010X222A1~
IK3*CLM*22*2300*8~
IK4*1*1028*7* ~
IK5*R*5~
AK9*R*1*1*0~
SE*8*0001~
GE*1*1~
IEA*1*000000001~

IK4 Segment

The IK4 segment is an optional segment in a 999 functional acknowledgement. The function of the IK4 segment is to provide details about, and report the location of, erroneous data elements. The elements in the IK4 segment provide information about the syntax error and the position of the erroneous element in the segment.

The following table lists the elements that the IK4 segment contains.

Element	Purpose
Element Position in Segment	This mandatory element indicates the relevant position of the erroneous data element in a data segment.
Data Element Reference Number	You use this optional element to find the data element in the data element dictionary.
Data Element Syntax Error Code	This code indicates errors found after the element has been syntactically edited. • 1= Mandatory Element Missing • 2= Conditional required data element missing • 3= Too many data elements • 4= Data element too short • 5= Data element too long • 6= Invalid character in data element • 7= Invalid code value
Copy of bad element	This is a copy of the erroneous data element.

ISA*00* *00* *ZZ*888888888 *ZZ*999999999
*110930*1148*^*00501*000000001*0*T*:~
GS*FA*888888888*999999999*20110930*114844*1*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HC*38*005010X222A1~
AK2*837*38001*005010X222A1~
IK3*CLM*22*2300*8~
IK4*1*1028*7* ~
IK5*R*5~
AK9*R*1*1*0~
SE*8*0001~
GE*1*1~
IEA*1*000000001~

IK5 Segment

The IK5 segment is mandatory for the 999 response message. The function of this segment is to acknowledge acceptance or rejection of, and report errors in, the transaction set. The elements in the IK5 segment provide information about whether the transaction set is to be accepted or rejected because of syntactical errors.

The following table lists the elements that the IK5 segment contains.

Element	Purpose
Transaction Set acknowledgement Code	This code indicates whether to accept or reject the condition based on the syntactical editing of the transaction set.
Transaction Set Syntax Error Code	This code in this optional element indicates the error found after the syntactical editing of a transaction set. • 1= Transaction set not supported • 2= Transaction set trailer missing • 3= Transaction set control number in header and trailer do not match • 4= Number of included segments does not match the actual count • 5= One or more segments are in error

ISA*00* *00* *ZZ*888888888 *ZZ*999999999
*110930*1148*^*00501*000000001*0*T*:~
GS*FA*888888888*999999999*20110930*114844*1*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HC*38*005010X222A1~
AK2*837*38001*005010X222A1~
IK3*CLM*22*2300*8~
IK4*1*1028*7* ~
IK5*R*5~
AK9*R*1*1*0~
SE*8*0001~
GE*1*1~
IEA*1*000000001~

AK9 Segment

The AK9 segment is a mandatory segment in a 999 functional acknowledgement. You use this segment to acknowledge the acceptance or rejection of a functional group, and report the number of transaction sets from the original trailer, the accepted sets, and the received sets in this functional group. The elements in the AK9 segment provide information about the number of documents (transaction sets) included in the functional group, and how many of these documents (transaction sets) were accepted by PCS.
The following table lists the elements that the AK9 segment contains.

Element	Purpose
Functional Group Acknowledgement Code	This code indicates whether to accept or reject the conditions based on the syntactical analysis of the functional group. • A= Accepted • E= Accepted, but the file contained errors • P= Partially accepted, but at least one transaction set was rejected • R= Rejected
Number of transaction sets included	This is the total number of transaction sets containing this data element.
Number of Received Transaction sets	The number of transaction sets received.
Number of Accepted Transaction sets	The number of accepted transaction sets in a functional group.

ISA*00* *00* *ZZ*888888888 *ZZ*999999999
*110930*1148*^*00501*000000001*0*T*:~
GS*FA*888888888*999999999*20110930*114844*1*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HC*38*005010X222A1~
AK2*837*38001*005010X222A1~
IK3*CLM*22*2300*8~
IK4*1*1028*7* ~
IK5*R*5~
AK9*R*1*1*0~
SE*8*0001~
GE*1*1~
IEA*1*000000001~

SE Segment
The SE segment indicates the end of an X12 document (transaction set).

The following table lists the mandatory elements that the SE segment contains.

Element	Purpose
Number of Included Segments	This element checks the number of elements in a transaction set.
Transaction Set Control number	This element checks the control number for the transaction set.

ISA*00* *00* *ZZ*888888888 *ZZ*999999999
*110930*1148*^*00501*000000001*0*T*:~
GS*FA*888888888*999999999*20110930*114844*1*X*005010X231A1~
ST*999*0001*005010X231A1~
AK1*HC*38*005010X222A1~
AK2*837*38001*005010X222A1~
IK3*CLM*22*2300*8~
IK4*1*1028*7* ~
IK5*R*5~
AK9*R*1*1*0~
SE*8*0001~
GE*1*1~
IEA*1*000000001~

277CA – Claims Acknowledgement

The 277CA transaction is used in addition to the 999 to report a status on all claims received. Claims that have rejected will need to be resubmitted for consideration. Claims that accepted will be processed accordingly. A current list of 277CA Status Codes can be found at: http://www.wpc-edi.com/content/view/715/1.

PCS Eligibility Verification

Eligibility verification is performed on the claims that pass syntax validation. Eligibility failures are reported at the claim level using the 277CA. Rejections will produce a 277CA with a claim status code of STC*A3:33 indicating that no eligibility match was found. All eligibility rejections in the 837 are returned to the submitter along with the 277CA.

33	Subscriber and subscriber id not found.
20	Accepted for processing

NM1*QC*1*DOE*JOHN*S***XX*UNKNOWN~
TRN*2* A13245678~
STC*A3:33*20101227**597*0~

NM1*QC*1*DECORT*MEAGAN*C***MI*0010096114E~
TRN*2*0003838221~
STC*A1:20*20110928*WQ*46.00~

Please contact edisupport@aultcare.com with any questions.

File Transfer Instructions:

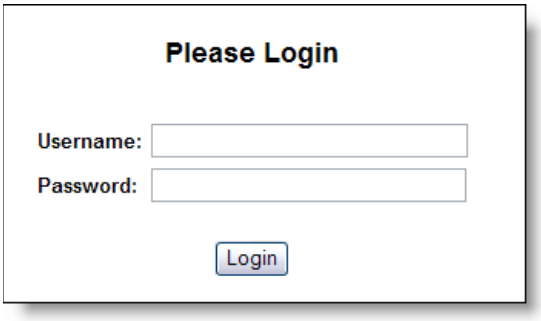
Navigate to one of the following websites:

https://aultcare.payerconnectivityservices.com Production
https://aultcaretest.payorconnectivity.com Test

Login:

1. Type the Username and Password.
    a. Test – Username consists of 8 digits beginning with a "g" and followed by an even numbering scheme. Example: g0000002
    b. Production – Username consists of 8 digits beginning with a "g" and followed by an odd numbering scheme. Example: g0000001

2. Click Login.

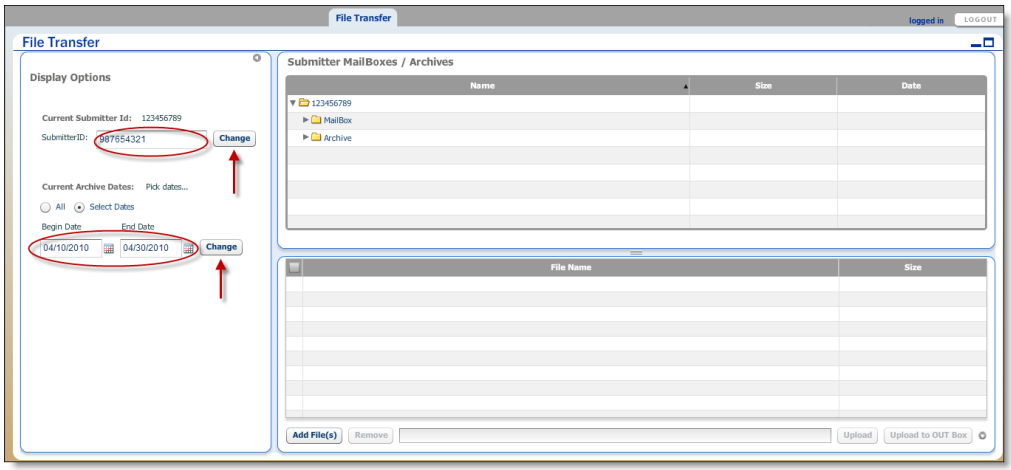


This File Transfer Portal provides the ability to upload files for processing, download response files and retrieve archived files.

Display Options Pane

The **Display Options** pane allows a user to view a submitter's files based on the user's role. Enter the submitter ID and then click **Change**. This will display the file information to the right in the **Submitter Mailboxes/Archives** pane. Most users will see the submitter number with no option for changing the submitter. If the user needs to obtain access to additional submitters, contact the EDI Support team for assistance by emailing www.edisupport@aultcare.com .

This pane also allows the user to search the Archives folder to locate either **All** files or files processed on a **Select Date**.



By default, all files are displayed. To locate files submitted during a specific date range, click **Select Dates**. Use this calendar to enter in the beginning and end dates.

NOTE: If the **Begin Date** is in the previous date range, the calendar will not allow the change except by entering the end date first.

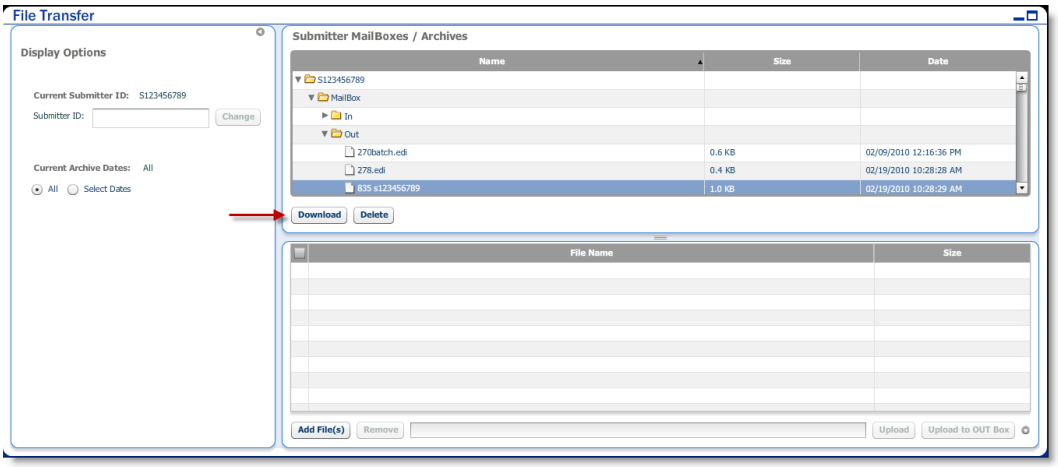
Submitter Mailboxes/Archives Pane

The **Submitter Mailboxes/Archives** pane lists all files for a given submitter. The node next to the submitter folder can be clicked to expand the folder. Below the submitter ID folder is the **Mailbox** and **Archive** folders. Click the node next to the **Mailbox** folder and the **In** and **Out** folders are displayed.

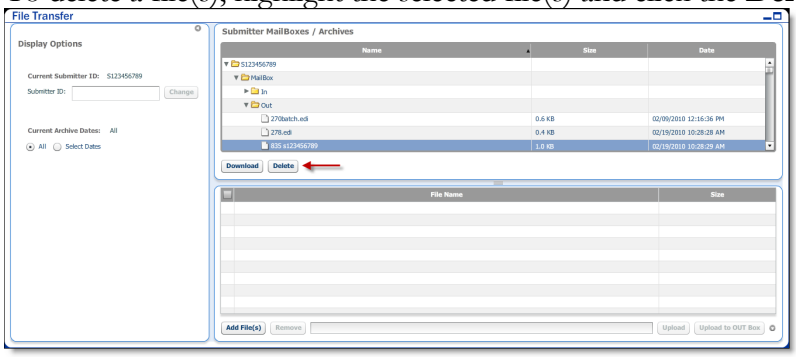
The **In** folder will display the file that was uploaded for a very short period of time. The system polls this folder regularly. When a file is found, the system removes it from the **In** folder and processes the file.

The **Out** folder contains all of the files that have processed as well as the response files for that submitter. These files can be saved to a local computer or deleted.

To download a file from the **Out** folder, highlight the selected file(s) to be downloaded to a local computer and click the **Download** button. A screen from the local computer will appear allowing the choice of where the file(s) should be saved. Select the appropriate location, click **Save**.



To delete a file(s), highlight the selected file(s) and click the **Delete** button.

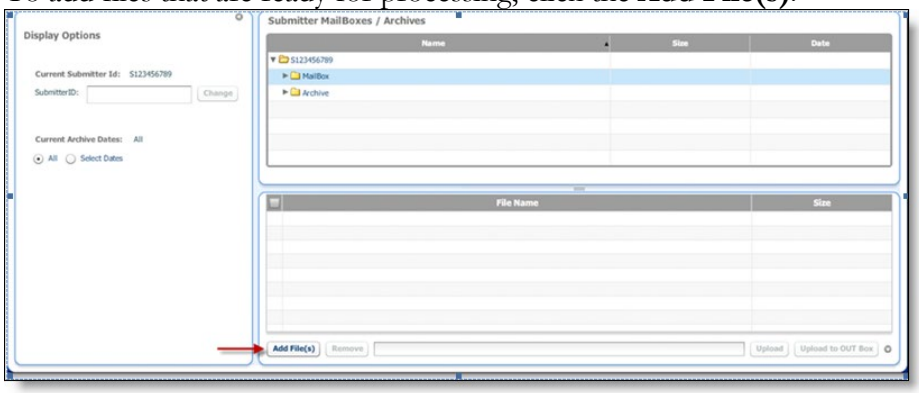


A **Delete file(s)** screen will appear showing the question "Are you sure you want to delete 1 file(s)." To confirm, click **Yes**.

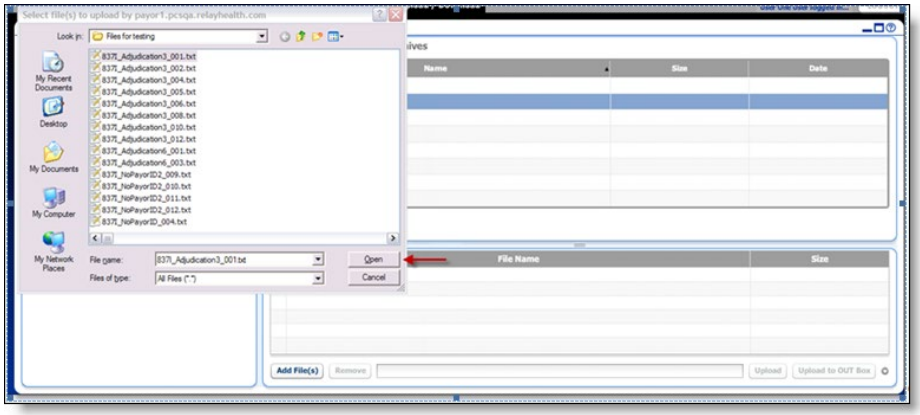
NOTE: Files from the **Archive** folder cannot be deleted.

Add Files

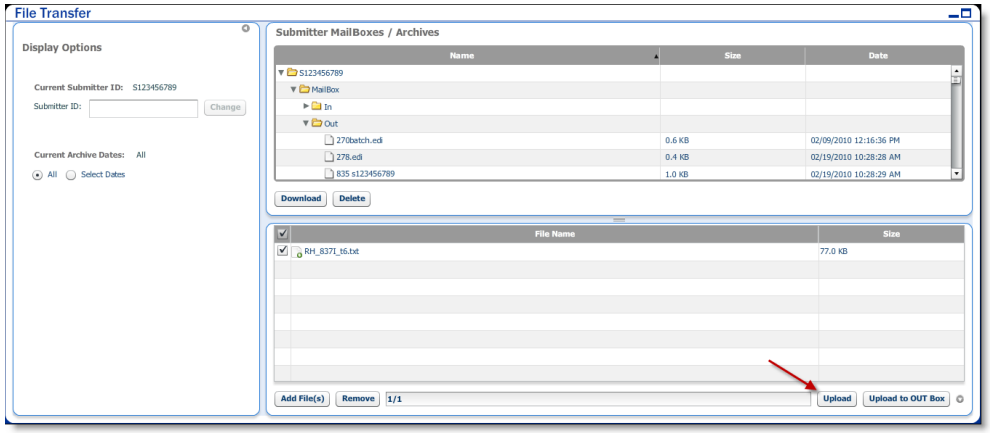
To add files that are ready for processing, click the **Add File(s)**.



Find and select the file(s) that should be added to PCS from a local computer.

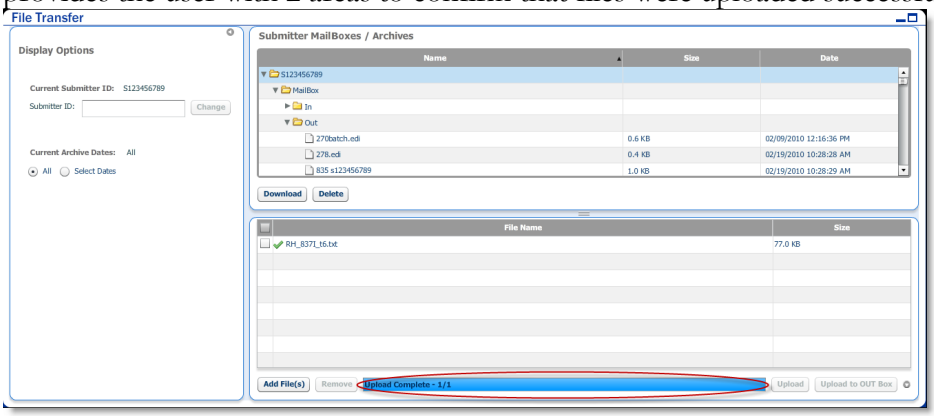


The selected file(s) are added to the upload pane. There will be a box with a check beside the file(s) name. Verify the files listed are correct, click **Upload**.



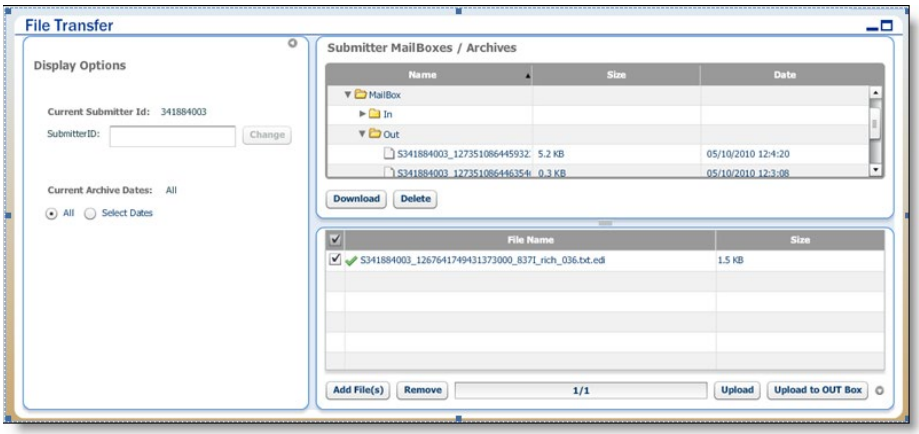
Once the **Upload** button is clicked, an **Upload Success!** Screen will appear. Click **OK**.

A blue confirmation bar will appear along the bottom of the pane showing the number of files that uploaded successfully. Once the file is uploaded there is a green check next to the file name. This provides the user with 2 areas to confirm that files were uploaded successfully.



Files will stay in the log until the session is complete or the user removes the files from the log. This allows the user to know what files have been uploaded into the system.

> *NOTE*: A session is considered the time that the user is logged into the system. Logging out, changing the Submitter ID or closing the screen will end the session. If PCS is inactive for an extended amount of time, the application will time out and the user will need to log in again.



> *NOTE*: Files that are uploaded go to the PCS system. Files that are downloaded go to the user's local computer.

Archive Folders

The Archive folders contain all files that have processed as well as the response/acknowledgements generated for that submitter.

Archived Folders are as follows:

837D	HIPAA 837 Dental Files
837I	HIPAA 837 Institutional Files
837P	HIPAA 837 Professional Files
277	277CA Acknowledgements
99x	999 Functional Acknowledgements
Unknown	TA1 Interchange Acknowledgements

Download Files

The user has the ability to download a file from the **Out** or **Archive** folders to a local computer. Highlight the file(s) that need to be downloaded and click **Download**. A screen from the local computer will appear allowing the choice of where the file(s) should be saved. Select the appropriate location, click **Save**.

The option to upload archived folders to the out folder can only be utilized by EDI Support.

When finished click on Logout.

7. Appendix A: Revision Summary

The information in this chapter lists the date and changes made to the AultCare 837 Companion Guide.

AultCare and Aultra 837 HIPAA Companion Guide Change Summary:

Refer to the Data Requirements column within the document for details of the updates listed below.

Note: Segment changes listed below apply to professional, institutional, and dental 837 files unless the segment is not used within one of the files per the national 837 implementation guide.

Date	Updated Loop	Updated Data Element	Data Updated
10/07/2011	5010 New Guide		
09/27/2012	2010BA	N301	Changed data requirements from "recommended for all claims" to "Required only when the subscriber is the patient. If the subscriber is not the patient then do not send."
09/27/2012	2010BA	N401	Changed data requirements from "recommended for all claims" to "Required only when the subscriber is the patient. If the subscriber is not the patient then do not send."
09/27/2012	2010BA	N402	Changed data requirements from "recommended for all claims" to "Required only when the subscriber is the patient. If the subscriber is not the patient then do not send."
09/27/2012	2010BA	N403	Changed data requirements from "recommended for all claims" to "Required only when the subscriber is the patient. If the subscriber is not the patient then do not send."
09/27/2012	2010BA	DMG02	Deleted "Recommended for all claims to facilitate claim processing."
09/27/2012	2010BA	DMG03	Deleted "Recommended for all claims to facilitate claim processing."
6/11/2020	2010AA	REF02	Removed **Note:** The Billing provider suffix will be accepted when supplied but is not required.
6/11/2020	2010BA	NM109	Removed: Removed SSN

6/11/2020	2300	HI01-1	Updated the Code List Qualifier code from BK to ABK
6/11/2020	2300	HI101-2	Updated ICD-9 to reflect ICD-10
6/11/2020	23010B	REF02	Removed **Note:** The provider suffix will be accepted when supplied, but is not required.
6/11/2020	2310D	REF02	Removed **Note:** The Supervising Provider suffix will be accepted when supplied but is not required.
6/11/2020	2310A	REF02	Removed **Note:** The Attending Physician suffix will be accepted when supplied but is not required.
6/11/2020	2310C	REF02	Removed **Note:** The Attending Physician suffix will be accepted when supplied but is not required.
6/15/2020	2400	SV101-1	Updated note for professional claims to reflect that 50 lines can be billed not 999. **Note:** A maximum of 50 lines can be accepted by AultCare and Aultra.
6/15/2020	2400	SV201-1	Added Note: A maximum of 999 lines can be accepted by AultCare and Aultra.
6/15/2020	Response/Acknowledgments	277CA	Removed social security (SSN)
2/26/2021	837 Electronic Claims Procedures for Providers and/or Vendors	Guidelines	Updated website to reflect https://www.aultcare.com/hipaa
2/26/2021	837 Electronic Claims Procedures for Providers and/or Vendors	Guidelines	Updated AultCare website to reflect https://www.aultcare.com
1/12/2022	Testing procedure		Updated URL from AultCare Test URL www.test.aultedi.com to https://aultcaretest.payorconnectivity.com
1/12/2022	Production Submission Procedures:		Updated URL from AultCare Test URL www.test.aultedi.com to https://aultcaretest.payorconnectivity.com
1/12/2022	File Transfer Instructions		Updated URL from AultCare Test URL www.test.aultedi.com to https://aultcaretest.payorconnectivity.com and updated the production URL from https://aultedi.com to https://aultcare.payorconnectivity.com
4/5/2023	Testing Procedure		Updated SFTP.aultedi.com to https://infoexchange.changehealthcare.com

4/5/2023	Production Submission Procedures:		Updated SFTP.aultedi.com to https://infoexchange.changehealthcare.com
8/30/2023			Updated AultCare's PrimeTime Health Plan logo

7. Appendix B: AultCare and Aultra Product Lines for Electronic Claims

AultCare or Aultra administers pay claims for those products listed below. Paper claims mailed to the addresses below can also be sent electronically to AultCare or Aultra using the 837 file layout. All of the claims for the different product lines can be combined into one Professional or Institutional file.

New files must still be tested as noted in the AultCare & Aultra 837 companion guide. Notice to AultCare or Aultra is required when a provider is added to an existing file. The provider system setup must be verified before the provider sends claims to AultCare and/or Aultra.

AultCare Product Lines:

AULTCARE
P O BOX 6910
2600 SIXTH STREET SW
CANTON, OH 44706-0910

MCKINLEY LIFE INSURANCE CO
P O BOX 6910
2600 SIXTH STREET SW
CANTON, OH 44706-0910

AULTCARE HMO
P O BOX 6910
2600 SIXTH STREET SW
CANTON, OH 44706-0910

PRIMETIME MEDICAL INSURANCE CO
P O BOX 6910
2600 SIXTH STREET SW
CANTON, OH 44706-0910

AULTRA ADMINSTRATIVE GROUP
P O BOX 35276
CANTON, OH 44735-5276

PRIMETIME HEALTH PLAN
P O BOX 6905
CANTON, OH 44706-0905