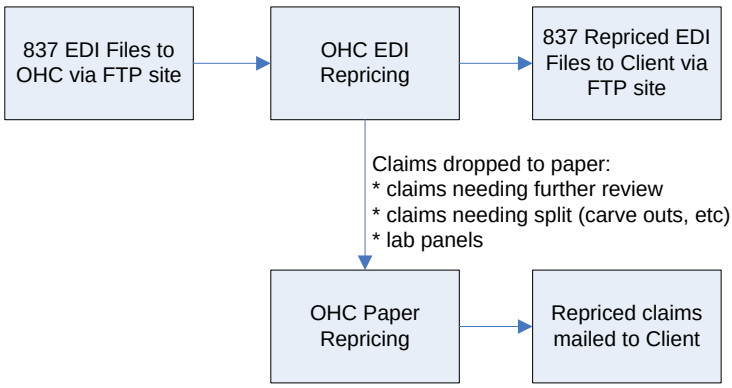
Ohio Health Choice
Direct EDI
837 Health Care Claim
Implementation Guidelines

Version 1.0
Updated 12/11/13

Purpose

This document describes the standard methods that Ohio Health Choice implements to exchange 837 Health Care Claims with its clients. It is our goal to meet the specific needs of each client, so please let us know if you have a particular requirement not addressed in this document.

Overview



- Client sends 837 files of claims to Ohio Health Choice
- Claims are repriced by Ohio Health Choice
- Ohio Health Choice creates repriced 837 claims by inserting repricing information into the originally received claim data.
- Ohio Health Choice sends repriced 837 files of claims back to client
- Some claims are processed on paper and mailed to the client with repricing information:
    - Claims that need split in order to process per provider agreement (ex. DRG's with carve outs)
    - Claims that need combined in order to process per provider agreement (ex. Mom and baby case rates)
    - Claims that include lab panel rollup codes
    - Claims that require further review
- By default, any rejection information is sent back to the client with the understanding that the client will reject to the provider. If desired, Ohio Health Choice can reject to the provider instead of the client.

Getting Started

These are the basic steps to initiate EDI claims with Ohio Health Choice:

- Create FTP account on either the Ohio Health Choice or the client's FTP site.
- Exchange pgp keys
- Establish an eligibility feed to Ohio Health Choice on a regular basis. This is especially necessary if the group numbers sent to Ohio Health Choice will be the original group numbers as submitted by the providers. Such group numbers are often wrong, and will require an eligibility lookup to resolve. When Ohio Health Choice is unable to determine the correct group number for a claim, it is rejected. Refer to Ohio Health Choice's eligibility documents for more information on submitting eligibility.
- Determine if any changes are needed to the standards described in this document.
- Create test files and repeat testing cycle as necessary
- Schedule a go-live date

Ohio Health Choice 837 File Standards

- Current versions are 005010X222A1 and 005010X223A2.
- There is no limit to the number of files that can be submitted to Ohio Health Choice each day, however each file needs to have a unique name.
- Ohio Health Choice will work with the client to determine the best timing and frequency for returning repriced claim files.
- Ohio Health Choice will return all processed claims in a single file (professional or institutional), regardless of whether they were originally submitted in a single file or multiple files. There is no correlation between incoming and outgoing files.
- Standard filename convention is "OHC" + "P" if professional, "F" if institutional + Ohio Health Choice client ID + _yymmddhhmmss.EDI.pgp. For example, the professional file for Ohio Health Choice client ID 12345 dated 9/1/07 at 3:30 pm would be named "OHCP12345_070901153000.EDI.pgp".

Client Specific Options

The Client may specify:

- Specific values for HCP04. By default, HCP04 is blank.
- Whether the Ohio Health Choice repricing reason codes should overwrite any existing NTE notes or whether they should be appended to the end of any existing NTE notes (up to 80 characters).
- Whether the Ohio Health Choice Claim ID is sent in a REF*9A segment. By default, any existing REF*9A segments would be overwritten with the Ohio Health Choice Claim ID.
- Whether Ohio Health Choice should notify providers when a claim cannot be processed due to missing or incorrect information, or whether the client will handle these provider notifications. Please see the "Repricing Information" section in this document for technical details.
- Whether 997 files will be exchanged.
- Whether emails should be sent whenever Ohio Health Choice receives and/or transmits a file to or from the FTP site.
- Whether an alternative to HCP13 = T7 should be used (See HCP13 details below)
- Whether claims that providers have erroneously sent directly to Ohio Health Choice will be processed and transmitted to the client in the normal repriced files, or will instead be rejected back to the provider with instructions to submit per the ID card.

Repricing Information

Repricing information will be sent in HCP and NTE segments:

Loop 2300 (Claim Information)

NTE Segment

NTE*ADD*6 - Priced based on prov contract

- NTE01 = "ADD"
- NTE02 = OHC reason code - OHC reason description

If an existing NTE segment is present for the claim, then one option is to append the OHC reason code to the existing data in NTE02. The OHC reason code will be truncated if the total length of NTE02 would exceed 80 characters. The other option is to overwrite the existing NTE with a new NTE containing only the OHC reason code.

HCP Segment

HCP*10*32.34
HCP*00*0.00**********T1

- HCP01 = 10 if par and 00 if non par. Note that the line level HCP01 contains accurate pricing methodology information.
- HCP02 = the total repriced amount for the claim. Note that non-par claims are repriced to $0.
- HCP04 = blank by default
- HCP13 =
    - T1 if the provider is out of network (non-par).
    - T6 if Ohio Health Choice cannot process a claim because it was not submitted correctly by the provider. If the client will be handling provider notifications in these cases (see "Client Specific Options" earlier in this document), then the NTE segment(s) will indicate the specific error, such as "46 – Invalid CPT". If Ohio Health Choice will be handling provider notifications, then the NTE segment(s) will indicate "59 – Provider Return".
    - T7 if Ohio Health Choice needs to drop a claim to paper to process it manually and then mail it to the client. In this case, there will be "T7" in HCP13 and NTE02 for each service line will be "58 - Claim to be repriced as nonEDI". Note that the Client may specify an alternative value for T7 if desired. Commonly, T6 is used as an alternative, in which case the client will also need to examine NTE02 for the 58 reason code.
    - Otherwise, this element will be blank..

Loop 2400 (Service Line)

NTE Segment – same as Loop 2300 (Claim Information), except NTE01 = "TPO"

NTE*TPO*6 - Priced based on prov contract

HCP Segment – same as Loop 2300 (Claim Information), except HCP01 will hold the actual repricing methodology for the service line.

HCP*03*15.38
HCP*00*0.00**********T1

Control Segment Values

Ohio Health Choice and the client will mutually agree upon these element values:

- ISA05 = Sender Qualifier
- ISA06 = Sender ID
- GS02 = Sender Code
- ISA07 = Receiver Qualifier
- ISA08 – Receiver ID
- GS03 – Receiver Code
- Loop 1000B NM103 (Receiver Name) and NM109 (Receiver Code)

Note that usually the Tax ID of 341895396 is used to identify Ohio Health Choice.

EDI Contact

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