Standard Companion Guide

Refers to the Implementation Guide

Based on X12 Version 005010X222A1

Health Care Claim – Professional

(837P)

Companion Guide Version Number 0.1

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CHANGE LOG

Version	Release Date	Changes
1.0	3/30/23	Initial draft release

PREFACE

This companion guide (CG) to the v5010 ASC X12N Technical Report Type 3 (TR3) adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with OptumRx.

Transmissions based on this companion guide, used in tandem with the TR3, also called 837 Health Care Claim: Professional ASC X12N (005010X222A1), are compliant with both ASC X12 syntax and those guides. There are separate transactions for Health Care Claims - institutional (837I) and professional (837P). This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

The TR3, also known as X12N Implementation Guide (IG), adopted under HIPAA, here on in within this document will be known as IG or TR3.

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1. INTRODUCTION

This section describes how Technical Report Type 3 (TR3), also called 837 Health Care Claim: Professional (837P) ASC X12N/005010X222A1, adopted under HIPAA, will be detailed with the use of a table. The tables contain a row for each segment that OptumRx has included, in addition to the information contained in the TR3s. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the TR3's internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically with OptumRx

In addition to the row for each segment, one or more additional rows are used to describe OptumRx's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The table below specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that OptumRx has included, in addition to the information contained in the TR3s.

The following is an example (from Section 9 – Transaction Specific Information) of the type of information that may be included:

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
71	1000A	**NM1**	Submitter Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comment about the segment itself goes in this cell.
123	2010BA	NM109	Subscriber Primary Identifier			This type of row exists to limit the length of the specified data element.
123	2010BA	NM108	Identification Code Qualifier			
				MI		This type of row exists when a note for a particular code value is required. For example, this note may say that value **MI** is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it.
184	**2300**	**HI**	Principal Diagnosis Code			
	2300	HI01-1	Code List Qualifier Code	**ABK**		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 SCOPE

This document is to be used for the implementation of the TR3 HIPAA 5010 837 Health Care Claim: Professional (referred to as Professional Claim or 837P Claim in the rest of this document) for the purpose of submitting a professional claim electronically. This companion guide is not intended to replace the TR3.

1.2 OVERVIEW

This CG is intended to assist you in implementing electronic Professional Claim transactions that meet OptumRx processing standards, by identifying pertinent structural and data related requirements and recommendations.

Updates to this companion guide occur periodically and are available online. CG documents are posted in the Electronic Data Interchange (EDI) section of our Resource Library on the Companion Guides page:

https://www.optum.com/business/hcp-resources/page.hub.edi-837-companion-guide.html

1.3 REFERENCE

For more information regarding the ASC X12 Standards for Electronic Data Interchange 837 Health Care Claim: Professional (005010X222A1) and to purchase copies of the TR3 documents, consult the Washington Publishing Company website: http://www.wpc-edi.com

1.4 ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979 ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 Committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standards is recognized by the United States as the standard for North America. EDI adoption has been proved to reduce the administrative burden on providers. Please note that this is OptumRx's approach to 837 Professional claim transactions. After careful review of the existing TR3 for the Version 005010X222A1, we have compiled the OptumRx specific CG. We are not responsible for any changes and updates made to the IG.

2. GETTING STARTED

2.1 EXCHANGING TRANSACTIONS WITH OPTUMRX

OptumRx exchanges transactions with clearinghouses, also referred to as Trading Partners. All OputmRx EDI transactions will be submitted to Optum clearinghouse, OptumInsight, the managed gateway for OptumRx.

2.2 CLEARINGHOUSE CONNECTION

Physicians, facilities and health care professionals should contact their current clearinghouse vendor to discuss their ability to support the 837 Health Care Claim: Professional transaction, as well as associated timeframes, costs, etc. This includes protocols for testing the exchange of transactions with OptumRx through your clearinghouse.

Optum: Physicians, facilities and health care professionals can submit and receive EDI transactions direct. Optum partners with providers to deliver the tools that help drive administrative simplification at minimal cost and realize the benefits originally intended by HIPAA — standard, low-cost claim transactions.

- Please contact Optum Support at 800-341-6141 to get set up.
- If interested in using Optum's online solution, Intelligent EDI (IEDI), contact the Optum sales team at 866-367-9778, option 3, send an email to IEDIsales@optum.com or visit https://www.optum.com/campaign/fp/free-edi.html.

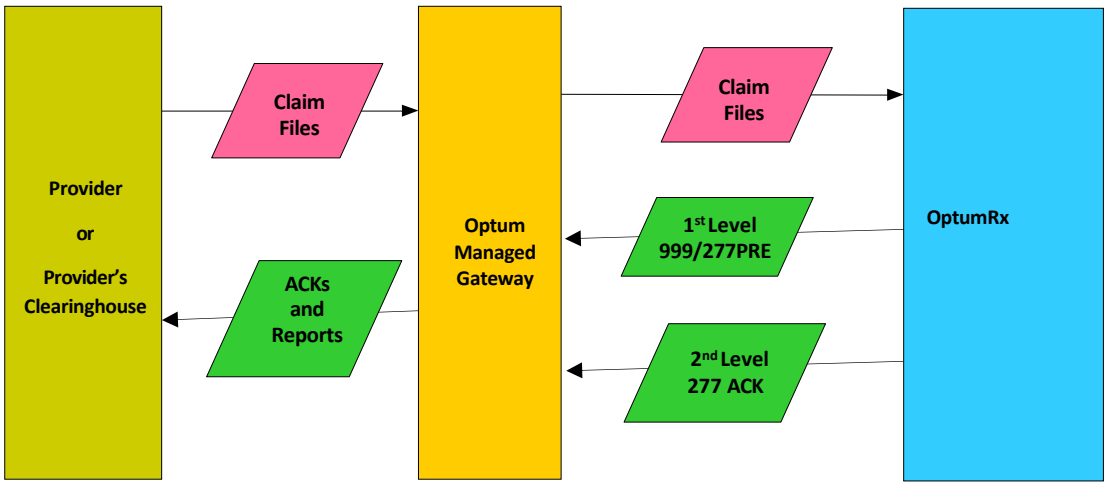
2.3 CERTIFICATION AND TESTING

All trading partners who wish to submit 837P claim transactions to OptumRx via the ASC X12 837 (Version 005010X222A1), and receive corresponding EDI responses, must complete testing to ensure that their systems and connectivity are working correctly before any production transactions can be processed.

For testing EDI transactions with OptumRx, care providers and health care professionals should contact their current clearinghouse vendor or Optum.

3. CONNECTIVITY AND COMMUNICATION PROTOCOLS

3.1 PROCESS FLOW: BATCH 837 Professional CLAIM



3.2 TRANSMISSION ADMINISTRATIVE PROCEDURES

OptumRx supports batch only 837P claim transmissions. Contact your current clearinghouse vendor to discuss transmission types and availability.

3.3 RE-TRANSMISSION PROCEDURES

Physicians, facilities and health care professionals should contact their current clearinghouse vendor for information on whether resubmission is allowed or what data corrections need to be made for a successful response.

3.4 COMMUNICATION PROTOCOL SPECIFICATIONS

Physicians, facilities and health care professionals should contact their current clearinghouse for communication protocols with Optum Rx.

3.5 PASSWORDS

Physicians, facilities and health care professionals should contact their current clearinghouse vendor to discuss password policies.

3.6 SYSTEM AVAILABILITY

Optum Rx will accept 837 claim transaction submissions at any time, 24 hours per day, 7 days a week. Unplanned system outages may occur occasionally and impact our ability to accept or immediately process incoming transactions. Optum Rx will send an email communication for scheduled and unplanned outages.

3.7 COSTS TO CONNECT

Clearinghouse Connection: Physicians, facilities and health care professionals should contact their current clearinghouse vendor or Optum to discuss costs.

Optum:

- Optum Support – 800-341-6141
- Optum's online solution, Intelligent EDI (IEDI)
  - Call 866-367-9778, option 3
  - Email IEDIsales@optum.com
  - Visit https://www.optum.com/campaign/fp/free-edi.html

4. CONTACT INFORMATION

4.1 EDI SUPPORT

If you need assistance with an EDI 837P transaction accepted by OptumRx, please contact OptumRx Support by:

- Sending an email to OptumRx_IT_ICE_Support@ds.uhc.com

For questions related to submitting transactions through a clearinghouse, please contact your clearinghouse or software vendor directly.

4.2 EDI TECHNICAL SUPPORT

Physicians, facilities and health care professionals should contact their current clearinghouse vendor or Optum for technical support. If using Optum, contact their technical support team at 800-225-8951, option 6.

4.3 PROVIDER SERVICES

Provider Services should be contacted at 866-795-7052 instead of EDI Support if you have questions regarding 837 Claim transactions that do not pertain to EDI. Provider Services is available Monday - Friday, 7 am - 7 pm central time zone.

4.4 APPLICABLE WEBSITES/EMAIL

Companion Guides: https://www.optum.com/business/hcp-resources/page.hub.edi-837-companion-guide.html

Optum: https://www.optum.com

OptumInsight/Optum EDI Client Center - https://www.enshealth.com

Optum EDI Support: supportedi@uhc.com

Washington Publishing Company: http://www.wpc-edi.com

5. CONTROL SEGMENTS/ENVELOPES

5.1 ISA-IEA

Transactions transmitted as a batch are identified by an interchange header segment (ISA) and trailer segment (IEA) which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification.

The table below represents only those fields that OptumRx requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction; the TR3 should be reviewed for that information.

LOOP ID	Reference	NAME	Values	Notes/Comments
None	**ISA**	**ISA Interchange Control Header**		
	ISA05	Interchange ID Qualifier	**ZZ**	ZZ = Mutually defined
	ISA06	Interchange Sender ID	MGDOPTUM [Submitter ID]	Right pad as needed with spaces to 15 characters.
	ISA08	Interchange Receiver ID	**OPTUMICE** [Receiver ID]	Right pad as needed with spaces to 15 characters.

5.2 GS-GE

EDI transactions of a similar nature and destined for one trading partner may be gathered into a functional group, identified by a functional group header segment (GS) and a functional group trailer segment (GE). Each GS segment marks the beginning of a functional group. There can be many functional groups within an interchange envelope. The number of GS/GE functional groups that exist in a transmission may vary.

The below table represents only those fields that OptumRx requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction; the TR3 should be reviewed for that information.

LOOP ID	Reference	NAME	Values	Notes/Comments
None	**GS**	**Functional Group Header**		**Required Header**
	GS03	Application Receiver's Code	**OPTUMICE** [Receiver ID]	Right pad as needed with spaces to 15 characters.
	GS08	Version/Release/Industry Identifier Code	**005010X222A1**	Version expected to be received by OptumRx

5.3 ST-SE

The beginning of each individual transaction is identified using a transaction set header segment (ST). The end of every transaction is marked by a transaction set trailer segment (SE). For real time transactions, there will always be one ST and SE combination. An 837 file can only contain 837 transactions.

The below table represents only those fields that OptumRx requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction; the TR3 should be reviewed for that information.

LOOP ID	Reference	NAME	Codes	Notes/Comments
None	**ST**	**Transaction Set Header**		**Required Header**
	ST03	Implementation Convention Reference	**005010X222A1**	Version expected to be received by OptumRx

5.4 CONTROL SEGMENT HIERARCHY

ISA - Interchange Control Header segment
GS - Functional Group Header segment
ST - Transaction Set Header Segment
First 837 Transaction
SE - Transaction Set Trailer segment
ST - Transaction Set Header segment
Second 837 Transaction
SE - Transaction Set Trailer segment
ST - Transaction Set Header
Segment Third 837 Transaction
SE - Transaction Set Trailer segment
GE - Functional Group Trailer segment
IEA - Interchange Control Trailer segment

5.5 CONTROL SEGMENT NOTES

The ISA data segment is a fixed length record and all fields must be supplied. Fields not populated with actual data must be filled with space.

1. The first element separator (byte 4) in the ISA segment defines the element separator to be used through the entire interchange.
2. The ISA segment terminator (byte 106) defines the segment terminator used throughout the entire interchange.
3. ISA16 defines the component element

5.6 FILE DELIMITERS

OptumRx requests that you use the following delimiters on your 837 files. If used as delimiters, these characters (*: ~ ^) must not be submitted within the data content of the transaction sets. Please contact OptumRx if there is a need to use a delimiter other than the following:

1. Data Element: The recommended data element delimiter is an asterisk (*)
2. Data Segment: The recommended data segment delimiter is a tilde (~)
3. Component Element: ISA16 defines the component element delimiter is to be used throughout the entire transaction. The recommended component-element delimiter is a colon (:)
4. Repetition Separator: ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a caret (^)

6. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

6.1 ELECTRONIC CLAIM SUBMISSION GUIDELINES

Following these guidelines will help you submit most of your claims electronically, without paper forms or attachments.

Services	Guidelines
Allergy Procedure Codes	Instead of submitting medical notes, use the **EDI Notes Field*** to indicate number of doses, vials or injections as well as the dose schedule.
Corrected Claims	Most corrected claims can be sent electronically. Submit a corrected claim as an 837 transaction with frequency code 7 to indicate replacement of a previous claim (Loop 2300 CLM05-3).
Participating Physician Covering Primary Care Physician (PCP)	When a OptumRx participating physician is covering for a PCP, use the EDI Notes Field* to indicate "Covering for Dr. X" instead of submitting an attachment.
Rejected Claims	Claim rejections that appear on clearinghouse reports have not been accepted by OptumRx and should be corrected and resubmitted electronically.
Secondary Claims	When another commercial insurance plan is primary and OptumRx is secondary, the secondary claim can be submitted electronically. Information from the primary payer's EOB/COB can be included in the electronic claim.
"Tracers" or Re-Bills	It isn't necessary to send a paper claim backup for a claim sent electronically: • Please allow 5-10 business days for your claim(s) to be processed. • To avoid duplicate claim denials, check the status of your claim as a 277CA EDI transaction
Unspecified CPT and HCPCS codes	Unlisted and Unspecified Service or Procedure Codes can be submitted an electronic claim, however, OptumRx will need to review additional details along with NDC if it is a drug related claims.
Product ID	When submitting drug related product ID, OptumRx requires NDC to be submitted in loop 2410 LIN-3 segment.
Subscriber Group or Policy Number	Medical Policy ID or a Group ID is required and must be submitted in loop 2000B SBR03 (Reference Identification) Segment
Voids and Replacements	A "replacement' encounter should be sent to OptumRx when an element of data on the encounter was either not previously reported or when there is an element of data that needs to be corrected. A replacement encounter should contain a claim frequency code of [7] in Loop 2300 CLM05-3 segment. A "void" encounter should be sent to OptumRx when the previously submitted encounter should be eliminated. A void encounter must match the original encounter with the exception of the claim frequency type code and the payer assigned claim number. A void encounter should not contain "negative" values within the encounter. It should contain a claim frequency code of [8] in Loop 2300 CLM05-3 segment. The replacement or void encounter is required to be submitted with the "Original Reference Number" (Payer Claim Control Number) in Loop 2300 REF segment. REF01 must be [F8] and REF 02 must be the "Original Reference Number". If the required information in Loop 2300 REF01 and REF02 is not submitted, the encounter will reject back to the submitter.

6.2 VALIDATION OF CLAIMS

OptumRx applies two levels of editing to inbound HIPAA 837 files and claims:

1. Level 1 HIPAA Compliance:

   Claims passing Level 1 Compliance are assigned a OptumRx Payer Claim Control Number and are "accepted" for front end processing.

2. Level 2 Front End Validation:
   - Member match
   - Provider match
   - WEDI SNIP Level 1-5 validation
   - Level 1 HIPAA Compliance:
3. Claims passing front end validation are accepted into the OptumRx adjudication system for processing.
4. Claims that do not pass front end validation will be rejected and returned to the submitter.

7. ACKNOWLEDGEMENTS AND REPORTS

7.1 ACKNOWLEDGEMENTS

999 – Functional Acknowledgement
This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a submitted X12 file. OptumRx will respond with a 999 when the X12 contains Functional errors. The submitted 837 will need to be corrected and resubmitted.

277CA
This file informs the submitter of the disposition of their claims through Level 2 Front End Validation, it reports both accepted and rejected claims.

7.2 REPORT INVENTORY

There are no known applicable reports.

8. TRADING PARTNER AGREEMENTS

8.1 TRADING PARTNERS

An EDI Trading Partner is defined as any OptumRx customer (provider, billing service, software vendor, clearinghouse, employer group, financial institution, etc.) that transmits to or receives electronic data from OptumRx.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

9. TRANSACTION SPECIFIC INFORMATION

The table below represents only those fields that OptumRx requires a specific value in or has additional guidance on what the value sent in the response means. The table does not represent all the fields that will be returned in a successful transaction. The TR3 should be reviewed for that information.

Loop	Reference	Name	Values	Notes/Comments
None	**BHT**	**Beginning of Hierarchical Transaction**		
	BHT02	Transaction Set Purpose Code	**00**	00 = Original 18 = Reissue Code identifying the purpose of the transaction.
	BHT06	Transaction Type Code	**CH**	CH = Chargeable Use CH when the transaction contains only fee for service claims or claims with at least one chargeable line item.
1000A	**Submitter Detail**			
1000A	NM1	Submitter Name		Required Segment
1000A	NM109	Identification Code	**MGDOPTUM**	Sender ID code. This number should be identical to the ISA06 and GS02.
1000B	**Receiver Detail**			
1000B	NM1	Receiver Name		Required Segment
1000B	NM103	Name Last or Organization Name	**Optum Rx**	Receiver Name (Organization)
1000B	NM108	Identification Code Qualifier	**46**	ETIN Code
1000B	NM109	Identification Code	**OPTUMICE**	Optum MedicalRx Receiver ID

2000B	**Subscriber Information**			
2000B	HL	Subscriber Hierarchical Level		If a OptumRx patient can be uniquely identified by a unique Member Identification Number, then the patient is considered the subscriber and is identified at this level. When the patient is the subscriber, loops 2000C and 2010Ca are not sent.
2000B	SBR03	Reference Identification	**Subscriber Group or Policy ID**	Subscriber Group or Policy ID Number on the Subscriber Medical ID card. The identifier assigned by the health plan or administrator to identify the group through which the coverage is provided to the subscriber.
2010BA	**Subscriber Name**			
2010BA	NM1	Subscriber Name		
2010BA	NM108	Identification Code Qualifier	**MI**	MI is the only valid value at this time. Claims received with value II will be rejected.
2010BB	**Payer Name**			
2010BB	NM1	Payer Name		
2010BB	NM103	Name Last or Organization Name	**Optum Rx**	OptumRx
2010BB	NM108	Identification Code Qualifier	**PI**	PI = Payer Identifier
2010BB	NM109	Identification Code	**ORXM1**	Optum MedicalRx
2300	Claim Information			
2300	CLM	Claim Information		
2300	DTP	Date-Initial Treatment		Submit initial treatment
2300	**Health Care Information Codes**			
2300	HI	Health Care Diagnosis Code		
2300	HI01-1	Code List Qualifier Code	**ABK**	
2300	HI02-1 to HI12-1	Code List Qualifier Code	**ABF**	
2400	**Professional Services**			
2400	SV1	Professional Service		
2300	SV103	Unit or Basis for Measurement Code	**MJ**	Submit code MJ when reporting anesthesia minutes in Loop 2400 SV104
2300	SV104	Quantity		**Units:** Submit a maximum unit quantity of 999 per occurrence of Loop 2400 SV1. When unit quantity is greater than 999, submit multiple occurrences with up to 999 units per occurrence. **Minutes:** Submit quantity as minutes for time based anesthesia services using MJ qualifier in Loop 2400 SV103.
2400	**Other Information**			

2400	HCP	Line Pricing / Repricing Information		Submit line pricing for repriced claims.
2410	LIN	Drug Identification		Submit NDC for all unlisted injectable drugs and for other injectable drugs when required per the contract between OptumRx and the provider.

10. APPENDECIES

10.1 IMPLEMENTATION CHECKLIST

The implementation check list will vary depending on your clearinghouse connection. A basic check list would be to:

1. Register with trading partner
2. Create and sign contract with trading partner
3. Establish connectivity
4. Send test transactions
5. If testing succeeds, proceed to send production transactions

10.2 FREQUENTLY ASKED QUESTIONS

1. **How does OptumRx support, monitor and communicate expected and unexpected connectivity outages?**
   Our systems do have planned outages. We will send an email communication for scheduled and unplanned outages.
2. **If an 837 is successfully transmitted to OptumRx, are there any situations that would result in no response being sent back?**
   No. OptumRx will always send a response. Even if OptumRx systems are down and the transaction cannot be processed at the time of receipt, a response detailing the situation will be returned.

10.3 FILE NAMING CONVENTIONS

837P File Naming Convention Criteria:

837P file is sent to OptumRx as received. The unzip file should contain less than 100 transactions.

Node	Description	Value
Unzip_ResponseType_<Batch ID>_<Submitter ID>_<DateTimeStamp>.RES		
Unzip	Responses will be sent as either unzipped depending on how OptumRx received the inbound batch file	**N - Unzipped**
ResponseType	Identifies the file response type	**837P – Health Care Claim Professional**
Batch ID	Response file will include the batch number from the inbound batch file specified in ISA13	**ISA13 Value from Inbound File**
Submitter ID	The submitter ID on the inbound transaction must be equal to ISA06 value in the Interchange Control Header within the file	**ISA06 Value from Inbound File**

DateTimeStamp	Date and time format is in the next column (time is expressed in military format as CDT/CST)	**MMDDYYYYHHMMSS**

999 and 277CA File Naming Convention Criteria:

Node	Description	Value
Unzip_ResponseType_<Batch ID>_<Submitter ID>_<DateTimeStamp>.RES		
Unzip	Responses will be sent as either unzipped depending on how OptumRx received the inbound batch file	**N - Unzipped**
ResponseType	Identifies the file response type	**999Ack – Implementation Acknowledgement Or 277CA - Health Care Claim Acknowledgment**
Batch ID	Response file will include the batch number from the inbound batch file specified in ISA13	**ISA13 Value from Inbound File**
Submitter ID	The submitter ID on the inbound transaction must be equal to ISA06 value in the Interchange Control Header within the file	**ISA06 Value from Inbound File**
DateTimeStamp	Date and time format is in the next column (time is expressed in military format as CDT/CST)	**MMDDYYYYHHMMSS**