

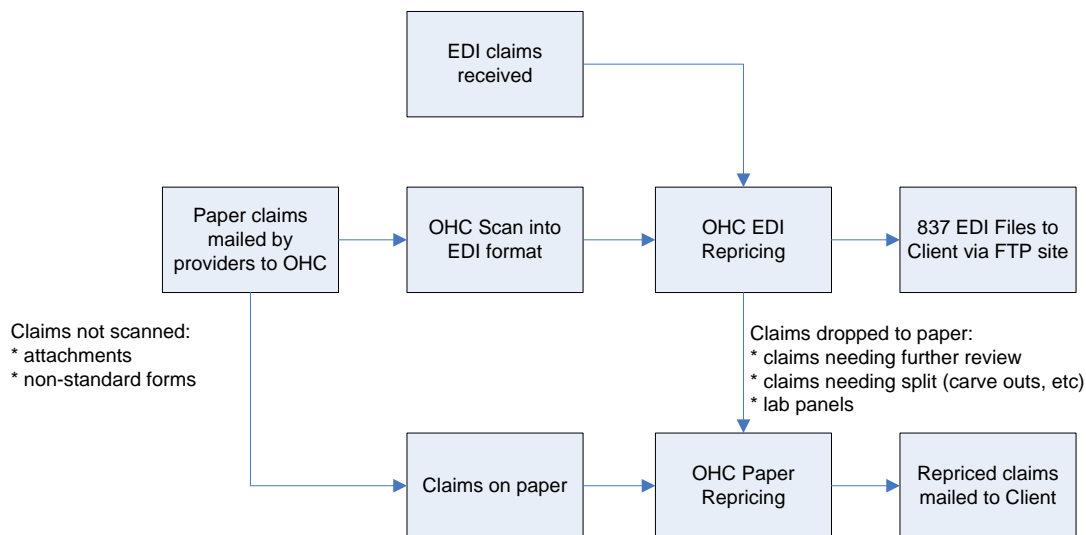
Ohio Health Choice
Outbound Only
837 Health Care Claim
Implementation Guidelines

Version 1.0
Updated 12/11/13

Purpose

This document describes the standard methods that Ohio Health Choice implements to send 837 Health Care Claims to 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



- Paper claims are received at Ohio Health Choice and scanned into an electronic format
- EDI claims are received at Ohio Health Choice from the clearinghouse or other EDI sources (such as partner networks)
- Claims are repriced by Ohio Health Choice
- EDI files to be sent to client are put on FTP site
- Some claims are processed on paper and mailed:
 - Claims that were submitted to Ohio Health Choice on paper with attachments
 - Claims on non-standard claim forms
 - 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
- Claims with missing or incorrect information are rejected and mailed back to the providers by Ohio Health Choice.

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.
- Provide Ohio Health Choice with pgp key
- Establish an eligibility feed to Ohio Health Choice on a regular basis. This is important because eligibility is used to determine group numbers when the providers do not submit accurate group information. 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.
- By default, one professional file and one institutional file transmitted per day. This frequency can be increased if desired.
- 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:

- Segment, element, and sub-element delimiters. By default these are ~, *, and : .
- Whether data is "nested" (by default) or not. For example, if two subscribers had claims under the same provider, there would only be one HL 20 level for the provider, and the two subscriber HL 22 levels would be nested under that. Patient data is also nested under subscribers, and claims under patients.
- Whether a separate ST/SE is used for each claim. By default, there is one ST/SE per file.
- 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. This mainly applies to claims forwarded to Ohio Health Choice from partner networks.

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). 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 from Ohio Health Choice

Ohio Health Choice will use the following default values for these elements unless the client specifies otherwise:

- ISA05 = 30 (Federal Tax ID)
- ISA06 = 341895396 (Ohio Health Choice tax ID)
- GS02 = 341895396

Control Segment Values required from Clients

The client will need to provide Ohio Health Choice with the desired values for these elements:

- ISA07 – Receiver Qualifier (usually 30 or ZZ)
- ISA08 – Receiver ID (usually a Tax ID)
- GS03 – Receiver Code
- Loop 1000B NM103 – (Receiver Name) and NM109 (Receiver Code)

EDI Contact

Diana Jacobs
Senior Programmer / Analyst
330-996-8205
800-554-0027 x68205
jacobsd@ohiohealthchoice.com