Healthcare and Family Services,
Bureau of Information Services

HIPAA 5010 - Health Care Claim: Institutional (837I)
Standard Companion Guide

Instructions related to Transactions based on ASC X12 Implementation Guide version 005010X223 and the ERRATA 005010X223A1dated October 2007 and ERRATA 005010X223A2 dated June 2010

837 Institutional Companion Guide Version Number: 1.5

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Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

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Transaction Instruction (TI)

1 TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with the ASC X12 version 005010X223 Health Care Claim Institutional (837I) Implementation Guide, Errata 005010X223A1 dated October 2007, and Errata 005010X223A2 dated June 2010. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12’s Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X223A2	Health Care Claim: Institutional (837)

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12 Implementation Guide
NON-SHADED rows represent “data elements” in the X12 Implementation Guide

HFS Unique 837I Items

005010X223A2 Health Care Claim: Institutional

Loop ID	Reference	Name	Codes	Notes/Comments
1000A	NM1	Submitter Name		
1000A	NM109	Identification Code		Must be your Federal Tax ID Number
1000B	NM1	Receiver Name		
1000B	NM103	Organization Name		Must be “ILLINOIS MEDICAID”
1000B	NM109	Identification Code		Must be “37-1320188”
2000A	PRV	Billing Provider Specialty Information		
2000A	PRV03	Provider Taxonomy Code		Taxonomy is required by HFS on all claims. T he provider must submit the appropriate taxonomy for the service billed. The HFS allowable taxonomy codes are identified in the Taxonomy for 837I table. A complete list of taxonomy codes can be found at http://www.wpc-edi.com/

Loop ID	Reference	Name	Codes	Notes/Comments
2010AA	NM1	Billing Provider Name		
2010AA	NM103	Name Last or Organization		Must be the Provider's name exactly as it is shown on the HFS Provider Information Sheet.
2000B	SBR	Subscriber Information		
2000B	SBR01	Payer Responsibility Sequence Number Code		HFS will only accept values "P", "S", "T", "A", "B", "C", "D", "E".
2010BA	NM1	Subscriber Name		
2010BA	NM103	Subscriber Last Name		Must be the Last Name of the Recipient exactly as it appears in HFS records.
2010BA	NM104	Subscriber First Name		Must be the First Name of the Recipient exactly as it appears in HFS records,
2010BA	NM105	Subscriber Middle Name or Initial		Must be the Middle Name of the Recipient exactly as it appears in HFS records.
2010BA	NM107	Name Suffix		Must be the Name Suffix of the Recipient exactly as it appears in HFS records.
2010BA	NM109	Subscriber Primary Identifier		Must be the Recipient's assigned 9-digit Recipient Identification Number.
2010BB	NM1	Payer Name		
2010BB	NM103	Payer Name		Must be "ILLINOIS MEDICAID".
2010BB	NM109	Payer Identifier		Must be "37-1320188"
2300	CLM	Claim Information		
2300	CLM01	Patient Control Number		HFS will process and return up to 20 characters only.
2300	CLM05-3	Claim Frequency Type Code		The only valid values are 1-5. See the "NUBC UB04 Billing Manual" for more details.
2300	DTP	Admission Date/Hour		
2300	DTP02	Date Time Period Format Qualifier	"DT"	HFS requires the value of "DT" – Date format of "CCYYMMDDHHMM" be used for all Inpatient, Hospice, and Interim Inpatient claims. LTC can use the D8 qualifier without the HHMM.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	CL1	Institutional Claim Code		
2300	CL102	Admission Source Code	"8"	Must be "8" for billing DCFS initial visits.
2300	CL103	Patient Status Code		Must use for Inpatient and LTC claims.
2300	PWK	Claim Supplemental Information		Providers should use one Attachment Control Number (ACN) for the entire claim and utilize the first ACN field (PWK06) available within the X12 claims transactions to facilitate the association of their submitted electronic attachments.
2300	PWK 01	Report type code		Refer to 837I Implementation Guide for 5010X223A1 or Attachment B of Provider Notice dated 11/24/21.
2300	PWK 02	Report Transmission Code		Must be "FT" File Transfer
2300	PWK 05	ID Code Qualifier		Must be "AC" Attachment Control Number
2300	PWK 06	ID Code		9-digit Recipient Identification Number, 8-digit date of service, 4-digit sequence. **Example:** (111111111010120210001)
2300	REF	Medical Record Number		
2300	REF02	Medical Record Number		HFS strongly recommends providing this data element on all claims. This information is returned to you to help locate files when records have been selected for peer review or audit.
2300	HI	Principal Procedure Code		
2300	HI01-1	Code List Qualifier	"BBR"	For Inpatient and LTC claims, must use "BBR" if reporting a procedure. For Outpatient claims, leave blank.
2300	HI01-2	Principal Procedure Code		For Inpatient and LTC claims, must use ICD-10 codes for claims submitted with service Through Date after 10/01/2015. Outpatient claims, must use HCPCS codes in SV201 of the 2400 Loop.
2300	HI	Occurrence Information		

Loop ID	Reference	Name	Codes	Notes/Comments
2300	HI01-2	Occurrence Code		If the home health services follow the Subscriber's discharge from a hospital, the facility must report the hospital discharge date using an Occurrence Code of "22". If the date is not reported, follow the prior approval requirements described in the Home Health Handbook. If the claim is subject to MDS reporting requirements, an occurrence code "50" and an associated occurrence code date for the MDS assessment must be reported. When appropriate, LTC providers will also need to send occurrence code 'A3' for Medicare exhaust and the date of the last covered Medicare date for Co-insurance days.
2300	HI	Occurrence Span Information		
2300	HI01-2	Occurrence Span Code	"74:	Code 74 is required for any LTC reported hospital or therapeutic leaves of absence.
2300	HI	Value Information		
2300	HI01-2	Value Code	"24" "24" "80" "81" "82"	For hospital outpatient Medicare/Medicaid crossover claims with dates of service through June 30, 2014, utilize Value Code "24" to report the total number of departments visited by the patient during the billing period. Report all other Value Code(s) as appropriate/applicable. For LTC claims for Developmental Training services, utilize Value Code "24" to report the 4-digit Agency Code of the day training facility in HI01-5 in whole numbers. For HFS Covered Days/Non Covered Days: All inpatient and LTC claims must report the covered and non-covered days and coinsurance days where applicable. Use the following Value Codes to report this information: "80"= Covered Days – Is required. "81" = Non Covered Days – Is situational. "82"= Co-insurance Days – Is situational.

Loop ID	Reference	Name	Codes	Notes/Comments
				For HFS outpatient series claims, the number of series days for which outpatient services were provided must be reported in loop 2300 with a Value Code of "80".
2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		
2320	AMT02	Monetary Amount		Use this field to report any primary insurance payment. This includes a TPL payments and Medicare payments.
2330B	DTP	Claim Check or Remittance Date		
2330B	DTP03	Adjudication or Payment Date		For HFS, this segment is required when loop 2320 is used.
2330B	REF	Other Payer Secondary identifier		
2330B	REF01	Reference Identification Qualifier	"2U"	Must be "2U"
2330B	REF02	Reference Identification		For HFS a secondary identification number is always required when loop 2320 is used. Must be the 3-digit TPL Code followed by the 2- digit Status Code assigned by HFS to other payers. For example: REF*2U*91001~ Code "910" = Medicare Part B Code "909" = Medicare Part A For other TPL codes, refer to Chapter 100.
2400	SV2	Institutional Service Line		
2400	SV202-2	Procedure Code		For Outpatient claims, use HCPCS procedure code with the appropriate revenue code (SV201). For additional

Loop ID	Reference	Name	Codes	Notes/Comments
				information see “APL Outpatient” under billing instructions. When appropriate, for LTC claims submit the RUG score value in the HCPCS field preceded by qualifier HP.
2400	DTP	Date – Service Date		
2400	DTP02	Date Time Period Qualifier	“D8”	HFS only uses the “From” date, if a date range (RD8 in DTP02) is specified.

4 TI Additional Information

4.1 Business Scenarios

Coordination of Benefits (COB) Information

Insurance in Addition to Illinois Medicaid

For claims where the subscriber has insurance in addition to Illinois Medicaid, utilize Loop 2330B, REF02 to report the 3-digit HFS TPL Source Code, followed by the 2 digit TPL Status Code. These instructions are relevant to all primary payers including Medicare. The complete list of TPL Source Codes can be found in Chapter 100, or please refer to the "Source Code" field found in the TPL section of the subscriber's MEDI eligibility verification for the three-digit TPL code. The list of TPL Status Codes can be found in Chapter H-200, Handbook for Hospital Services, Appendix H-2B.

For Example: Medicare Part B TPL Source Code is "910" and the TPL Status Code of "01" for TPL Adjudicated
REF*2U*91001

Loop 2320 within the 837I can be used for reporting amounts paid by another payer including Medicare. Loop 2330B within the 837I can be used for Other Payer Secondary Identification.

The Department does not accept COB claims from any other payer, including Medicare, **except** that the Department will accept COB claims from Medicare for LTC claims. Providers should submit claims to the Department in compliance with HFS current billing policies.

4.2 Payer Specific Business Rules and Limitations

General Information

This section contains information on processing electronic claims based on the 005010X223 version of the ASC X12N Institutional Health Care Claim (837I) Implementation Guide, Errata (005010X223A1) dated October 2007, and the Errata (005010X223A2) dated June 2010. This document will identify information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services (HFS).

Questions, comments, or suggestions regarding this information should be directed to hfs.webmaster@illinois.gov

Billing Information

The Institutional 837 (837I) must be used to submit the following types of electronic claims to HFS:

Inpatient hospital services, both Medicaid and Medicare Crossovers

Outpatient hospital

Outpatient Medicare Crossovers

ASTC

Birth Center Services

Home Health Services

Hospice Services

Psychiatric Clinic Services

Alcohol and Substance Abuse Services

Renal Dialysis Services, including State Renal, Medicaid and Medicare crossovers

Long Term Care Services:

- Nursing Facility Services
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)
- Supportive Living Program (SLP)
- Developmental Training Services

Attachments - If a claim requires an attachment, the attachment must be uploaded to our Attachment Warehouse and referenced in the PWK segments.

Amount Fields - The maximum number of characters to be submitted in the dollar amount field is nine (9) characters. Dollar amounts in excess of 9,999,999.99 (excluding commas and the decimal point) may be rejected.

Code guidelines - HFS will process the following number of codes and will not consider additional codes for adjudication and payment determination of the claims at this time. However, additional codes in each group up to the maximum specified in the Implementation Guide will not cause the claim to reject.

Code	Number
Occurrence Span	7
Occurrence Codes	11
Condition Codes	14
Value Codes	15
Principal Procedure	1
Other Procedures	24
Principal Diagnosis	1
Admitting Diagnosis	1
External Cause of Injury (ECI) Codes (ICD-9 diagnosis codes starting with E)	3
External Cause of Morbidity Codes (ICD-10 diagnosis codes starting with V,W,X,Y)	3
Other Diagnoses	24
Modifiers	4
NDCs	1 per Revenue Line

DCFS Screening Visit – To identify a hospital service as a "DCFS Screening", the provider must use Source of Admission "8" (CL102, Loop 2300) for billing of DCFS initial visits.

Home Health – If the home health services follow the Subscriber's discharge from a hospital, the facility must report the hospital discharge date in the Occurrence Information (HI) of Loop 2300, using Occurrence Code "22". If the date is not reported, follow the prior approval requirements described in the Home Health Handbook.

If more than one skilled nursing visit per day is needed within 60 days of hospital discharge, providers must submit a prior approval request for the total number of visits required for the approval period. The provider must omit the discharge date from the Occurrence Information (HI) of Loop ID 2300 and indicate the number of visits in Loop ID 2400 SV205.

HCPCS Procedure Codes must be five (5) characters.

ICD-9 CM Diagnosis codes have a maximum size of five (5) characters, excluding the decimal point.

ICD-9 Procedure codes have a maximum size of four (4) characters, excluding the decimal point.

ICD-10 Diagnosis Codes and ICD-10 Procedure Codes must have a maximum of seven (7) characters, excluding the decimal point.

Covered and Non-covered Days and Co-insurance Days – HFS requires that for all inpatient and LTC claims the covered, non-covered and co-insurance days, when applicable, must be reported. The information is to be sent in the 2300 Loop – HI Value Information segment.

Valid Values:
"80" = Covered Days
"81" = Non Covered Days
"82" = Co-insurance Days

For HFS Outpatient series claims, the number of series days for which outpatient services were provided must also be reported as Value Code "80" = Covered Days.

Modifiers – HFS will consider up to 2 modifiers in adjudication and payment determination for Alcohol and Substance Abuse Claims only in the 837I format. For all other claims NO modifiers will be considered in adjudication and payment determination.

National Provider Identifier (NPI)
The NPI is required on all electronic claim submittals. The NPI that is submitted in the 837 Transaction must be a NPI that has been reported to the department, prior to billing, to ensure that a crosswalk can be made from the NPI to their HFS legacy number. If the NPI is not reported to the department, it cannot be crosswalked and HFS will reject the claim.

If an institutional provider obtains multiple NPIs for their subparts, such as, psychiatric, rehabilitation, and renal dialysis, and they use these multiple NPIs to bill HFS, ALL of these NPIs must be reported to HFS to be entered into the NPI crosswalk.

Loop 2300, HI01-2 Value Code – For outpatient claims' dates of service through June 30, 2014, report the total number of "Departments Visited" by the patient during the billing period using Value Code "24". See Section H-260.42 and Appendix H-2B of the archived Handbook for Hospital Services for additional information. Claims for LTC Developmental Training services reporting Value Code 24 must report the four-digit Developmental Training Agency code in the dollar field of this element. If the agency code begins with a zero, only report the three digits. As an example, if the agency code is 0100, only report 100.

COB Claims - The Department does not accept COB claims from any other payer, excluding Medicare. Providers should submit claims to the Department in compliance with HFS current billing policies.

Patient/Subscriber - The patient is always the subscriber. Claim information should only be placed at the subscriber, (or SBR Segment) hierarchical level (even when using the mother's Recipient Identification Number to bill newborn services). Claims with information in the Patient hierarchical level will not be accepted into our processing system. Do not use the PAT segment for the patient

Taxonomy – For HFS, the billing provider taxonomy code will be utilized to derive the Department's unique categories of service. The HIPAA Provider Taxonomy code is a ten-character code and associated description specified for identifying each unique specialty for which a provider is qualified to provide health care services.

Value Codes - **Effective with dates of service on or after July 1, 2007**, coinsurance and deductibles will be reported in Loop 2320, CAS segment, Claim Adjustment Group Code "Patient Responsibility" (PR). The following Reason Codes will be used to report coinsurance and deductible amounts:

"1" = Deductible "2" = Coinsurance

Void or Replacement of a Claim – At this time, the department cannot accept a Void or Replacement of a Claim.

Transmission Information:
HFS will continue to support the Medicaid Electronic Data Interchange (MEDI) system whereby authorized Providers and their agents can submit and receive electronic transactions via the Internet. Providers will have the ability to submit single claims as well as batch files utilizing the MEDI system. Additionally the MEDI system supports claim status inquiries, eligibility inquiries, and supports an option to obtain an electronic remittance advice. To access the MEDI system, use the following URL and click the login option: http://www.myhfs.illinois.gov/

The Department will also continue to support its Recipient Eligibility Verification (REV) system. The REV system allows authorized Vendors a means to submit and receive electronic transactions, on behalf of Providers, for processing eligibility inquiries, claim submission and claim status. For more information on REV vendors use the following link: REV Vendors

5 TI Change Summary

Revision Date: 05/03/2011	Revision Description: Updated the TPL Status Code information to the appropriate reference in the Handbook for Hospitals from Appendix 17 to Appendix H-2A. Updated reference to the NUBC UB04 Billing Manual for Claim Frequency Type Code in the Instruction Table for CLM05-3.
Revision Date: 02/27/2012	Revision Description: Added Hospice to claims that require an admission date and hour.
Revision Date: 07/23/2015	Revision Description: Corrected references to include ICD-10 terminology.
Revision Date: 06/07/2016	Revision Description: Added instructions for LTC billing implementation; updated links to other handbooks and webpages; put end date for utilizing "Departments Visited" for hospital outpatient crossover claims.
Revision Date: 11/24/2021	Revision Description: Added instructions for Electronic Attachments in Loop 2300, PWK segment; Topic 4.2 under Billing Information, corrected Attachments language; general clean-up of references to paper submissions.
Revision Date:	Revision Description: