UnitedHealthcare West

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3)
Implementation Guides
Based on ASC X12 Version 005010X222A1
Health Care Claim: Professional (837)

Companion Guide Version Number: 1.4

April 2015

Preface

This companion guide (CG) to the v5010 ASC X12N Technical Report Type 3 (TR3) adopted under HIPAA clarifies and specifies the data content when exchanging electronically with UnitedHealthcare West. Transmissions based on this companion guide, used in tandem with the TR3, also called Health Care Claim: Professional (837) ASC X12N/005010X222A1, are compliant with both ASC X12 syntax and those guides. 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.

EDITOR'S NOTE:

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1 INTRODUCTION

1.1 SCOPE

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

1.2 OVERVIEW

This CG will replace, in total, the previous UnitedHealthcare West CG versions for Health Care Professional Claim and must be used in conjunction with the TR3 instructions. The CG is intended to assist you in implementing electronic Professional Claim transactions that meet UnitedHealthcare West processing standards, by identifying pertinent structural and data related requirements and recommendations.

Updates to this Companion Guide will occur periodically and new documents will be posted on http://www.uhc.com/hipaa-and-edi/companion-docs with reasonable notice, or a minimum of 30 days, prior to required implementation.

In addition, all trading partners will receive an email with a summary of the updates and a link to the new documents posted online.

1.3 REFERENCES

For more information regarding the ASC X12 Standards for Electronic Data Interchange Health Care Claim: Professional (837) ASC X12N/005010X222A1 and to purchase copies of the TR3 documents, consult the ASC X12 store web site - http://store.x12.org/store/.

1.4 ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator and clearinghouse 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. Electronic Data Interchange (EDI) adoption has been proved to reduce the administrative burden on Providers.

2 GETTING STARTED

2.1 WORKING WITH UNITEDHEALTHCARE WEST

There are three methods to connect with UnitedHealthcare West for submitting and receiving EDI transactions; clearinghouse connection, Connectivity Director, and direct connection.

Clearinghouse Connection:

Physicians and Healthcare professionals should contact their current clearinghouse vendor to discuss their ability to support the Professional Claim transaction, as well as associated timeframe, costs, etc.

Physicians and Healthcare professionals also have an opportunity to submit and receive a suite of EDI transactions via the OptumInsight clearinghouse. For more information, please contact your OptumInsight Account Manager. If you do not have an OptumInsight Account Manager, please contact the OptumInsight Sales Team at (800) 341- 6141 option 3 for more information.

Connectivity Director:

Direct connection to UnitedHealthcare West for sending Professional Claim transactions is available via Connectivity Director. This connection type will support batch and real-time submissions and responses. Trading partners are able to get more information and register for Connectivity Director via http://www.unitedhealthcarecd.com.

Direct Connection:

Direct connection to UnitedHealthcare West is available via FTP with PGP encryption, SFTP or a web service connection. With PGP Encryption, UnitedHealthcare West will also require the trading partner PGP key. A signed "User Agreement for EDI Data Exchange Services" must be completed prior to direct connectivity set up. If you are interested in this type of direct connection, please contact the EDI Customer Support via email at EDISupport@phs.com or 1-800-203-7729 Monday – Friday: 9:00 a.m. – 5:00 p.m. PST.

Please note; Direct Connection is not available for Encounter Submissions.

2.2 TRADING PARTNER REGISTRATION

Clearinghouse Connection:

Physicians and Healthcare professionals should contact their current clearinghouse vendor to discuss their ability to support the Professional Claim transaction.

Connectivity Director:

Register for Connectivity Director via http://www.unitedhealthcarecd.com.

Direct Connection:

A signed "EDI Data Ex Services Agreement" must be completed prior to set up. There is no cost imposed on the trading partner by UnitedHealthcare to set up or use the direct connection process. If you are interested in this type of direct connect, please send an email to EDISupport@uhc.com or contact the EDI support line at 1-800-203-7729.

Please note; Direct Connection is not available for Encounter Submissions.

2.3 CERTIFICATION AND TESTING OVERVIEW

UnitedHealthcare West does not certify Providers or Clearinghouses.

3 TESTING WITH UNITEDHEALTHCARE WEST

Clearinghouse Connection:

Physicians and Healthcare professionals should contact their current clearinghouse vendor to discuss testing.

Connectivity Director:

All trading partners who wish to submit Professional Claim Transactions to UnitedHealthcare West must complete testing to ensure that their systems and connectivity are working correctly before any production transactions can be processed. Connectivity Director will assist in this testing process. Trading partners are able to get more information and register for Connectivity Director via this link http://www.unitedhealthcarecd.com.

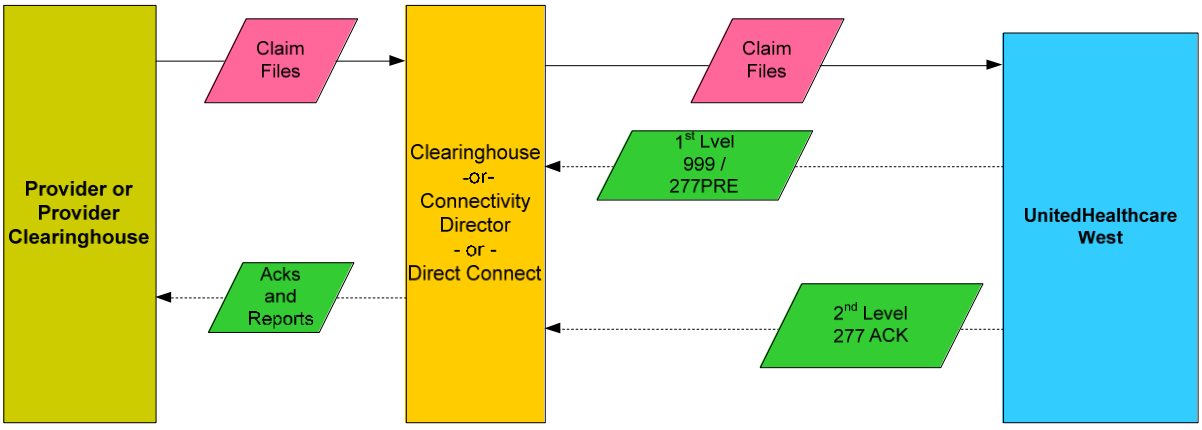
Direct Connection:

If you wish to test the Professional Claim transaction in UnitedHealthcare West's testing region please contact your EDI Account manager. If you do not have an EDI Account Manager please call EDI Customer Support at 1-800-203-7729 or via email at EDIsupport@uhc.com.

4 CONNECTIVITY/COMMUNICATIONS WITH UNITEDHEALTHCARE WEST

4.1 PROCESS FLOWS

Batch Professional Claim:



4.2 TRANSMISSION ADMINISTRATIVE PROCEDURES

OptumInsight and Connectivity Director can be used in either batch or real-time modes. Connectivity Director supports manual transactions via the website (batch only) or programmatically via several different communication protocols.

4.3 RE-TRANSMISSION PROCEDURE

Physicians and Healthcare professionals should contact their current clearinghouse vendor for information on the most current process.

4.4 COMMUNICATION PROTOCOL SPECIFICATIONS

Clearinghouse Connection:

Physicians and Healthcare professionals should contact their current clearinghouse vendor to discuss communication protocol specifications.

Connectivity Director:

Connectivity Director currently supports the following communications methods:

- HTTPS Batch and Real-Time
- FTP + PGP Batch
- FTP over SSL Batch

Direct Connection:

Direct connection supports the following communication methods:

- §§ FTP with PGP for batch (UnitedHealthcare West will provide PGP encryption key.)
- §§ SFTP for batch (UnitedHealthcare West will provide user id and password.)
- §§ Web services for real-time.
- §§ Please note; Direct Connection is not available for Encounter Submissions.

4.5 PASSWORDS

Clearinghouse Connection:

Physicians and Healthcare professionals should contact their current clearinghouse vendor to discuss the process for obtaining a password.

Connectivity Director:

To create a new connectivity director account please follow the instructions online at https://www.UnitedHealthcareCD.com.

Direct Connection:

Passwords for direct connection will be supplied upon signing of the trading partner agreement. Passwords will be sent via secure e-mail.

Please note; Direct Connection is not available for Encounter Submissions.

4.6 SYSTEM AVAILABILITY

UnitedHealthcare West will accept 837 claim transaction submissions at any time, 24 hours per day; 7 days a week. No changes to current system availability are expected.

Any scheduled or unplanned outages will be communicated via email.

4.7 COSTS TO CONNECT

Clearinghouse Connection:

Physicians and Healthcare professionals should contact their current clearinghouse vendor to discuss costs.

Connectivity Director:

There is no cost imposed on the trading partners by UnitedHealthcare West to set-up or use Connectivity Director.

Direct Connection:

There is no cost imposed on the trading partners by UnitedHealthcare West to set-up or use direct connectivity.

5 CONTACT INFORMATION

5.1 EDI CUSTOMER SERVICE

Most questions can be answered by referencing the materials posted at the EDI Resource Center at:
https://www.uhcwest.com/commonPortal/link?navnode=Library.BLOT&product=Commercial&audience=Provider-Before-Logon&region=CA&cid=600711338.

If you have questions related to transactions submitted through a clearinghouse please contact your clearinghouse vendor.

For connectivity options contact UnitedHealthcare West EDI Support at:

- Email: EDIsupport@uhc.com
- Telephone: (800) 842-1109

5.2 EDI TECHNICAL ASSISTANCE

Clearinghouse Connection

- Hospital and Healthcare facilities should contact their current clearinghouse vendor for technical assistance.

Connectivity Director

- Email: Unitedhelpdesk@ediconnect.com
- Connectivity Director Customer Support line: (800) 445-8174

UnitedHealthcare West EDI Issue Reporting

- Email: supportedi@uhc.com
- Telephone: (800) 842-1109

Encounter Data Collection

- Contact the Encounter Data Collection Team at:
- Email: encountercollection@uhc.com
- Telephone: (866) 351-0390

5.3 PROVIDER SERVICE NUMBER

Providers should call the contact numbers listed in the “Contact Us” page of the Provider Portal located here:

https://www.uhcwest.com/commonPortal/link?product=Commercial&audience=Provider-Before-Logon&region=CA&navnode=ProviderContactUs.0
Please select the correct state from the pull-down menu as they may be different based on product line. Provider Services is available Monday – Friday 8 a.m. to 5 p.m. in provider's time zone.

5.4 APPLICABLE WEBSITES / E-MAIL

Connectivity Director – http://www.unitedhealthcarecd.com

Companion Guides - www.uhcwest.com- > Provider>Library>Resource Center>Electronic Data Interchange>Companion Guides

UnitedHealthcare West EDI help desk – EDIsupport@uhc.com

OptumInsight - www.optuminsight.com

ASC X12 store web site - http://store.x12.org/store/

6 CONTROL SEGMENTS / ENVELOPES

6.1 ISA-IEA

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

The tables below represent only those fields that UnitedHealthcare West requires a specific value in or has additional guidance on what the value should be. The tables do 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	*[Submitter ID]*	This is the Submitter ID assigned by UnitedHealthcare West.
	ISA08	Interchange Receiver ID	**87726** (Claims) **95958** (Encounters)	UnitedHealthcare West Payer ID -Right pad as needed with spaces to 15 characters.

6.2 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 the transmission.

The table below represents only those fields that UnitedHealthcare West requires insertion of a specific value 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	**87726** (Claims) **95958** (Encounters)	UnitedHealthcare West Payer ID Code
	GS08	Version / Release / Industry Identifier Code	**005010X222A1**	Version expected to be received by UnitedHealthcare West.

6.3 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 table below represents only those fields that UnitedHealthcare West requires insertion of a specific value 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	ST	Transaction Set Header		Required Header
	ST03	Implementation Convention Reference	**005010X222A1**	Version expected to be received by UnitedHealthcare West.

6.4 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

6.5 CONTROL SEGMENT NOTES

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

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

6.6 FILE DELIMITERS

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

Data Element: The first element separator following the ISA will define what Data Element Delimiter is used throughout the entire transaction. **The recommended Data Element Delimiter is an asterisk (*).**

Segment: The last position in the ISA will define what Segment Element Delimiter is used throughout the entire transaction. **The recommended Segment Delimiter is a tilde (~).**

Component-Element: Element ISA16 will define what Component-Element Delimiter is to be used throughout the entire transaction. **The recommended Component-Element Delimiter is a colon (:).**

Repetition Separator: ISA11 defines the repetition separator to be used throughout the entire transaction. **The recommended repetition separator is a caret (^).**

7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

7.1 ELECTRONIC CLAIM SUBMISSION GUIDELINES

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

Services	Guidelines
Laboratory Services	When performed in the office on an urgent basis, use modifier **"ST"** in the modifier field.
Allergy Procedure Codes	Instead of submitting medical notes, use the **EDI Notes Field*** to indicate number of doses, vials, or injections and as well as the dose schedule.
UnitedHealthcare West Participating Covering PCP	Instead of submitting an attachment, use the **EDI Notes Field*** to indicate "Covering for Dr. X".
"Tracers" / re-bills	It isn't necessary to send a paper claim backup for a claim sent electronically. §§ Please allow 20-30 business days for your claim(s) to be processed. §§ To avoid duplicate claim denials, please check the status of your claim on www.uhcwest.com instead of submitting a tracer.
Claims rejected on your clearinghouse reports	These claims have not been received by UnitedHealthcare West and should be corrected and resubmitted electronically.
Medicare Primary claims	When Medicare is primary, check your Medicare Explanation of Benefits (EOB) to see if the claim has already been forwarded to the secondary carrier for you. If it hasn't been forwarded or has been sent to the wrong carrier, then submit the claim and the EOB/Coordination of Benefits (COB) information electronically. ***See EOB/COB Electronic Details below.*
Other Commercial Payer Primary claims	When another commercial insurance plan is Primary, submit the Primary carrier's EOB/COB information electronically.
Lifetime Events	A lifetime event is described as a medical procedure that can only occur once

Services	Guidelines
	in a lifetime. Such events include but are not limited to Hysterectomy, Prostatectomy, Appendectomy, and Amputations, etc. Lifetime events must be reported with a unit value of only 1.
Required Member Cost Share/Revenue reporting.	For Commercial and Medicare Advantage plans UnitedHealthcare requires[1] contracted providers to submit current, complete and accurate encounter data - including member cost share/revenue - weekly in order to effectively track member cost share. This submission should include the utilization data pertaining to all services which are provided directly by the Medical Group and its Participating Providers during the preceding week as well as well as the utilization data pertaining to services that were processed and finalized by the Medical Group during the preceding week including but not limited to any sub-capitation arrangement. UnitedHealthcare welcomes and encourages your encounter submissions more frequently than weekly (e.g., twice a week, daily). Greater encounter submission frequency allows us to more effectively administer products where member costs share administration is essential. [1]*Centers for Medicare & Medicaid Services mandate for Maximum Allowable Out-of-Pocket Cost Amount for Medicare Parts A and B Services 75 FR 19709, effective Jan. 1, 2011-"Public Law 111-148 Act Entitled the Patient Protection and Affordable Care Act H.R.3590" effective January 1, 2014.*
Interest Payments	Under the capitated delegated agreement with UnitedHealthcare to submit encounter data, any finalized claim in part or in entirety that contains interest payments, must display these payments using claim adjustment reason code **(CARC) 225 – Payment or Interest Paid by Payer**. This code should only be used for plan to plan encounter reporting. According to section 1.1.1.1 of the 005010X222A1, balancing to the claim payment involves the subtraction of adjustments from the service line payment total. A positive dollar amount for interest would reduce the payment of the claim. A negative dollar amount would increase the payment on the claim. As a result, reporting the payment of interest by a prior payer in the 837 would require a "negative dollar" amount in order to balance.
Voids and Replacements	A "replacement' encounter should be sent to UnitedHealthcare West 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 UnitedHealthcare West when the previously submitted encounter should be eliminated. A voided encounter must match the original encounter with the exception of the claim frequency type code and the payer assigned claim number. A voided encounter should not contain "negative" values within the encounter. A voided encounter should contain a claim frequency code of **[8]** in Loop 2300 CLM05-3 segment. The replacement or voided 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.

Sequestration	As required by federal law under a sequestration order dated March1, 2013, Medicare Fee-For-Service claims with dates of service or dates of discharge on or after April 1, 2013 incurs a two percent reduction in Medicare payment. [Source: Center for Medicare and Medicaid Services]. Under the capitated delegated agreement with UnitedHealthcare to submit encounter data, any finalized claim in part or in entirety that contains a reduction in payment due to "sequestration" should be reported to UnitedHealthcare using claim adjustment reason code **(CARC) 253 – Sequestration**. Sequestration reduction should be presented at the service line level.
In Network/Out of Network	Under the capitated delegated agreement with UnitiedHealthcare to support the Medicare Advantage EOB for Part C, all encounter submissions must reflect whether the services provided to the member is "in-network" or "out of network". Any finalized claim/encounter that contains a service that is "out of network" should be reported using claim adjustment reason code **(CARC) 242 – Services Not Provided by Network/Primary Care Providers**, at the service line level.

The following claims and services should continue to be submitted to UnitedHealthcare West on paper with supporting documentation.

Services	Guidelines
Corrected Medical claims	Please refer to the Claims Reconsideration website and follow the instructions.
Unspecified CPT & HCPCS codes	**UnitedHealthcare West** needs to review medical notes in order to process claims billed with unspecified CPT and HCPCS codes. *Please indicate a specific CPT or HCPCS code whenever possible to avoid sending medical notes.*

***EDI Notes**

§§ Please contact your software vendor for assistance with entering notes in your practice management system.

§§ For Professional claims, 80 characters of free form text can be entered at the claim level in the Loop 2300 NTE segment with an **"ADD'** qualifier.

****EOB/COB Electronic Details**

Section 1.4.1 of the TR3 for 837P explains COB changes

For secondary claims to be paid electronically, the COB information must be submitted per TR3 requirements in the applicable Loops and Segments. Loops include:

LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION

LOOP ID - 2330A OTHER SUBSCRIBER NAME

LOOP ID - 2330B OTHER PAYER NAME

LOOP ID - 2330C OTHER PAYER REFERRING PROVIDER LOOP

ID - 2330D OTHER PAYER RENDERING PROVIDER LOOP ID -

2330E OTHER PAYER SERVICE FACILITYLOCATION

LOOP ID - 2330F OTHER PAYER SUPERVISING PROVIDER

LOOP ID - 2430 LINE ADJUDICATION INFORMATION

7.2 VALIDATION OF CLAIMS

UnitedHealthcare West applies 2-levels of editing to inbound HIPAA 837 **files** and **claims**:

1. **Level-1 HIPAA Compliance**:

   Claims passing are assigned a UnitedHealthcare West Payer Claim Control Number and are "accepted" for **front-end** processing.

2. **Level-2 Front-End Validation:**

   a. Member match
   b. Provider match
   c. WEDI SNIP Level 1-5 Validation

3. Encounters or Claims passing **front-end** validation are accepted into the **Adjudication** system for processing.

4. Encounters or Claims that "do not pass" **front-end** validation will be rejected and returned to the Submitter.

5. Professional Encounters or Claims that are received before the service date (prior to 10/1/2015) with I C D -10 code qualifiers will be rejected by UnitedHealthcare West. Note: Mandate date for accepting the ICD -10 is set as 10/1/2015.

6. Professional Claim with the value 'II' (Standard Unique Health Identifier) in Subscriber Name, field NM108 will be rejected by UnitedHealthcare West**.** If this situational segment is used, a value of **MI** should be sent. ***addenda info, now situational Note: Mandate date is still not decided for using the Standard Unique Health Identifier.

8 ACKNOWLEDGEMENTS AND OR REPORTS

8.1 ACKNOWLEDGEMENTS

TA1 - Transaction Acknowledgement
This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Envelope of the submitted X12 file. United Healthcare West Real- will only respond with a TA1 when the X12 contains Envelope errors. The submitted 837 will need to be corrected and resubmitted.

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. United Healthcare West

will respond with a 999 when the X12 contains Functional errors. The submitted 837 will need to be corrected and resubmitted.

277PRE - This file informs the submitter with more detail about why the claim failed validation. The 277PRE is generated when claims in the batch file failed Level 1 validation. If no claims failed Level 1 validation, then the 277PRE is not created.

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

8.2 REPORT INVENTORY

None identified at this time.

9 TRADING PARTNER AGREEMENTS

9.1 TRADING PARTNERS

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

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.

For example, a Trading Partner Agreement may specify among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

10 TRANSACTION SPECIFIC INFORMATION

The below table represents only those fields that UnitedHealthcare West requires a specific value in or has additional guidance on what the value sent in the response means. The table does not represent all of 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**		
	BHT06	Transaction Type Code	**CH or RP**	**CH** = Chargeable Use CH when the transaction contains only fee for service claims or claims with at least one chargeable line item. **RP** = Capitated Encounters Use RP when submitting Encounters
1000A	**Submitter Detail**			
	PER	**Submitter Contact**		
	PER02	Contact name	*[Submitter Contact Name]*	UHC requires contact name even if 1000A NM1 submitter name is the same.
1000B	**Receiver Detail**			
	NM1	**Receiver Name**		
	NM103	Name Last or Organization Name	**UNITED HEALTHCARE (BHT06 = CH)** **UNITEDHEALTHCARE WEST (BHT06 = RP)**	Receiver Name
	NM108	Identification Code Qualifier	**46**	46 = Electronic Transmitter ID qualifier
	NM109	Identification Code	**87726** [for Claims] **95958** [for Encounters]	
2010AA	**Billing Provider Name**			
	NM1	**Billing Provider Name**		
	NM108	Billing Provider ID Qualifier	**XX**	NPI Identifier
	NM109	Billing Provider Identifier		Must be populated with a ten digit number, begin with 1, 2, 3, or 4 and have the correct check digit in the 10th position.
	N4	**Billing Provider City, State, Zip Code**		
	N403	Zip Code		The full nine (9) digits of the ZIP Code are required.
	REF	**Billing Provider Tax Identification**		
	REF01	Reference ID Qualifier	**EI**	EI = Employer's Identification Number

Loop	Reference	Name	Values	Notes/Comments
	REF02	Reference ID		Billing Provider Tax ID. 9 digits with no separators.
2000B	**Subscriber Information**			
	SBR	**Subscriber Information**		
	SBR01	Payer Responsibility Sequence Number Code	**S**	S = Secondary
2010BA	**Subscriber Name**		If a UnitedHealthcare West patient is a Dependent then the dependent information must be supplied in Loop 2000C & 2010CA. If the claim is for the Subscriber only then Loop 2000C & 2010CA are not required.	
	NM1	**Subscriber Name**		
	NM108	Subscriber Id Qualifier	**MI**	MI is the only valid value at this time. Claims received with value II will be rejected.
	NM109	Subscriber Primary Identifier		The Member ID of the Subscriber is required for NM109; however, if the patient is a Dependent, their unique Member ID must be entered here regardless of the Name in NM103/NM104.
2010BB	**Payer Name**			
	NM1	**Payer Name**		
	NM103	Last Name or Organization Name	**UNITED HEALTHCARE (BHT06 = CH)** **UNITEDHEALTHCARE WEST (BHT06 = RP)**	Payer Name
	NM108	Identification Code Qualifier	**PI**	PI = Payer Identifier
	NM109	Identification Code	**UNITED HEALTHCARE (BHT06 = CH)**	When BHT06 = RP Please check with your clearinghouse for specific identification code that must be used
	N3	Payer Address	**PO BOX 30968**	When BHT06 = RP
	N4	Payer City, State, Zip Code	**SALT LAKE CITY UT 841300968**	When BHT06 = RP
	REF	**Billing Provider Secondary Identification**		
	REF01	Reference ID Qualifier	**G2**	G2 = Provider Commercial Number
	REF02	Reference ID		The full thirty nine (39) digit Submitter ID is required

Loop	Reference	Name	Values	Notes/Comments
2300	**Claim Loop**			
	CLM	**Claim Information**		
	CLM02	Total Claim Charge Amount		Must balance to the sum of the SV1 service lines in Loop 2400.
	CLM05-3	Claim Frequency Type Code	**1**, **7**, **8**	1=Original claim submission 7=Replacement 8=Deletion
	PWK	**Claim Supplemental Information**		
	PWK01	Report Type Code	**9**	Populated for chart review submissions only
	PWK02	Attachment Transmission Code	**AA**	Populated for chart review submissions only. Available upon request at provider site
	DTP	**Date-Initial Treatment**		
		Submit Initial Treatment Date for End Stage Renal Disease (ESRD). Submit Initial Treatment Date for dental services required as the result of an accident.		
	DTP	**Date-Admission**		
		Submit Admission Date for Emergency Room (ER) visits when patient is admitted from the ER		
	HI	**Health Care Information Codes**		
		Submit only **ICD9** codes. Claims or Encounters received with value ICD10 codes will be rejected until ICD10 implementation on 10/1/2015.		
2320	**Other Subscriber Information**			
	SBR	**Other Subscriber Information**		
	SBR01	Payer Responsibility Sequence Number Code	**P**	P = Primary
	AMT	**Coordination of Benefits (COB) Payer Amount Paid**		
	AMT01	Monetary Amount	**D**	D = Payor Amount Paid
	AMT02	Payer Paid Amount		Value is Contracted Rate or Medicare Fee Schedule Rate or Calculated Capitation Rate less any applicable patient responsibility submitted in CAS Segment

Loop	Reference	Name	Values	Notes/Comments
2330A	**Other Subscriber Name**			
	NM1	**Other Subscriber Name**		
	NM108	Identification Code Qualifier	**MI**	MI is the only valid value at this time. Claims received with value II will be rejected.
	NM109			Member ID / Subscriber ID
2330B	**Other Payer Name**			
	NM1	**Other Payer Name**		
	NM103	Name Last or Organization Name		Name of Delegated Medical Group
	NM108	Identification Code Qualifier	**PI**	
	NM109	Identification Code		When BHT06 = RP Please check with your clearinghouse for specific identification code that must be used
2400	**Service Line Information**			
	SV1	**Professional Service**		
	SV103	Unit or Basis for measurement code	**MJ**	Submit code MJ when reporting anesthesia minutes in Loop 2400 SV104
	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.
	MEA	**Test Result**		
	MEA01	Measurement reference ID code	**TR**	TR = Hematocrit Hematocrit (HCT) test level is requested on all claims with services for erythropoietin (EPO).
	MEA02	Measurement qualifier	**R2**	R2 = Hematocrit To indicate test results being reported for Hematocrit
	MEA03	Measurement value		Submit Hematocrit test result value
	HCP	**Line Pricing/Repricing Information**		
		Submit line pricing for repriced claims. Providers do not submit this data. This data is to be submitted by re-pricers only.		
2410	**Drug Identification**			
	LIN	**Drug Identification**		
		Submit NDC for all unlisted injectable drugs and for other injectable drugs when required per the contract between UHG and the provider		

Loop	Reference	Name	Values	Notes/Comments
2430	**Line Adjudication Information**		Member Cost Share amounts made at the Line Level must be submitted in Loop 2430 (Line Level).	
	SVD	**Line Adjudication Information**		
	SVD02	Monetary Amount		Value is Contracted Rate or Medicare Fee Schedule Rate or Calculated Capitation Rate less any applicable patient responsibility submitted in CAS Segment as identified below
	CAS	**Line Level Adjustments**		
	CAS01	Claim Adjustment Group Code		All of the Claim Adjustment Group Codes are allowed. Note: When submitting **Member Cost Share** use code **PR** and include the appropriate Claim Adjustment Reason Code in (CAS02) as listed below.
	CAS02	Claim Adjustment Reason Code		When submitting Member Cost Share using the PR qualifier, specify the appropriate reason code: 1 = Deductible Amount 2 = Coinsurance Amount 3 = Co-payment Amount View Code Source 139 Claim Adjustment Reason Code: http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

11 APPENDECIES

11.1 IMPLEMENTATION CHECKLIST

The implementation check list will vary depending on your choice of connection; Direct Connect or Clearinghouse. However, 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

11.2 BUSINESS SCENARIOS

Please refer to Section 4.4 above, which points to the appropriate website for Washington Publishing where the reader can view the 5010 Technical Report Type 3 (TR3, formerly known as Implementation Guide), which contains various business scenario examples.

11.3 TRANSMISSION EXAMPLES

Please refer to Section 4.4 above, which points to the appropriate website for Washington Publishing where the reader can view the TR3, which contains various transmission examples.

11.4 FREQUENTLY ASKED QUESTIONS

1. Does this Companion Guide apply to all UnitedHealthcare West payers?
No. The changes will apply to commercial and government business for UnitedHealthcare West using payer ID 87726 for claims and 95958 for encounters.

2. How does UnitedHealthcare West support, monitor, and communicate expected and unexpected connectivity outages?
Our systems do have planned outages. For the most part, transactions will be queued during those outages. We have identified the planned maintenance windows in the UnitedHealthcare West section 3.6 of this document. We will send an email communication for scheduled and unplanned outages.

3. If an 837 is successfully transmitted to UnitedHealthcare West, are there any situations that would result in no response being sent back?
No. UnitedHealthcare West will always send a response. Even if UnitedHealthcare West' systems are down and the transaction cannot be processed at the time of receipt, a response detailing the situation will be returned.

11.5 FILE NAMING CONVENTIONS

ZipUnzip_ResponseType_<Batch ID>_<Submitter ID>_<DateTimeStamp>.RES

Node	Description	Value
ZipUnzip	Responses will be sent as either zipped or unzipped depending how UnitedHealthcare West received the inbound batch file.	**N – Unzipped** **Z – Zipped**

ResponseType	Identifies the file response type.	**999 – Implementation Acknowledgement**
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.	**ISA08 Value from Inbound File**
DateTimeStamp	Date and time format is in the next column. Time is expressed in military format and will be in CDT/CST.	**MMDDYYYYHHMMSS**

11.6 CHANGE SUMMARY

Version	Release Date	Changes
1.0	September 2011	Initial External Release
1.1	April 2012	Section 7.1: • Added note regarding Member Cost Share/Revenue Section 10: • Removed AMT references from Loop 2300 in the table. • Added Loop 2320 and CAS elements • Added Loop 2430 and CAS elements
1.2	November 2012	Section 10: • Added Loop 2000B and SBR elements • Loop 2010AA changed from Receiver Detail to Billing Provider Detail • Added Loop 2010BB NM1 and N3 and N4 elements • Loop 2300 CLM02 Notes/Comments changed from SV2 to SV1 • Added Loop 2320 SBR and AMT elements • Loop 2320 CAS 02 Added http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/ • Added loop 2330A and 2330B and NM1 elements • Added loop 2430 and SVD elements • Loop 2430 CAS 02 Added http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
1.3	March 2014	ICD-10 effective date change to 10/01/2015
1.4	April 2015	Section 7.1: • Updated requirements for submitting voids and replacements Section 10: • Added Loop 2010BB REF02 requirement (Submitter ID) • Added Loop 2320 AMT Payer Paid Amount requirement