COLORADO
Department of Health Care Policy & Financing

gainwell

# Colorado Medical Assistance Program

## Behavioral Health Administration (BHA):

## Health Care Claim Professional (837) Transaction Standard Companion Guide

## Companion to Health Care Claim ASC X12N 837 005010X222 Implementation Guide

**Note:** This companion guide is only for use if the payer is Behavioral Health Administration (BHA). BHA is a state-funded program that is not part of Health First Colorado (Colorado's Medicaid program) or Child Health Plan *Plus* (CHP+). BHA is a separate entity that is addressing behavioral health needs of individuals not covered by other medical assistance programs.

**May 2025**

**Disclosure Statement**

**Preface**

This companion guide to the Health Care Claims (837s) adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with the Department of Health Care Policy & Financing (the Department). Transmissions based on this companion guide, used in tandem with the **ASC X12N 837 005010X222 and the associated addendum 005010X222A1 implementation guides,** 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 implementation guides 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 implementation guides.

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# 1. INTRODUCTION

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

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into transition 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 specification or are not in the standard’s implementation specifications
- Change the meaning or intent of the standards implementation specifications

## SCOPE

The companion guide is to be used with, and to supplement the requirements in the HIPAA ASC X12 implementation guides, without contradicting those requirements. Implementation guides define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of the companion guide is to provide trading partners with a guide to communicate information specific to the Colorado Medical Assistance Program that is required to successfully exchange transactions.

The companion guide is intended for the business and technical users, within or on behalf of trading partners, responsible for the testing and setup of electronic claim status request and response transactions to the fiscal agent on behalf of the Department.

## OVERVIEW

This section of the companion guide will provide guidance for establishing a relationship with the Department for the business purpose of submitting Health Care Claims (837s).

## ADDITIONAL INFORMATION

It is assumed that the trading partner has purchased and is familiar with the ASC X12 Type 3 Technical Report (TR3) being referenced in this companion guide.

# 2. GETTING STARTED

## TRADING PARTNER REGISTRATION

Any entity intending to exchange electronic transactions with the Department must agree to the Trading Partner Agreement at the end of the trading partner profile process. A trading partner profile can be completed using the Provider Web Portal.

***Note:*** Providers must be enrolled and approved before registering as a trading partner.

The Web Portal and the Secure File Transfer Protocol (SFTP) will include the ability for file and report retrieval. Billing agents and clearinghouses will have the option of retrieving the transaction

responses and reports themselves and/or allowing each individual provider the option of retrieval. The trading partner will access the system using the assigned login and password. Refer to the File Delivery and Retrieval System Vendor Interface Specifications on the Electronic Data Interchange (EDI) Support web page for more information.

## 3. TESTING WITH THE PAYER

This section contains a detailed description of the testing phase.

Testing is required for Health Care Claims (837s).

Before exchanging production transactions with the Department, each trading partner must complete production authorization testing.

Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

Trading partners are encouraged to submit 10 successful and unique submissions and receive the associated 999 (accepted) acknowledgement in response to obtain approval to promote to production.

Trading partner authorization testing is detailed in the Trading Partner Testing Packet for ASC X12 transactions available on the Colorado Electronic Data Interchange (EDI) Support web page.

Questions may be directed to the Provider Services Call Center.

## 4. CONTACT INFORMATION

Visit the Colorado Department of Health Care Policy & Financing's website for general information.

### ELECTRONIC DATA INTERCHANGE (EDI) SERVICES

Contact the Provider Services Call Center with any questions.

## 5. CONTROL SEGMENTS/ENVELOPES

### ISA-IEA

This section describes the use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters. (See Section 9 Transaction-Specific Information below.)

### GS-GE

This section describes the use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how the Department expects functional groups to be sent and how the Department will send functional groups. These discussions will describe how similar transaction sets will be packaged and the use of functional group control numbers. (See Section 8 Transaction-Specific Information below.)

### ST-SE

This section describes the use of transaction set control numbers. (See Section 8 Transaction-Specific Information below.)

Transactions (ST-SE envelopes) are limited to a maximum of 5000 CLM segments.

## 6. ACKNOWLEDGEMENTS AND REPORTS

The acknowledgement process will create the TA1 and the 999 acknowledgements for the inbound transactions, as well as an HTML report.

- 999s will be returned in all cases.
- HTML reports will be returned only in case of errors.
- TA1s will be returned based on the ISA14 indicator.
    - If ISA14 = 1
        - Positive scenario: TA1 will be sent
        - Negative scenario: TA1 will be sent
    - If ISA14 = 0
        - Positive scenario: TA1 will not be sent
        - Negative scenario: TA1 will be sent

## 7. TRADING PARTNER AGREEMENTS

An Electronic Data Interchange (EDI) trading partner is defined as any customer of the Department (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to or receives electronic data from the fiscal agent on behalf of the Department.

Payers have EDI Trading Partner Agreements (TPA) 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.

## 8. TRANSACTION-SPECIFIC INFORMATION

This section describes how ASC X12N implementation guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that contains additional information not found in the IGs. 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 IGs 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, composite or simple data element pertinent to trading electronically with the Department

In addition to the row for each segment, one (1) or more additional rows are used to describe the 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.

All clients of the Department are considered “subscribers,” and no patient loops are allowed. The patient will always be the subscriber. See the implementation guide for additional information.

The Trading Partner ID (TPID) is the number that is assigned to the provider/submitter to uniquely identify their electronic transaction. This may also be referred to as the Electronic Claim Submission (ECS) number or TPID.

**Health Care Claim Professional (837P)**

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| **HEADER** | **ISA** | **Interchange Control Header** | | **The ISA is a fixed-length record with fixed-length elements.**<br>**All inbound files are constrained to a single ISA segment for tracking and balancing.**<br>**Note:** Deviating from the standard ISA element sizes will cause the Interchange to be rejected. |
| | ISA01 | Authorization Information Qualifier | 00 | |
| | ISA02 | Authorization Information | | No data is expected in this data element. |
| | ISA03 | Security Information Qualifier | 00 | |
| | ISA04 | Security Information | | No data is expected in this data element. |
| | ISA05 | Interchange ID Qualifier | ZZ | |
| | ISA06 | Interchange Sender ID | | Enter the Trading Partner ID (TPID) assigned by the Colorado Medical Assistance Program. |
| | ISA07 | Interchange ID Qualifier | ZZ | |
| | ISA08 | Interchange Receiver ID | COMEDASSISTPROG | |
| | **GS** | **Functional Group Header** | | |
| | GS02 | Application Sender's Code | | Enter the Trading Partner ID (TPID) assigned by the Colorado Medical Assistance Program. |
| | GS03 | Application Receiver's Code | COMEDASSISTPROG | |
| | GS08 | Version/Release/ Industry Identifier Code | 005010X222A1 | Standards Approved for Publication by ASC X12 Procedures Review Board. |
| | **ST** | **Transaction Set Header** | | |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | ST03 | Version, Release, or Industry Identifier | 005010X222A1 | |
| | **BHT** | **Beginning of Hierarchical Transaction** | | |
| | BHT06 | Claim or Encounter Identifier | CH, RP | For submitting fee-for-service claims, enter the following value: CH<br>For submitting encounter claims, enter the following value: RP<br>**Note:** Fee-for Service and encounter claims must be submitted in separate transaction. |
| **1000B** | **NM1** | **Receiver Name** | | |
| | NM103 | Receiver Name | COLORADO MEDICAL ASSISTANCE PROGRAM | |
| | NM109 | Receiver Primary Identifier | COMEDASSIST PROG | |
| **2000B** | **SBR** | **Subscriber Information** | | |
| | SBR09 | Claim Filing Indicator Code | | For Medicare Crossover Claim, enter one of the following values:<br>16, MA, or MB<br>Otherwise enter the following value: MC |
| **2010BA** | **NM1** | **Subscriber Name** | | |
| | NM108 | Identification Code Qualifier | MI | |
| | NM109 | Subscriber Primary Identifier | | Enter the Colorado Medical Assistance Program Client ID |
| **2010BB** | **NM1** | **Payer Name** | | |
| | NM108 | Identification Code Qualifier | PI | |
| | NM109 | Payer Identifier | CO_BHA | |
| **2300** | **CLM** | **Claim Information** | | |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | CLM05-3 | Claim Frequency Code | 1, 7, 8 | Only codes 1, 7, and 8 are recognized for Colorado Medical Assistance Program Claims processing.<br>If code 7 or 8 is used, the Payer Claim Control Number (2300/REF02) must also be included. |
| | **PWK** | **Claim Supplemental Information** | | **Colorado Medical Assistance Program does not support the use of this segment at this time.** |
| | **REF** | **Referral Number** | | |
| | REF02 | Referral Number | | Needed for timely filing requirements, enter the previous Internal Control Number (ICN). |
| | **REF** | **Payer Claim Control Number** | | |
| | REF02 | Payer Claim Control Number | | Enter the Colorado Medical Assistance Program Internal Control Number (ICN) for the claim that is being adjusted. |
| | **REF** | **Claim Identifier For Transmission Intermediaries** | | **Colorado Medical Assistance Program requires this segment to be used for all Encounter Claim submissions.** |
| | REF02 | Value Added Network Trace Number | | The system does not store any alphabetic characters. If a TCN contains alphabetic characters, only the leading numeric values will be stored in interChange for query and reporting. If a TCN contains more than 17 numeric characters, the system will truncate the number to only retain the first 17 characters.<br>• Ex: TCN received starts with a number – 123A45, the system will store and report 123 as the TCN for the encounter. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | | | | • Ex: TCN received starts with alphabetic character =A12345, the system will not store and report a TCN for the encounter.<br>• Ex: TCN received =”2227211813004333 867”, the system will store “22272118130043338”<br>Enter the Managed Care Entity Claim Number. |
| | **REF** | **Medical Record Number** | | |
| | REF02 | Medical Record Number | | Maximum length of 30 bytes supported |
| **2320** | **SBR** | **Other Subscriber Information** | | **For MCO Encounter claims, the MCO will be considered an Other Payer and the MCO payment information should be included in the last iteration of this loop.** |
| | SBR09 | Claim Filing Indicator Code | | Enter one of the following values, which correctly identifies the type of Medicare coverage provided by the policy:<br>16, MA, or MB<br>For Managed Care Organization Encounter claims, enter "ZZ" to identify the submitting MCO as a Payer on the claim. |
| **2400** | **SV1** | **Professional Service** | | |
| | SV101-2 | Procedure Code | | If a drug is being billed, an appropriate J-code or other drug related HCPCS code must be used. |

**APPENDIX 1: Change Summary**

| Date | Change | Responsible Party |
|---|---|---|
| 12/18/2023 | Original Document, copied from 837P companion guide for all trading partners. Changed payer information to CO_BHA. | Gainwell Technologies |
| 5/1/2025 | Removed deprecated information | Gainwell Technologies |