The Voice of Accountable Physician Groups

May 11, 2016

Dear CAPG member,

After several months of collaborative work by fifteen of the largest health plans and physician organizations in the state, CAPG is pleased to endorse the IHA-led initiative that has developed a fully standardized interpretation of the most challenging 837 submission items. Building on the work of the ICE group over the last several years, IHA was tasked to create a single industry interpretation of the most challenging and non-standardized data elements in the 837 encounter form. The initiative has relied on a consensus process including plans, physician organizations, CAPG management and board, CAHP management, CMS, DHCS, Covered California and DMHC. This 837 standardization represents the first outcome of this initiative, with the more challenging work of standardizing encounter edit reports from health plans to physician groups already underway.

The purpose of this communication is to make your organization aware of these consensus interpretations and to encourage you to prepare to make the necessary modifications in your IT and operational processes, including with any clearinghouses. All organizations participating in the workgroup, including Aetna, Anthem, Blue Shield, Cigna, Health Net, UnitedHealthcare, Hill Physicians Medical Group, Brown & Toland, Sutter Health, Sharp HealthCare, HealthCare Partners, Monarch Healthcare, Dignity Health, Memorial Care Health System, and Kaiser Permanente, have already begun the changes necessary with a commitment of completion by the end of 2016. In addition to the endorsement of CAPG, we have confirmed that both CMS and DHCS are supportive of the work and direction this initiative has taken and at this time do not see any conflicts between this standardization exercise specific to the 837 form and their submission requirements. These new standardized interpretations detailed in section D of this letter, represent an agreed upon definition of data elements that were identified as having different interpretations across provider groups and health plans in California,

resulting in volume and quality of data being compromised. Within the next few months you will receive specific notification from your contracted health plans about timelines for implementation specific to each health plan. This communication is intended to notify you about the upcoming changes in advance and provide you with more time to prepare accordingly. **There is no immediate action to be taken.**

We're attaching more information on the project to provide you with context and address any issues or concerns you may have. For additional questions please contact Eyal Gurion from IHA at egurion@iha.org.

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D: Description of the 837P and 837I data elements and agreed definition:

Data Element	Loop	Segment	Agreed definition	Comments
Frequency Code (Replacement Claim)	2300	CLM05-3	Claim frequency code will always be on the claim. A frequency code of 7 or 8 signifies an adjusted or void claim and must have an original claim associated with it via reference segment. If the claim does not have a reference segment, those claims that come in with a frequency code of 7 or 8 can be rejected by the plan. If a previously adjusted claim now has another adjustment encounter/claim, the newest encounter will be based on the process date and will link to previous claims.	If the original claim was processed as an encounter, and is then adjusted, in the ref segment, the previously processed reference will be sent in with a 7. If this happens again, and the encounter is adjusted, the reference segment is pulled from the 2nd claim, not the first claim. If there's more than one adjusted claim, the previous (most current) ref segment will be populated. In the case when ref segments are the same (based on Patient ID, etc.), payer duplicate logic will need to be invoked to pick up the previously processed encounter. In the case where a 7 or 8 is sent and the plan does not have an encounter, the plan will write logic to accept the encounter.
Frequency Code (Void Claim)	2300	CLM05-3		
Original Claim number (If frequency code = 7)	2300	REF02 (F8 qualifier)		
Original Claim number (If frequency code = 8)	2300	REF02 (F8 qualifier)		

Data Element	Loop	Segment	Agreed definition	Comments
Out of Network Flag	2300	HCP15	1 or 3 is out of network. Networks are based on PO or group level attribution; default to in-network unless there is a clear out of network episode	Service is in network even if the provider is out of network, which is difficult to program. Could be tied to a referral. IHA/ICE will discuss the programming piece further
Patient Amount Paid	2300	AMT (F5 – qualifier, 837P)	AMT F5 & F3 segment, will be populated with the sum of the patient copay, co-insurance, and deductible. The purpose is to ensure quality of patient responsibility data reported in CAS PR segments. Per X12 guidelines, do not report a zero in this segment. Does not necessarily reflect actual patient payment.	
Patient (responsibility) amount estimated	2300	AMT (F3 – qualifier, 837I)		
Adjudication/payment/ remit date	2430	DTP03	The date when the encounter was finalized in the payer's system, i.e. process date of claim on the payer side. Any time a new adjustment is sent, the process date has to be greater than the previous claim date. If a claim is adjusted use the date the claim was adjusted.	

Data Element	Loop	Segment	Agreed definition	Comments
Payer Paid Amount (Total)	2320	AMT (D qualifier)	Definitions: Payer Paid amount: amount paid by the plans Patient responsibility: based on benefits but not necessarily patient payment Billed amount: amount billed Allowed amount is valuation of how that claim is determined, or the provider paid/approved amount + the patient responsibility amount(s).	Within CAS segments: For Medi-Cal and Medicare product - lines within this CAS segment, transactions must balance, reporting PR1-3 as is (copay/co-insurance, deductible), and where possible, report Medi-Cal and Medicare standard fee schedule as the allowed amount; whatever is reported should be reflected in PO/plan systems accordingly. For Commercial - revealing actual rates is preferred; if that is not possible, there is a standard methodology that can be used for a plug, per ICE recommendation. Edit numbers are contained to MA. POs will send a value in the fields in question. The value must correctly reflect accurate patient out of pocket and has to balance. There is a claim adjustment reason code 24 that explains charges are covered under a capitation agreement Per the ICE recommendation: at the line level, when paid amount becomes a negative number, balance it out: add the CO 24 qualifier and put that negative value in to balance it out.
Line adjustment group code	2430	CAS01		
Adjustment/patient responsibly amount	2430	CAS02		
Service line Paid amount	2430	SVD02		
Allowed Amount (Intended to be used as payer allowed amount)	2400	HCP02	Repriced allowed amount segment would be where we place the allowed amount of the claim header. This is the other element of CAS.	For those encounters where transparency is a concern (commercial rates) the allowed amount would be the billed amount since providers aren't disclosing a contract rate