

HIPAA 837 Companion Document for Direct Submitters



*For use with the
ASC X12N 837 Health Care Institutional & Professional
Claim Transaction Set Implementation Guides & Addenda
ASC X12N 837I (004010X096) & (004010X096A1)
ASC X12N 837P (004010X098) & (004010X098A1)*

And the National Provider Identification

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Tufts Health Plan
705 Mt Auburn St
Watertown, MA 02472

Revision	Revision Date	Comments
1	11/2001	
2	10/2002	Included statement on CLM size under the section titled General Transaction Information – Key Points Updated rejection criteria in Appendix B
3	03/2003	Updated Key Points Updated specifications to Loop 2400 on 837P Updated Testing Guidelines Updated Security Regulations Notice Updated EDI Setup Form in Appendix C Updated Input Data in Appendix D
4	11/2003	Updated General Transaction Information – Key Points New Claims rejection edit and error message.
5	04/2004	Updated EDI Setup Form
6	07/2005	Updated “Secure Horizon” references to read “Medicare Preferred”. Updated general text
7	02/2007	Updated document for National Provider Identifier (NPI) implementation. Updated general text
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Introduction

Tufts Health Plan (Tufts HP) is accepting X12N 837 Institutional (837I) & X12N 837 Professional (837P) Health Care Claims, as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The X12N 837I and 837P versions of the 4010 implementation guide and August 2002 addenda for the Health Care Institutional and Professional Claims has been established as the standard for Health Care claims transaction compliance.

Audience

This document has been designed to aid both the technical and business areas. It contains Tufts HP specifications for the transactions as well as contact information and key points.

Document Purpose

This document has been prepared to serve as a Tufts HP specific companion guide to the 837I & 837P Transaction Sets. This document *supplements* but does not contradict any requirements in the 837 I&P Transaction Set Implementation Guides (IG). The primary focus of the document is to clarify specific segments and data elements that should be submitted to Tufts HP on the 837 Institutional & Professional Claim Transactions. This document contains the following sections:

“General Transaction Information” explains the initial step you will need to implement the 837 transactions as well as key points.

“Tufts Health Plan Specifications/Requirements” contains example summary and detail reports.

“Tufts Health Plan Specifications/Requirements” provides Tufts HP-specific information to be used in addition to the required segments and data elements in the 837 Implementation Guides.

“Connecting to Tufts Health Plan” explains how to connect to Tufts HP and send your 837 transaction. It also contains a statement in relation to security.

“Appendix B – Rejection Criteria/Error Messages on Submitter Reports” outlines electronic claim error messages found on Tufts HP submitter reports.

“Appendix C – EDI Set-up Form”

“Appendix D – Enveloping Specifications”

This document will be subject to revisions as new versions of the 837 Institutional & Professional Health Care Claim Transaction Set Implementation Guides are released.

General Transaction Information

Getting Started

In order to submit a valid transaction, please refer to the National Electronic Data Interchange Transaction Set Implementation Guides & Addenda for the Health Care Claim: Institutional ASC X12N 837 (004010X096) & (004010X096A1) and the Health Care Claim: Professional ASC X12N 837 (004010X098) & (004010X098A1). The transaction guides can be ordered from the Washington Publishing Company's website at www.wpc-edi.com.

For questions relating to the Tufts HP 837 Institutional Claim Transaction, the Tufts HP 837 Professional Claim Transaction, or testing please contact the Tufts HP EDI Operations Department at 888-880-8699 x4042 or email your questions to EDI_Operations@Tufts-Health.com.

Tufts HP billing guidelines are not included in this document. Please refer to our website at <http://www.tuftshealthplan.com/> for these guidelines, or contact Provider Services at 888-884-2404.

Please note Tufts HP is not responsible for any software utilized by the submitter for the ASC X12N 837I or ASC X12N 837P transactions.

Key Points

Notes for both the 837I and 837P Transactions

- Tufts HP will accept 837 Institutional and Professional Claim Transactions for all business products, however they must be sent in separate files. They cannot be sent on the same file.
- As stated in the Implementation Guide, a maximum of 5000 CLM segments will be accepted by Tufts HP
- Submitters must go through the appropriate set-up/authorization process in order to transmit electronic claims to Tufts HP. Please refer to the "*Connecting with Tufts Health Plan*" section of this document before submitting electronic claims.
- Tufts HP is adhering to structural specifications for required and situational fields as stated in the implementation guides. If the incoming 837I or 837P structure does not comply, the file will fail in the validation process. The submitter will receive a 997 acknowledgement for notification the file has failed.
- Tufts HP requires certain situational data in order to effectively process claims. For detailed information on this subject please refer to the "*Tufts Health Plan Specifications/Requirements*" section of this document.
- Each Tufts HP member is uniquely identified. Thus Tufts HP strongly recommends treating all members as subscribers, and submitting member ID in Element NM109 of Loop 2010BA
- If Pay-to Provider Information (Loop 2010AB) is not sent in the 837 transaction, Tufts HP will capture payee information from the Billing Provider Information (Loop 2010AA).

- Tufts HP Provider Identifiers will no longer be allowed in the Secondary Identification REF Segments as of May 23rd, 2007 now that the National Provider Identifiers (NPI) have been released. Please follow the 837 I and P implementation guides on how to utilize the National Provider ID (NPI).
- For Frequency Types 6, 7, and 8, (Element CLM05-3), Tufts HP's original claim number (Original Reference Number – Element REF02) must be submitted as stated in the implementation guides. Tufts HP also strongly recommends sending the Original Reference Number with Frequency Types 3, 4, and 5.
- When contacting Tufts HP with claims questions for claims with Frequency Types 3, 4, 5, 6, 7, and 8, (Element CLM05-3), please use Tufts HP's original claim number even though a new claim number for that submission will be assigned.
- The Tufts HP implementation of Coordination of Benefits (COB) Information utilizes the COB Header (Loop 2320), Other Subscriber Information (2330A), Other Payer Information (2330B) and COB Detail (Loop 2430) within the 837 transaction. Tufts HP strongly recommends closely reviewing these loops in the implementation guide before submitting COB information.
- Although the HIPAA Transaction Set Implementation Guide allows the repeating of Provider Information (2000A Loop) for each claim, the size of transmission files can be reduced by up to 20% by using only one repeat of Provider information followed by all Subscriber and Claim information for that Provider. File transmission files can be further reduced by grouping the claims of each subscriber together.

Notes Specific to the 837I Transaction

- As stated in the implementation guide, Service Facility Information (Loop 2310E) should be submitted if the Provider of Services is different from the Pay-to Provider (Loop 2010AB). Tufts HP strongly recommends that Service Facility Information always match Pay-to Provider Information given that the payee should always equal the provider on Tufts HP institutional claims.
- Tufts HP will capture all four Procedure Code Modifiers (Element SV201-3) if sent, but only the first modifier will be utilized during processing.
- **Present On Admission (POA) Indicators.**

Effective October 1, 2007, Medicare began to accept a Present On Admission (POA) Indicator for every diagnosis on inpatient acute care hospital claims. **However, providers must submit the POA on hospital claims beginning with discharges on or after January 1, 2008.** Critical access hospitals, Maryland waiver hospitals, long term care hospitals, cancer hospitals, psychiatric hospitals, inpatient rehabilitation facilities, and children's inpatient facilities are exempt from this requirement.

Provider Types Affected

Hospitals who submit claims to fiscal intermediaries (FI) or Part A/B Medicare Administrative Contractors (A/B MACs) for Medicare beneficiary inpatient services.

You should make sure that your billing staffs are aware of this requirement, and that your physicians and other practitioners and coders are collaborating to ensure complete and accurate documentation, code assignment and reporting of diagnoses and procedures.

1. General Reporting Requirements

- Pertain to all claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information.
- Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.
- POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes.
- Issues related to inconsistent, missing, conflicting, or unclear documentation must still be resolved by the provider.

If a condition would not be coded and reported based on UHDDS definitions and current official coding guidelines, then the POA indicator would not be reported.

- CMS does not require a POA indicator for the external cause of injury code unless it is being reported as an “other diagnosis.”

2. Reporting Options and Definitions

- Y - Yes (present at the time of inpatient admission)
- N – No (not present at the time of inpatient admission)
- U - Unknown (documentation is insufficient to determine if condition is present at time of inpatient admission)
- W – Clinically undetermined (provider is unable to clinically determine whether condition was present at time of inpatient admission or not)
- 1 -- Unreported/Not used – Exempt from POA reporting (This code is the equivalent of a blank on the UB-04, but blanks are not desirable when submitting data via the 4010A1).

The POA data element on your electronic claims must contain the letters “POA”, followed by a single POA indicator for every diagnosis that you report. The POA indicator for the principal diagnosis should be the first indicator after “POA,” and (when applicable) the POA indicators for secondary diagnoses would follow. The last POA indicator must be followed by the letter “Z” to indicate the end of the data element (or FIs and A/B MACs will allow the letter “X” which CMS may use to identify special data processing situations in the future).

Note that on claims submitted electronically via 837, 4010 format, you must use segment K3 in the 2300 loop, data element K301.

Below is an example of what this coding should look like on an electronic claim:

*If segment K3 read as follows: “POAYNUW1YZ,” it would represent the POA indicators for a claim with 1 principal and 5 secondary diagnoses. The principal diagnosis was POA (Y), the first secondary diagnosis was not POA (N), it was unknown if the second secondary diagnosis was POA (U), it is clinically undetermined if the third secondary diagnosis was POA (W), the fourth secondary diagnosis was exempt from reporting for POA (1), and the fifth secondary diagnosis was POA (Y). *(Above information taken from - REVISED PRESENT ON ADMISSION MM5499 0507.pdf- MLN Matters)*

*Example: **K3*POAYYYYYYYY11Z** - Would refer to the following Diagnoses on the claim:*

HI***BK<41071***BJ<41071

HI***BF<40290*BF<4414*BF<42731*BF<78057*BF<27800*BF<3051*BF<49320*BF<7821*BF<V5861*BF<V5866**

Notes Specific to the 837P Transaction

Tufts HP strongly recommends that Rendering Provider Information (Loop 2310B) be sent on all professional claims. If the Rendering Provider Loop is not sent, the grid below determines how Tufts HP will capture the Provider Information.

Loop	Description
Rendering Provider Information (Loop 2310B)	Tufts HP uses this information for the Rendering Provider.
Pay-to Provider Information (Loop 2010AB)	Tufts HP uses this information for the Payee. If Loop 2310B is not present, Tufts HP uses this information for the Rendering Provider as well as the Payee.
Billing Provider Information (Loop 2010AA)	Tufts HP uses this information for the Billing Provider. If Loop 2010AB is not present, Tufts HP uses this information for the Payee as well as for the Billing Provider. If neither Loop 2310B nor Loop 2010AB is present, Tufts HP uses this information for the Rendering Provider, Payee, and Billing Provider.

- Tufts HP will capture all four Procedure Code Modifiers (Element SV101-3) if sent, but only the first modifier will be utilized during processing.

Submitter Reports

- When a compliant file is received, the submitter (EPZ) report will typically be available within one business day.
- Submitter (EPZ) reports include basic file information: submission status, submission date, reasons for file rejections, and file totals. For an example of a submitter report, see Appendix A.
- For the Tufts HP rejection criteria and associated error messages that are sent on submitter reports, see Appendix B.

Tufts Health Plan Specifications/Requirements

In addition to the required segments and data elements in the 837 Implementation Guides, the following grid documents Tufts Health Plan specific requirements.

Usage Key: R = Required, S = Situational

Requirements Specific to the 837I Transaction

Loop	Segment ID	Segment	Data Element ID	Data Element	Usage	Comments
N/A	REF	Transmission Type Identification	REF02	Transmission Type Code	R	When submitting test records and during production, please use 004010X096A1.
1000A	NM1	Submitter Name	NM109	Submitter Identifier	R	Tufts HP will work with trading partners prior to implementation to determine the six-digit submitter code.
2010AA	NM1	Billing Provider Name	NM108	Identification Code Qualifier	R	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations. Effective May 23 rd 2007. A Qualifier of "XX" must now be submitted.
2010AA	NM1	Billing Provider Name	NM109	Billing Provider Identifier	R	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations. Effective May 23 rd 2007. Providers must now submit their 10 digit NPI Number
2010AA	REF	Billing Provider Secondary Identification	REF01	Reference Identification Qualifier	R	With "XX" – NPI in use, either the Employee Identification Number "EI" or the Social Security Number "SY" qualifier must be used.

Tufts Health Plan Specifications/Requirements

Loop	Segment ID	Segment	Data Element ID	Data Element	Usage	Comments
2010AA	REF	Billing Provider Secondary Identification	REF02	Billing Provider Additional Identifier	R	This number - SSN or TIN - sent, must be the same as it appears on the Providers 1099 Tax Form.
2010AA	REF	Billing Provider Secondary Identification	REF01	Reference Identification Qualifier	R	If you currently use a THP Legacy ID containing an address suffix you will need to create an additional REF segment using the qualifier of "LU" for location code
2010AA	REF	Billing Provider Secondary Identification	REF02	Billing Provider Additional Identifier	R	If using a secondary address the suffix must be entered. Example: A
2010AB	NM1	Pay-To Provider Name	NM108	Identification Code Qualifier	S	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations. Effective May 23 rd 2007. A Qualifier of "XX" must now be submitted.
2010AB	NM1	Pay-To Provider Name	NM109	Pay-to Provider Identifier	S	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations. Effective May 23 rd 2007. Providers must now submit their 10 digit NPI Number
2010AB	REF	Pay-to Provider Secondary Identification	REF01	Reference Identification Qualifier	S	With "XX" – NPI in use, either the Employee Identification Number "EI" or the Social Security Number "SY" qualifier must be used.
2010AB	REF	Pay-to Provider Secondary Identification	REF02	Pay-to Provider Additional Identifier	S	This number - SSN or TIN - sent, must be the same as it appears on the Providers 1099 Tax Form.
2010AB	REF	Pay-to Provider Secondary Identification	REF01	Reference Identification Qualifier	S	If you currently use a THP Legacy ID containing an address suffix you will need to create an additional REF segment using the qualifier of "LU" for location code
2010AB	REF	Pay-to Provider Secondary Identification	REF02	Pay-to Provider Additional Identifier	S	If using a secondary address the suffix must be entered. Example: A
2000B	SBR	Subscriber Information	SBR01	Payer Responsibility Sequence Number Code	R	This data element is NOT a payer counter. It is a code that indicates the order of responsibility for

Tufts Health Plan Specifications/Requirements

Loop	Segment ID	Segment	Data Element ID	Data Element	Usage	Comments
						payment.
2010BA	NM1	Subscriber Name	NM109	Subscriber Primary Identifier	S	Each Tufts HP member is uniquely identified. Thus Tufts HP strongly recommends treating all members as subscribers, and submitting member ID in Element NM109 of Loop 2010BA.
2010CA	NM1	Patient Name	NM109	Patient Primary Identifier	S	Each Tufts HP member is uniquely identified. Thus Tufts HP strongly recommends treating all members as subscribers, and submitting member ID in Element NM109 of Loop 2010BA.
2300	REF	Original Reference Number (ICN/DCN)	REF02	Claim Original Reference Number	R	For frequency types 6, 7, and 8, Original Reference Number (Claim Number) must be submitted as stated in the implementation guide. Tufts HP also strongly recommends sending Original Reference Number with frequency types 3, 4, and 5.
2300	HI	Occurrence Information	HI01-2	Occurrence Code	R	If claim is accident or employment related, Tufts HP requires the appropriate occurrence code. Please note that Related Causes Information usage has been changed to 'Not Used' in the Addenda. Tufts HP will only process one iteration of HI01.
2300	HI	Occurrence Information	HI01-4	Occurrence Associated Date	R	If claim is accident or employment related, Tufts HP requires the appropriate occurrence date. Please note that Related Causes Information usage has been changed to 'Not Used' in the Addenda. Tufts HP will only process one iteration of HI01.

Tufts Health Plan Specifications/Requirements

Loop	Segment ID	Segment	Data Element ID	Data Element	Usage	Comments
2310A	NM1	Attending Physician Name	NM108	Identification Code Qualifier	R	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations. Effective May 23 rd 2007. A Qualifier of "XX" must now be submitted.
2310A	NM1	Attending Physician Name	NM109	Attending Physician Primary Identifier	R	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations. Effective May 23 rd 2007. Providers must now submit their 10 digit NPI Number
2310E	NM1	Service Facility Name	NM108	Identification Code Qualifier	R	National Provider Identifier (NPI) is now mandated for use by the HIPAA regulations Effective May 23 rd 2007. A Qualifier of "XX" must now be submitted.
2310E	NM1	Service Facility Name	NM109	Service Facility Primary Identifier	R	National Provider Identifier (NPI) is now mandated for use by the HIPAA regulations Effective May 23 rd 2007. Providers must now submit their 10 digit NPI Number
2310E	REF	Service Facility Secondary Identification	REF01	Reference Identification Qualifier	R	Tufts HP requires that with "XX" – NPI in use, The Employee Identification Number "EI" qualifier should be sent.
2310E	REF	Service Facility Secondary Identification	REF02	Service Facility Additional Identifier	R	This number - TIN - sent, must be the same as it appears on the Providers 1099 Tax Form.
2400	SV2	Institutional Service Line	SV202-3	Procedure Modifier	S	Tufts HP will capture all four Procedure Code Modifiers if sent, but only the first modifier will be utilized during processing.

Requirements Specific to the 837P Transaction

Loop	Segment ID	Segment	Data Element ID	Data Element	Usage	Comments
N/A	REF	Transmission Type Identification	REF02	Transmission Type Code	R	When submitting test records and during production, please use 004010X098A1.
1000A	NM1	Submitter Name	NM109	Submitter Identifier	R	Tufts HP will work with trading partners prior to implementation to determine the six-digit submitter code.
2010AA	NM1	Billing Provider Name	NM108	Identification Code Qualifier	R	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations. Effective May 23 rd 2007. A Qualifier of "XX" must now be submitted.
2010AA	NM1	Billing Provider Name	NM109	Billing Provider Identifier	R	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations. Effective May 23 rd 2007. Providers must now submit their 10 digit NPI Number.
2010AA	REF	Billing Provider Secondary Identification	REF01	Reference Identification Qualifier	R	With "XX" – NPI in use, either the Employee Identification Number "EI" or the Social Security Number "SY" qualifier must be used.
2010AA	REF	Billing Provider Secondary Identification	REF02	Billing Provider Additional Identifier	R	This number - SSN or TIN - sent, must be the same as it appears on the Providers 1099 Tax Form.
2010AA	REF	Billing Provider Secondary Identification	REF01	Reference Identification Qualifier	R	If you currently use a THP Legacy ID containing an address suffix you will need to create an additional REF segment using the qualifier of "LU" for location code
2010AA	REF	Billing Provider Secondary Identification	REF02	Billing Provider Additional Identifier	R	If using a secondary address the suffix must be entered. Example: A

Tufts Health Plan Specifications/Requirements

Loop	Segment ID	Segment	Data Element ID	Data Element	Usage	Comments
2010AB	NM1	Pay-To Provider Name	NM108	Identification Code Qualifier	S	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations Effective May 23 rd 2007. A Qualifier of "XX" must now be submitted.
2010AB	NM1	Pay-To Provider Name	NM109	Pay-to Provider Identifier	S	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations. Effective May 23 rd 2007. Providers must now submit their 10 digit NPI Number.
2010AB	REF	Pay-to Provider Secondary Identification	REF01	Reference Identification Qualifier	S	With "XX" – NPI in use, either the Employee Identification Number "EI" or the Social Security Number "SY" qualifier must be used.
2010AB	REF	Pay-to Provider Secondary Identification	REF02	Pay-to Provider Additional Identifier	S	This number - SSN or TIN - sent, must be the same as it appears on the Providers 1099 Tax Form.
2010AB	REF	Pay-to Provider Secondary Identification	REF01	Reference Identification Qualifier	S	If you currently use a THP Legacy ID containing an address suffix you will need to create an additional REF segment using the qualifier of "LU" for location code
2010AB	REF	Pay-to Provider Secondary Identification	REF02	Pay-to Provider Additional Identifier	S	If using a secondary address the suffix must be entered. Example: A
2000B	SBR	Subscriber Information	SBR01	Payer Responsibility Sequence Number Code	R	This data element is NOT a payer counter. It is a code that indicates the order of responsibility for payment.
2010BA	NM1	Subscriber Name	NM109	Subscriber Primary Identifier	S	Each Tufts HP member is uniquely identified. Thus Tufts HP strongly recommends treating all members as subscribers, and submitting member ID in NM109 of loop 2010BA.

Tufts Health Plan Specifications/Requirements

Loop	Segment ID	Segment	Data Element ID	Data Element	Usage	Comments
2010CA	NM1	Patient Name	NM109	Patient Primary Identifier	S	Each Tufts HP member is uniquely identified. Thus Tufts HP strongly recommends treating all members as subscribers, and submitting member ID in NM109 of loop 2010BA.
2300	REF	Original Reference Number (ICN/DCN)	REF02	Claim Original Reference Number	R	For frequency types 6, 7, and 8, Original Reference Number (Claim Number) must be submitted as stated in the implementation guide. Tufts HP also strongly recommends sending Original Reference Number with frequency types 3, 4, and 5.
2310A	NM1	Referring Provider Name	NM108	Identification Code Qualifier	S	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations. Effective May 23 rd 2007. A Qualifier of "XX" must now be submitted.
2310A	NM1	Referring Provider Name	NM109	Referring Provider Primary Identifier	S	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations. Effective May 23 rd 2007. Providers must now submit their 10 digit NPI Number.
2310B	NM1	Rendering Provider Name	NM108	Identification Code Qualifier	R	National Provider Identifier (NPI) is now mandated for use by the HIPAA regulations Effective May 23 rd 2007. A Qualifier of "XX" must now be submitted.
2310B	NM1	Rendering Provider Name	NM109	Rendering Provider Primary Identifier	R	National Provider Identifier (NPI) is mandated for use by the HIPAA regulations. Effective May 23 rd 2007. Providers must now submit their 10 digit NPI Number.

Tufts Health Plan Specifications/Requirements

Loop	Segment ID	Segment	Data Element ID	Data Element	Usage	Comments
2310B	REF	Rendering Provider Secondary Identification	REF01	Reference Identification Qualifier	R	Tufts HP requires that with “ XX ” – NPI in use, either the Employee Identification Number “ EI ” or the Social Security Number “ SY ” qualifier be sent.
2310B	REF	Rendering Provider Secondary Identification	REF02	Rendering Provider Additional Identifier	R	This number - SSN or TIN - sent, must be the same as it appears on the Providers 1099 Tax Form.
2400	SV1	Professional Service Line	SV101-3	Procedure Modifier	S	Tufts HP will capture all four Procedure Code Modifiers if sent, but only the first modifier will be utilized during processing.

Connecting to Tufts Health Plan

Setup Process

Direct Submitters

Providers interested in submitting electronic claim transactions should contact EDI Operations at Tufts HP via email or telephone to request setup. Please refer to the “*Contact Information*” section for details. A direct submitter EDI setup form can be found in Appendix C.

EDI Operations will coordinate the appropriate process to set up an electronic data interchange. This includes completing enveloping requirements in Appendix D.

Upon setup completion, EDI Operations will notify the submitter and review the testing procedures. After this review, test claims can be sent to Tufts HP.

NEHEN Providers

Providers interested in submitting electronic claim transactions via NEHEN should contact the vendor directly who will then facilitate set up with EDI Operations. EDI Operations will facilitate an IP address for the provider, working through the NEHEN support staff.

Upon setup completion, EDI Operations notifies the submitter and NEHEN technical support that the eGateway and telecommunications are set up. The submitter can then configure its eGateway to send the claims transactions to the Tufts HP test eGateway. Upon successful testing between Tufts HP and the new submitter, the submitter migrates to a production status.

Testing

EDI Operations will work with the submitter to setup a username name and password. After establishing a username name and password, the submitter can begin sending claim transactions to the test environment.

1. During the testing process, EDI Operations will examine submitted test transactions for required elements. EDI Operations will also ensure that the submitter gets a response during the testing mode. EDI Operations will notify the provider upon the successful completion of testing.
2. When the submitter is ready to send an 837 transaction to the production mailbox, they will be notified by EDI Operations, and given a GO LIVE date to move to the production environment.
3. The submitter's username name remains the same when moving from test to production.

HIPAA Security Regulations

The HIPAA Security regulations were finalized recently. The final regulations outline standards for the security of individual health information used by health plans, health care clearinghouses and health care providers. Tufts Health Plan has taken reasonable and appropriate steps to be compliant with the Security Rule

System Maintenance

The Tufts HP system used by the 837 transaction has a standard maintenance schedule of Sunday 8PM to 12AM EST. The system is unavailable during this time.

Contact Information

The following sections provide contact information for any questions regarding HIPAA, 837 transactions, EDI, documentation, or training.

For General HIPAA Questions

If you have any general HIPAA questions, please access the Tufts Health Plan HIPAA website. To access the site:

Go to <http://www.tuftshealthplan.com/providers>

Select the **Electronic Services** link.

For 837 Transaction Questions

The following table provides specific contact information by department and responsibility.

For Questions Regarding...	Contact	Phone Number	Email Address
General 837 Initial Contact for Setup and Testing	Kevin Whalen	(888) 880-8699 x3344 Fax: (617) 923-5555	Kevin_Whalen@tufts-health.com
EDI Claims Submission	Tufts HP EDI Operations	(888) 880-8699 x4042 Fax: (617) 923-5555	EDI_Operations@tufts-health.com
HMO, POS or PPO Claim Information	Provider Services Tufts Health Plan	(888) 884-2404 Fax: 617-972-9452	
Tufts Health Plan Medicare Preferred Claim Information	Customer Relations	(800) 279-9022 Fax: 617-972-9487	

Appendix A – Submitter (EPZ) Reports

Example EDI Claim Acceptance Summary Report

REPORT DATE: TUFTS HEALTH PLAN PAGE:
 REPORT ID: ELECTRONIC DATA INTERCHANGE (EDI)
 CLAIMS ACCEPTANCE

EVENT ID:

THIS REPORT LISTS THE TOTAL NUMBER OF CLAIMS ACCEPTED/ REJECTED FOR YOUR EDI SUBMISSION BY TUFTS HEALTH PLAN FOR THE DATE INDICATED. PLEASE ENSURE THAT ALL REJECTED CLAIMS ARE CORRECTED AND RESUBMITTED WITHIN ANY APPLICABLE FILING LIMIT. IF YOU HAVE ANY QUESTIONS REGARDING THIS REPORT, PLEASE CONTACT THE EDI OPERATIONS DEPT (617) 972-9400 EXTENSION 4042.

MAIL TO: SUBMISSION DATE:
 SUBMITTED BY:
 VOLUME SERIAL ID:
 PAYEE ID:

TOTAL CLAIM LINES	TOTAL CLAIMS	TOTAL AMOUNT BILLED
TOTAL RECORDS		
-----	-----	-----

TOTAL CLAIMS SUBMITTED:
 TOTAL CLAIMS ACCEPTED:
 TOTAL CLAIM REJECTED:

REJECTED CLAIMS

Record #	Patient Account #	Error Message	Field Content
XXXXXX	XXXXXXXXXX	Invalid Member ID	XXXXXXXXXX

Example EDI Claim Acceptance Detail Report

REPORT DATE: TUFTS HEALTH PLAN PAGE:
REPORT ID: ELECTRONIC DATA INTERCHANGE (EDI) CLAIMS
EVENT ID:

MAIL TO: SUBMISSION DATE:
SUBMITTED BY:
VOLUME SERIAL ID:
PAYEE ID:

Record #	Account #	Claim #	Product
XXXXXX	XXXXXXXXXX	XXXXXXXX	XXX

TOTAL CLAIMS:

Appendix B – Rejection Criteria/Error Messages on Submitter Reports

The grid below outlines electronic claim error messages that can be found on Tufts HP submitter reports.

Rejection Criteria for 837 Institutional Claims

Message	Criteria
CLAIM ACCEPTED	Tufts Health Plan accepted the claim submitted.
INVALID MEMBER ID	Member ID/Suffix is not in Tufts Health Plan system.
INVALID SUBSCRIBER	Subscriber is not in Tufts Health Plan system.
ADMIT/REF NPI NOT ON FILE AT PAYER	Admit/Ref NPI is not in Tufts Health Plan system.
PROVIDER NPI NOT ON FILE AT PAYER	Provider NPI is not in Tufts Health Plan system.
INVALID PRIMARY DIAG CODE	Primary diag code is not in Tufts Health Plan system, or the 1 st position of diag code is E-Code.
INVALID SECONDARY DIAG CODE	Secondary diag code is not in Tufts Health Plan system.
INVALID ADDR-SUFFIX	Payment address suffix is incorrect.
INVALID PAT. DOB	Patient's date of birth does not match Tufts Health Plan patient date of birth on file.
DOB EXCEEDS DOS FOR MEMB-ID	Member's date of birth is after date of service.
WRONG DATE OF BIRTH FOR MEM	Date of birth is not within 7 days of member's date of birth.
PAT. ACCT. SPACES	Patient account number is not submitted.
INVALID BEGIN DOS	Beginning date of service is invalid.
INVALID END DOS	End date of service is invalid for type of bill. [Except for frequency types 2 or 3 (Interim Bills) that do not require end date of service.]
DOB > BEGIN DOS	Date of birth is greater than the date of service.
DOB > TODAY	Date of birth is greater than today's date.
INVALID SEX	Value does not equal 'F', 'M', or 'U'.
ASSIGN BEN. MUST = Y	Value does not equal 'Y'.
INVALID TYPE OF BILL	Value is not a valid type of bill as defined by HIPAA.
INSTITUTE INPAT. NOT ACCEPTED	Type of bill is not valid for type of submission.
INSTITUTE OUTPAT. NOT ACCEPTED	Type of bill is not valid for type of submission.
BEGIN DOS > TODAY	Begin date of service is after today's date.
19970101 IS > THAN BEGIN DOS	Begin date of service is before 01/01/1997.
BEGIN DOS NOT = ADM. DATE	Begin date of service does not equal the admit date.
END DOS > TODAY	End date of service must be before today's date. [Except for frequency types 2 or 3 (Interim Bills) that do not require end date of service.]
DOB > END DATE	Date of birth cannot be after the end date. [Except for frequency types 2 or 3 (Interim Bills) that do not require end date of service.]
BEGIN DOS > END DOS	Beginning date of service cannot be after the end date. [Except for frequency types 2 or 3 (Interim Bills) that do not require end date of service.]
ADM HR REQUIRED FOR INPATIENT CLAIM	The admit hour is not submitted.
INVALID ADM. HOUR	Admit hour is invalid.
SOURCE OF ADM. REQ. FOR INPATIENT CLAIM	Source of admission is not submitted.
INVALID SOURCE OF ADMISSION	Source of admission is invalid

Appendix B – Rejection Criteria/Error Messages on Submitter Reports The grid below outlines electronic claim error messages that can be found on Tufts HP submitter reports.

Message	Criteria
SOURCE OF ADMISSION NOT NUMERIC	Source of admission must be a valid value. [Can not be numeric.]
DISCHARGE HR NOT NUMERIC	Discharge hour must be numeric. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge hour.]
DISCHARGE HR REQ FOR INPATIENT CLAIM	Discharge hour is not submitted. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge hour.]
INVALID DISCHARGE HOUR	Discharge hour is invalid. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge hour.]
RELEASE OF INFO. FLAG MUST BE OBTAINED	Release of information code does not equal Y.
INVALID ADMIT DATE	Admit date is invalid.
DOB > ADM DATE	Date of birth is greater than the admit date.
ADM DATE > TODAY	Admit date is greater than today's date.
19970101 IS > THAN ADM DATE	Admit date is before 01/01/1997.
ADM. DATE NOT = BEG. DOS	Admit date does not equal the begin date of service.
INVALID DISCHARGE DATE	Discharge date is invalid. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge date.]
BEGIN DOS > DISCHARGE DATE	Begin date of service is greater than the discharge date. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge date.]
ADM. DIAG. REQUIRED FOR INPATIENT CLAIM	Admit diag is not submitted.
INVALID ADM. DIAG	Admit diag is invalid.
ADMISSION TYPE REQUIRED	Admission type is not submitted.
INVALID ADMISSION TYPE	Admission type is invalid.
ADM TYPE XREF INVALID - MUST BE 1-4,9	Admission type is invalid.
ADMISSION TYPE MUST BE 1-4, 9	Admission type does not equal 1-4 or 9.
DISCHARGE STATUS REQUIRED	Discharge status is not submitted. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge status.]
INVALID DISCHARGE STATUS	Discharge status is not valid. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge status.]
INVALID DISCHARGE STATUS RANGE	Discharge status range is not valid. [Except for frequency types 2 or 3 (interim bills) that do not require a discharge status range.]
ATT PHYS ID IS REQUIRED	Attending Physician ID is not submitted
INVALID OTHER DIAG2	Not a valid diagnosis code in Tufts Health Plan's system.
INVALID OTHER DIAG3	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG4	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG5	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG6	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG7	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG8	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG9	Not a valid diagnosis code in Tufts Health Plan's

Appendix B – Rejection Criteria/Error Messages on Submitter Reports The grid below outlines electronic claim error messages that can be found on Tufts HP submitter reports.

Message	Criteria
	system
INVALID OTHER DIAG 10	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 11	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 12	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 13	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 14	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 15	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 16	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 17	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 18	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 19	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 20	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 21	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 22	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 23	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER DIAG 24	Not a valid diagnosis code in Tufts Health Plan's system
INVALID OTHER PROC 1	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 2	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 3	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 4	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 5	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 6	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 7	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 8	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 9	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ'.
INVALID OTHER PROC 10	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from

Appendix B – Rejection Criteria/Error Messages on Submitter Reports The grid below outlines electronic claim error messages that can be found on Tufts HP submitter reports.

Message	Criteria
	the beginning to end date of service.
INVALID OTHER PROC 11	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 12	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 13	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 14	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 15	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 16	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 17	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 18	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 19	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 20	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 21	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 22	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 23	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
INVALID OTHER PROC 24	Not a valid HCPCS/CPT code if qualifier is 'BO'. Not a valid ICD-9 procedure code if qualifier is 'BQ' from the beginning to end date of service.
PAYEE ID IS NOT EQUAL TO PROVIDER ID	Payee ID and Provider ID do not equal. [Tufts HP requires that Payee ID and Provider ID equal on institutional claims.]
PAYEE NPI NOT ON FILE AT PAYER	Payee NPI value is not found in THP Provider NPI Source System.
INVALID PRIM-PROC	Primary procedure code is invalid and/or not effective on the beginning date of service of claim.
INVALID PRIM-PROC MODIFIER	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 2	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 3	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 4	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID 001414 PRIM-PROC	Procedure must have a valid admit refer ID.

Appendix B – Rejection Criteria/Error Messages on Submitter Reports The grid below outlines electronic claim error messages that can be found on Tufts HP submitter reports.

Message	Criteria
DOS > RECEIPT DATE	Date of service is greater than date received
INVALID DOS	Date of service is invalid.
INVALID NOS - NOT NUMERIC	Number of service is invalid. [Must be numeric.]
DISCHARGE HOUR IS REQ. FOR THIS REV. CODE	Discharge hour not submitted for type of claim or type of bill [Specifically for revenue codes 760, 761, 762 or 769.]
AMT. BILLED NOT NUMERIC	Amount billed is invalid. [Must be numeric.]
REV. CODE REQUIRES AMT. BILLED > 0	Amount billed is invalid for service line. [Must contain amount greater than 0.]
DOS NOT IN RANGE OF BEG. AND ENDING DOS	Date of service is not in range of the beginning and ending date of service. [Except frequency type 2 or 3 (interim bills) that do not require ending date of service.]
DOS=0 AND BEG. AND ENDING DOS ARE NOT EQUAL	Date of service is not submitted on the service line.
REV. CODE REQUIRED FOR INSTITUTIONAL CLAIM	This revenue code requires a valid procedure code.
INVALID REVENUE CODE	Revenue code invalid and/or not effective for beginning date of service of claim.
INVALID PRINCIPLE PROCEDURE	Not a valid HCPCS/CPT code if qualifier is 'BP' from the beginning to end date of service. Not a valid ICD-9 procedure code if qualifier is 'BR' from the beginning to end date of service.

Rejection Criteria for 837 Professional Claims

Message	Criteria
CLAIM ACCEPTED	Tufts Health Plan accepted the claim submitted.
INVALID MEMBER ID	Member ID/Suffix is not in Tufts Health Plan system.
INVALID SUBSCRIBER	Subscriber is not in Tufts Health Plan system.
ADMIT/REF NPI NOT ON FILE AT PAYER	Admit/Ref NPI is not in Tufts Health Plan system.
PROVIDER NPI NOT ON FILE AT PAYER	Provider NPI is not in Tufts Health Plan system.
PAYEE ID CANNOT EQUAL PROVIDER ID#	Payee/Pay To ID # submitted cannot be used as Provider/Rendering ID #
CLAIM TYPE NOT ACCEPTED	Provider type not authorized to submit professional claims
INVALID PRIMARY DIAG CODE	Primary diag code is not in Tufts Health Plan system or if 1 st position of diag code is E-Code.
INVALID SECONDARY DIAG CODE	Secondary diag code is not in Tufts Health Plan system.
INVALID ADDR-SUFFIX	Payment address suffix is incorrect.
INVALID PAT. DOB	Patient's date of birth does not match Tufts Health Plan patient date of birth on file.
DOB EXCEEDS DOS FOR MEMB-ID	Member's date of birth is after date of service.
WRONG DATE OF BIRTH FOR MEM	Date of birth is not within 7 days of member's date of birth.
PAT. ACCT. SPACES	Patient account number is not submitted.
DOB > TODAY	Date of birth is greater than today's date.
INVALID SEX	Value does not equal 'F', 'M', or 'U'.
ASSIGN BEN. MUST = Y	Value does not equal 'Y'.
INVALID EMPLOYMENT FLAG	Employment flag is invalid
INVALID AUTO ACCIDENT FLAG	Auto accident flag is invalid
INVALID OTHER ACCIDENT FLAG	Other accident flag is invalid

Appendix B – Rejection Criteria/Error Messages on Submitter Reports The grid below outlines electronic claim error messages that can be found on Tufts HP submitter reports.

Message	Criteria
PATIENT OR AUTH SIGNATURE MUST BE OBTAINED	Patient or Authorization signature has not been obtained
INSURED OR AUTH SIGNATURE MUST BE OBTAINED	Insured or Authorization signature has not been obtained
INVALID TYPE OF BILL	Value is not a valid type of bill as defined by HIPAA.
RELEASE OF INFO. FLAG MUST BE OBTAINED	Value does not equal 'Y'.
INVALID PLACE OF SERVICE CODE	Place of service is invalid.
DOS BEYOND RECEIPT DATE	Date of service cannot exceed the receipt date.
INVALID PRIM-PROC	Primary procedure code is invalid and/or not effective on the beginning date of service of claim.
INVALID PRIM-PROC MODIFIER	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 2	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 3	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID PRIM-PROC MODIFIER 4	Modifier is invalid and/or not effective on beginning date of service of claim.
INVALID 001414 PRIM-PROC	Procedure must have a valid admit refer ID.
INVALID DOS	Date of service is invalid.
INVALID NOS - NOT NUMERIC	Number of service is invalid. [Must be numeric.]
AMT. BILLED NOT NUMERIC	Amount billed is invalid. [Must be numeric.]

Appendix C – EDI Set-up Form

Type of practice: Solo Group Billing Service Hospital/Facility
 Type of account: New Existing (indicate changes below)
 Transaction Type: 837 Institutional 837 Professional claim
 835

Information on solo, group, billing service client(s), hospital/facility

Name: _____
 Address: _____
 City: _____ State: _____ Zip code: _____
 Office contact: _____ Practice Tax ID: _____
 Telephone: () _____ Fax () _____
 E-Mail Address _____
 Practice Management System/Computer Vendor: _____
 Vendor Contact Name: _____ Telephone: () _____

Payment Information (if different than above)

Name of payee: _____ National Provider Identifier number: _____
 Address: _____
 City: _____ State: _____ Zip code: _____
 Payee tax ID: _____

Provider Information

Name of Provider	National Provider Identifier Number

Please contact EDI Operations (888-880-8699 x4042) if you have any questions regarding this form. EDI Operations will contact you after this information is verified to initiate electronic transactions.
 Completed forms can be sent to EDI_Operations@tufts-health.com or faxed to 617-923-5555.

Appendix D – Enveloping Specifications

Trading Partner1 (SENDER)	170558746
Trading Partner2 (RECEIVER)	<Receiver ID> #
APRF (Application Reference)	837
Segment Terminator (OPTIONAL)	LF (Line Feed)
Element Separator (OPTIONAL)	

ISA (Interchange Control Header Segment)

The ISA is a fixed record length segment and all positions within each of the data elements are required. The first element separator defines the element separator used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange.

The **Input Data** column below contains text in *[bracketed italics]*, which indicates special input data dependent on sender, time, date, etc.

Elements	Size	Name	Input Data	Remarks
ISA01	2	Authorization Information Qualifier	00	No Authorization Information Present.
ISA02	10	Authorization Information	<i>[Submitter-specific ID number, or ten-space placeholder]</i>	If no Authorization Information number is present, simply enter 10 spaces in this field.
ISA03	2	Security Information Qualifier	00	No Security Information Present.
ISA04	10	Security Information/Password	<i>[Submitter-specific ID number, or ten-space placeholder]</i>	If no Authorization Information number is present, simply enter 10 spaces in this field.
ISA05	2	Interchange ID Qualifier/Trading Partner Qualifier	ZZ	Mutually Agreed
ISA06	15	Interchange Sender ID/ Trading Partner ID	<i>Tufts Health Plan Submitter ID</i>	Sender ID (Provided by Tufts Health Plan)
ISA07	2	Interchange ID Qualifier/Tufts Health Plan Qualifier	01	DUNS (Dun & Bradstreet)
ISA08	15	Interchange Receiver ID/Tufts Health Plan ID	170558746	Tufts Health Plan DUNS
ISA09	6	Interchange Date	<i>[Enter the date using the format YYMMDD; for example, January 1, 2003 would be entered as 030101]</i>	Date of the interchange
ISA10	4	Interchange Time	<i>[Enter the time using the format HHMM; for example, 1:30 PM would be entered as 1330]</i>	Time of the interchange
ISA11	1	Interchange Control Standards ID	U	U.S. EDI Community of ASC X12, TDCC, and UCS
ISA12	5	Interchange Control Version Number	00401	Version Number

Elements	Size	Name	Input Data	Remarks
ISA13	9	Interchange Control Number/Last Control Number	<i>[Sender-specific control number]</i>	Assigned and maintained by the interchange sender, must be identical to the associated Interchange Trailer, IEA02. Must increment by one number at the end of the value with each file submitted within the same business day (12:00 am to 11:59 pm).
ISA14	1	Acknowledgement Request	1	Code sent by the sender to request a 997 acknowledgement. 1 Acknowledgement Requested
ISA15	1	Usage Indicator/ Acknowledgment Test Indicator	<i>[Enter either T or P]</i>	T - Test Data, P - Production Data.
ISA16	1	Component Element (Sub-Element) Separator	<i>[Enter any separator character, for example : or >]</i>	Used to separate component data elements within a composite data structure; must be unique. ASCII Value - Component element separator.

IEA (Interchange Control Trailer Segment)

To define the end of an interchange of zero or more functional groups and interchange-related control segments.

The **Input Data** column below contains text entered in *[bracketed italics]* indicates special input data dependent on sender, time, date, etc.

Elements	Size	Name	Input Data	Remarks
IEA01	1/5	Number of Included Functional Groups	<i>[Submitter-specific ID number]</i>	A count of the number of functional groups included in an interchange
IEA02	9	Interchange Control Number	<i>[Submitter-specific ID number]</i>	A control number assigned by the interchange sender

GS (Functional Group Header Segment)

To indicate the beginning of a functional group and to provide control information.

The **Input Data** column below contains text entered in *[bracketed italics]* indicates special input data dependent on sender, time, date, etc.

Elements	Size	Name	Input Data	Remarks
GS01	2	Functional Identifier Code	HC	Health Care Claim
GS02	2/15	Application Sender's Code	<i>Tufts Health Plan Submitter ID</i>	Code identifying party sending transmission.
GS03	2/15	Application Receiver's Code	170558746	Code identifying party receiving transmission.
GS04	8	Date	<i>[Enter the date using the format YYYYMMDD; for example, January 1, 2003 would be entered as 20030101]</i>	Functional Group creation date.
GS05	4/8	Time	<i>[Enter the time using the format HHMM; for example, 1:30 PM would be entered as 1330]</i>	Functional Group creation time. Time expressed in 24-hour clock.
GS06	1/9	Group Control Number/Last Control Number	<i>[Submitter-specific number]</i>	Assigned and maintained by the sender, must be identical to the associated functional group trailer, GE-02.
GS07	1/2	Responsible Agency Code	X	Accredited Standards Committee X12
GS08	1/12	ANSI Version Code/Functional Ack. Version	004010X096A1 and/or 004010X098A1	Health Care Claim for Institutional Health Care Claim for Professional

GE (Functional Group Trailer Segment)

The **Input Data** column below contains text entered in *[bracketed italics]* indicates special input data dependent on sender, time, date, etc.

Elements	Size	Name	Input Data	Remarks
GE01	1/6	Number of Transaction Sets Included	<i>[Submitter-specific number]</i>	Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element
GE02	1/9	Group Control Number	<i>[Submitter-specific number]</i>	Assigned number originated and maintained by the sender