ARIZONA FOUNDATION FOR MEDICAL CARE

ANSI X12 837 V.5010
COMPANION GUIDE

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1. EDI Communication

1.1 Scope

The Claims EDI Companion Guide addresses how Providers, Payors, or Clearinghouses transmit Professional and Institutional Claim electronic transactions with AFMC.
An AFMC Electronic Data Interchange (EDI) Trading Partner is defined as any client that transmits or receives electronic data from AFMC. AFMC supports transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

1.2 Overview

This Companion Guide includes information needed to sustain communication exchange with AFMC. This information is organized in the sections listed below.

Getting Started: This section includes information related to AFMC's operating hours. It also contains a list of valid characters in text data.

Testing: This section includes testing information as well as other relevant information needed to complete transaction testing.

Communications: This section includes information on AFMC's transmission procedures as well as communication and security protocols.

Contact Information: This section includes contact numbers for AFMC support.

Frequently Asked Questions: This section includes questions about HIPAA and the 5010 transition.

Business Rules: This section contains business rules that will cause the claim to reject on the Proprietary Report and Health Care Claim Acknowledgment (277)

Control Segments/Envelopes: This section contains information needed to create the ISA/IEA and GS/ control segments for transactions.

Acknowledgments and Reports: This section contains information on all transaction acknowledgments sent by AFMC. These include the Proprietary Report, Health Care Claim Acknowledgment (277) and An Implementation Acknowledgment for Health Care Insurance (999).

Segments not in use: This section discusses segments not currently used by AFMC.

2. Getting Started

2.1 System Operating Hours

AFMC is available to handle EDI transactions from 7am – 5pm on business days.

2.2 Valid Characters in Text Data (AN, string data element type)

For data elements that are type AN, "string", AFMC cannot accept characters from the extended character sets.

3 Testing Overview

AFMC is currently accepting request for testing the ASC X12 5010 837 file format. EDI transactions are transmitted through Ancillary Benefit Systems (ABS), a wholly owned subsidiary of AFMC. This section provides a general overview of what to expect during the testing phases.

3.1 Testing Policy

All Trading Partners must be approved to submit 5010 transactions.

3.2 Testing

A minimum of 3 test files must be exchanged. All test files must be transmitted in the test folder. The first round (structural) of testing must contain a minimum of 5 claims. The second round of testing must contain a minimum of 25 claims. The third round of testing must contain a minimum of 100 claims. Test files should accurately represent the variety of claims currently submitted in production. Emails will be sent notify of the test results.

4. Communications

4.1 Exchanging FTP Access Information and PGP keys

AFMC can either pick up files from your FTP site or retrieve files from our FTP site. To obtain access to our FTP site please fill out the information at https://www.azfmc.com/ftp-access-request PGP key encryption is required unless the Trading Partner is using 128-bit Secure Socket Layer (SSL) ftp client.

4.2 Re-transmission procedures

Please contact us before re-transmitting any files.

4.3 Security Protocols

If you use our FTP site AFMC EDI Operations personnel will assign User IDs and Passwords to Trading Partners. Passwords are required to be changed every 90 days. Also, the password should be changed if there are personnel changes in the Trading Partner office.

5. Contact information

5.1 EDI Customer Service

Contact information for EDI Support:
Telephone Number: (602) 253-7404
Email Address: cedi@azfmc.com
or
Address: EDI Support
19420 N. 59th Ave., Suite B221
Glendale, AZ 85308-6888

To better service you, please have your User ID available when contacting EDI Operations.
EDI Operations personnel are available for questions from 7:00 am to 5:00 pm, Monday through Friday.

5.2 Provider Services

Please reference our provider reference guide located at https://www.azfmc.com/provider-reference-guide for information on provider services. An account, tin and pin are required to access this document.

5.3 Call Center

If you need additional assistance with claims status and enrollment that are not available with our webtools at www.azfmc.com then please contact our Call Center. AFMC's Call Center Provider Unit is available to assist you Monday – Friday, 8 am to 5 pm MST. Our toll free number is 1-800-624-4277. Our mission is to provide our

clients with outstanding customer service, performed in a timely manner by well trained, highly skilled representatives operating under the absolute highest standard of quality.

6. Frequently Asked Questions

6.1 What is HIPAA?
The Health Insurance Portability and Accountability Act (HIPAA) is the federal regulation that requires the use of standard X12 transactions to report and inquire about healthcare services. The current version is 4010A1 and the new version of the standards is called 5010.

6.2 What is version 5010 of the X12 HIPAA Transaction and Code Set Standards?
HIPAA X12 version 5010 are new sets of standards that regulate the electronic transmission of specific healthcare transactions, including eligibility, claim status, referrals, claims, and remittances. Covered entities are required to conform to HIPAA 5010 standards.

The compliance date for 5010 transactions is January 1, 2012.

6.3 What 5010 transactions does AFMC support?
- **276/277** – Health Care Claim Status Request and Response
- **278** – Health Care Services – Request for Review and Response; Health Care Services Notification and Acknowledgment
- **834** – Benefit Enrollment and Maintenance
- **837** – Health Care Claim (Professional and Institutional

Transaction guides can be purchased at http://store.x12.org/.

6.4 What are the major differences between HIPAA 4010A1 and HIPAA 5010?
5010 fully supports the reporting of National Provider Identifiers (NPI) and the new ICD-10 codes. The 5010 version is more streamlined because unused content from the 4010 version has been removed.

6.5 Will there be changes to the paper claims because of 5010?
No, the most recent UB-04 and 1500 accommodate the relevant data reported in 5010.

6.6 Who needs to needs to send and receive the 5010 version?
All covered entities that currently send or receive the 4010 version with AFMC. After January 1, 2012 the 4010 version will no longer be supported.

6.7 Will testing be required for the 5010 version?
Yes, 3 sets of tests are required before the transition can be made to the 5010.

6.8 When will AFMC start testing?
Testing will begin in March 2011.

6.9 How to contact AFMC to participate in testing?
Please contact us to be added to the testing schedule. (contact us should link to edi email)

6.10 What notification will be sent to indicate readiness to begin testing?
An email will be sent providing instructions on exchanging the test files.

6.11 How will AFMC notify clients of the testing results?
An email will be sent indicating the test results. If errors occur then a follow-up phone call will be exchanged.

6.12 Will AFMC be supporting both the 4010 and 5010 at the same time?
Yes, the 4010 version will be supported until January 1, 2012.

6.13 When will be AFMC's production "go-live" date?
The anticipated date for production is May 1, 2011.

7. Business Rules
This section should be used with AFMC Internal Claim Status Codes and Description on page 12 for the full list of business rules applied to claims

7.1 TIN
If the TIN is not provided or sent as all 9's it will result in rejected claims.

7.2 Policy Number
The policy number on a claim has the following rules applied:

- May contain:
    - A-Z
    - 0-9
    - slash (/)
    - space ( )
    - ampersand (&)
    - hyphen (-)
    - period (.)
    - comma (,)
    - pound sign (#)
- No other special characters are allowed.
- May not equal the Payor ID.
- May not contain all **0's.**
- May not contain all **9's.**
- May not contain any of the following laterals:
    123456789
    INDIVIDUAL
    SELF
    NONE
    N/A
    NOT APPLICABLE

Note: If the subscriber does not have a group number (as is the case with many individual policies), leave this segment blank. An incorrect policy number will delay your claim processing time.

7.3 Names
Names on a claim have the following rules applied:

- May contain:
    A-Z
    0-9
    slash (/)
    space ( )
    ampersand (&)
    hyphen (-)
    period (.)

comma (,)
pound sign (#)

- No other special characters are allowed.
- May not be blank.
- Must begin with letters from “A –Z”
- May not contain any of the following laterals:
  123456789
  INDIVIDUAL
  SELF
  NONE

7.4 Frequency Code
The correct frequency code for the type of claim must be submitted. Incorrect codes will result in rejected claims.

7.5 Paperwork
This code must be used if a claim includes a report and it is simultaneously sent to AFMC. AFMC will request documentation for the claim if the code is not included.

7.6 Notes
Notes can be used for medication that does not have a CPT code or for any information that may be needed to process the claim.

7.7 Health Care Diagnosis Code
This segment must contain codes that follow the guidelines of the ICD9 CM coding manual(s). Incomplete codes will result in rejected claims.

7.8 Procedure Code
Codes must follow the guidelines of the CPT4 or HCPCS coding manual(s). Incomplete or incorrect codes will result in rejected claims.

7.9 Procedure Modifier
This segment must contain codes that follow the guidelines of the CPT4 coding manual(s). Incorrect codes will result in rejected claims.

7.10 Contract Language
Claims maybe rejected if they do not have the required data per your contract to price. The most common issue to arise is surgery codes are not supplied on the institutional bill. Review your contract language if a claim has been rejected to see if additional data is required to price.

8. Control Segments / Envelopes
Interchange Control (ISA/IEA) and Function Group (GS/GE) envelopes must be used as indicated in the implementation guides. AFMC only supports one interchange (ISA/IEA envelope) per edi file.

8.1 ISA
* “^” may be used as a data Element Separator, but will not be accepted as a segment terminator. LineFeed is not an acceptable delimiter.

Segment ISA 01 Authorization Information Qualifier
Use “00”

Segment ISA02 Authorization Information

Leave Blank

Segment ISA03 Security Information Qualifier
Use “00”

Segment ISA04 Security Information
Leave Blank

Segment ISA05 Interchange ID Qualifier
Use “ZZ”

Segment ISA06 Interchange Sender ID
Use Sender’s Tax Identification Number

Segment ISA07 Interchange ID Qualifier
Use “ZZ”

Segment ISA08 Interchange Receiver ID
Use Receiver’s Tax Identification Number
“860629899”

Segment ISA14 Acknowledgment Requested
Use “0”
Note: AFMC will send a 999 file.

8.2 GS

Segment GS02 Application Sender’s Code
Use Sender’s Tax Identification Number

Segment GS03 Application Receiver’s Code
Use Receiver’s Tax Identification Number
“860629899”

9. Acknowledgments and Reports

9.1 Proprietary Reports

AFMC produces a custom report in the following format for all 837 files that were accepted for processing.

3/8/2011 Ancillary Benefit Systems 12:37
EDI Claim Report

FILE: TEST

Prv TIN: 201688729 Prv Last: HARRIS II DO Prv First: GERALD

PatAcct: 8443ds42009 Name: TEST LASTNAME, FIRSTNAME Status: R
ID: 2231328 Payer: ARIZONA FOUNDATION

Line#: 0 Error#: 80
Err Desc: ICD9 CODE INVALID AT THE TIME OF SERVICE

TotCharge: 435.00
PatAcct: 84800 42109 Name: TEST LASTNAME, FIRSTNAME Status: A
ID: 2231328 Payer: ARIZONA FOUNDATION
Line#: 0 Error#: 0
Err Desc:

TotCharge: 50.00

10 ASC X12 Acknowledgments
AFMC produces the 999 (Transaction Implementation Acknowledgment for Health Care Insurance) and 277 (Claim Acknowledgment) acknowledgments for each 837 received. The difference between the 997 and the 999 is the business identifier. A 277 is only generated when the file was accepted for processing. The 277 indicates if each claim has been accepted for processing.

11. Segments not in use
This section covers segment not supported. If you would like to use these segments then please notify us and we contact our customers to make sure they will accept these segments. We can then perform testing to accept the following segments:

- Foreign Currency Information
- Billing Provider Specialty Information
- Pay-To Plan Name
- Billing Provider Secondary Information
- Billing Provider Contact information
- Property and Casualty Subscriber Contact Information
- Subscriber Secondary Identification
- Property and Casualty Claim Number
- Payer Secondary Identification
- Billing Provider Secondary Identification
- Date - Property and Casualty Date of First Contact

Segments not in use continued

- File Information
- Ambulance Certification
- Patient Condition Information: Vision
- Homebound Indicator
- EPSDT Referral
- Ambulance Pick-up Location
- Ambulance Drop-off Location
- Other Payer Referring Provider
- Other Payer Rendering Provider
- Other Payer Service Facility
- Other Payer Supervising Provider
- Other Payer Billing Provider
- Ambulance Transport Information
- Durable Medical Equipment Certification
- Ambulance Certification
- Hospice Employee Indicator
- Condition Indicator/Durable Medical Equipment

12. This section covers our plan for dual systems processing to handle transactions in both **4010** and **5010** formats.

12.1 Adjustments performed when the claims were sent in version 4010 and sent out with version 5010.

12.1.1 If a PO Box is sent in the billing segment it will be transferred to the pay-to segments. The billing segment will be filled with the service facility location.

12.1.2 When data is sent in a deleted 5010 segment it will be stored in our database for future reference. It will not be sent back in the 5010 file.

12.1.3 When a code is not available in the 5010, the closest code will be sent in the 5010 file.

12.1.4 If data is required in the 5010, but not the 4010 we will fill in the correct data to the best of our ability. An example is the plus4 is required in the 5010, but is situational in the 4010. We require our providers to update this information when renewing their membership each year and all new applications now require this data.

12.2 Adjustments performed when the claims were sent in version 5010 and sent out with version 4010.

12.2.1 When data is sent in an added 5010 segment it will be stored in our database for future reference. It will not be sent back in the 4010 file.

12.2.2 When a code is not available in the 4010, the closest code will be sent in the 4010 file.

12.2.3 If data is required in the 4010, but not the 5010 we will fill in the correct data to the best of our ability.

12.2.4 When data is sent in the longer field lengths in the 5010 it will be truncated in the 4010 return file.

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AFMC INTERNAL CLAIM STATUS CODES AND DESCRIPTIONS WITH CORRESPONDING ASC X12 5010 277 CODES

The following list of codes is a cross reference of internal codes used by AFMC and the HIPAA compliant 4010 – 277 codes. Codes in the first column will appear on AFMC's .RPT report. While this report is in a non-compliant format, it should allow the recipient to easily determine the status of a claim at a glance.

AFMC Code	Description	Acknowledgement Code	Claim Status Codes
1	No Service City	A6	126
2	Service City must be more than 2 characters	A6	126
3	No Service Address	A6	126
4	No Service State	A6	126
5	Service State must be 2 letters	A6	126
6	No Service Zip	A6	126
7	Service Zip < 5 characters	A6	21
8	Service Zip must be numeric	A7	126
9	No Billing Address	A6	126
10	No Billing City	A6	126
11	Billing City must be more than 2 characters	A7	126
12	No Billing Last Name	A6	125
13	Billing State must be 2 letters	A6	126
14	No Billing Zip	A6	126
15	Billing Zip < 5 characters	A6	126
16	Billing Zip must be numeric	A7	126
17	No Provider Name	A6	125
18	No Patient Account	A6	478
19	Invalid character in Patient Account	A7	21
20	Invalid character in Other Insured Last	A7	125
21	No Insured ID	A6	164
22	Invalid Insured ID	A7	164
23	Insured ID contains all 1 character	A7	164
24	Invalid character in Insured ID	A7	164
25	Insured Last Name is blank	A6	125
26	Invalid character in Insured Last	A7	125
27	Insured Last must begin A-Z	A7	125
28	Insured First Name is blank	A6	125
29	Invalid character in Insured First	A7	125
30	Insured MI must be A-Z	A7	125
31	No Insured or Patient Address	A6	126
32	Invalid Insured Address	A7	126
33	No Insured or Patient City	A6	21
34	Invalid Insured City	A7	126
35	Invalid Insured State	A7	126
36	Invalid Insured Zip	A7	126
37	Insured Zip invalid length	A7	126
38	Insured Zip must be all numbers	A7	126
39	Invalid Units on Service Line	A7	476
40	No Patient or Insured Address	A6	126
41	Invalid Patient Address	A7	126
42	No Patient or Insured City	A6	126
43	No Patient or Insured State	A6	126
44	Invalid Patient Zip	A7	126

AFMC Code	Description	Acknowledgement Code	Claim Status Codes
45	Patient Zip invalid length	A6	126
46	Patient Zip must be all numbers	A7	126
47	Patient City must be longer than 2 characters	A6	126
48	Invalid Policy Number	A7	163
49	Policy Number contains all 1 character	A7	163
50	Policy Number contains all 9's	A7	163
51	Invalid character in Insured Policy Number	A6	163
52	Patient Last Name is blank	A6	125
53	Invalid character in Patient Last Name	A7	125
54	Patient Last Name must begin A-Z	A7	125
55	Patient First Name is blank	A6	125
56	Invalid character in Patient First Name	A7	125
57	Patient MI must be A-Z	A7	125
58	Patient DOB is blank	A6	21
59	Patient DOB is a future date	A7	21
60	Patient Sex is blank	A6	157
61	Patient Relationship to Insured is blank	A6	21
62	Invalid character in Other First Name	A7	125
63	Primary Diagnosis Code is blank	A6	21
64	Diagnosis Code 3 w/o Diagnosis Code 2	A6	21
65	Diagnosis Code 4 w/o Diagnosis Code 2	A6	21
66	Diagnosis Code 4 w/o Diagnosis Code 3	A6	21
67	Service From Date is blank	A6	21
68	Service From Date before Patient DOB	A7	21
69	Service Through Date is blank	A6	21
70	Service Through Date before Service From Date	A7	21
71	Service From Date is future date	A7	21
72	Service Through Date is future date	A7	21
73	Invalid Modifier on Service Line	A7	21
74	Diagnosis Pointer blank on Service Line	A6	477
75	Charge > 999999.99 on Service Line	A7	21
76	Charge < 0 on Service Line	A7	402
77	Invalid Procedure on Service Line	A7	21
78	Date of Service > 18 months timely filing limit	A3	263
79	ICD9 Code requires fourth or fifth digit	A7	21
80	ICD9 Code invalid at the time of service	A7	21
81	Procedure Code invalid at the time of service	A7	454
83	Unable to locate enrollee in an AFMC endorsed plan	A3	32
84	Unable to locate Employer with Policy # provided	A3	32
85	Employer Group is no longer active with AFMC	A3	27
86	Insurance Company is no longer active with AFMC	A3	27
87	Employer Group only has CHOICE plan	A3	116
88	Duplicate Claim	A3	54
89	Provider's Name not located in AFMC's database	A7	21
90	Provider is not in-network with AFMC	A6	109
91	Patient not active at time of service	A3	90
92	Tax ID Blank	A6	21
93	AFMC does not reprice	A3	0
94	No Ref Provider Taxid or Lic#	A6	21
95	Invalid Discharge Status	A6	21
96	Admit Day is > today	A6	122
97	TIN cannot be 999999999	A6	125
99	Provider Last cannot be XX	A6	122
100	Statement Dates are invalid	A7	21

AFMC Code	Description	Acknowledgement Code	Claim Status Codes
101	Occurrence Dates are invalid	A7	21
102	Otr Procedures invalid	A6	122
103	Occur Code without Occur Date	A6	122
104	Invalid Other Procedure Info	A7	490
105	Invalid Occurrence Info	A7	462
106	Surgery Procedure Code Required.	A6	666
107	Invalid Discharge Status	A6	122
108	Principle Procedure invalid	A6	122
109	Invalid Discharge Status	A7	234
110	Invalid Principal Procedure Info	A7	465
111	Missing DRG is required	A6	256
112	Payer not participating in Chiro Network	A3	0
113	Unable to locate provider and enrollee in AFMC's database	A3	32
114	Rendering Provider NPI Required	A6	562
115	Facility NPI Required	A6	562
116	Billing NPI Required	A6	562
117	Rendering Provider NPI Invalid	A7	562
118	Facility NPI Invalid	A7	562
119	Billing NPI Invalid	A7	562
120	Referring NPI Invalid	A7	562
121	Valid Rendering Provider's NPI Needed	A7	562
122	Facility NPI Must be Submitted before Claim	A7	562
123	Claims must be submitted directly to the payor	A3	0