CAREBRIDGE

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Iowa
Home Health 837i Claim Element Technical Details

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INTRODUCTION TO HOME HEALTH 837I CLAIM ELEMENTS TECHNICAL DETAILS

OVERVIEW

The purpose of this document is to assist Third-Party EVV Vendors in understanding the requirements and expectations regarding additional claim elements being added in Q3-Q4 2024 for Home Health Services submitted on institutional claims (837i) files. It is **highly recommended** that all vendors complete the additional claim elements testing (testing guide available here). This document is intended for Technical teams within Third-Party EVV Vendors who will be implementing the file exchange process.

SUMMARY OF NEW CLAIM ELEMENTS AND CORRESPONDING FIELDS

The following claim related fields have been added to the inbound EVV Visit file data specification:

1. **Facility Type Code**
    a. EVV Visit File New Fields
        i. FacilityType
2. **Claim Frequency Code for Initial Claims**
    a. EVV Visit File New Fields
        i. InitialClaimFrequency
3. **Admission Date/Patient Certification**
    a. EVV Visit File New Fields
        i. AdmissionDate
4. **Patient Status Code**
    a. EVV Visit File New Fields
        i. PatientStatus
5. **Attending Provider**
    a. EVV Visit File New Fields
        i. AttendingProviderName
        ii. AttendingProviderNPI
        iii. AttendingProviderTaxonomyCode
6. **Referring Provider**
    a. EVV Visit File New Fields
        i. ReferringProviderName
        ii. ReferringProviderNPI
7. **Condition Codes**
    a. EVV Visit File New Fields
        i. ConditionCode
8. **Value Code**
    a. EVV Visit File New Fields
        i. ValueCode
        ii. ValueCodeAmount

OVERVIEW OF REQUIREMENTS FOR NEW HOME HEALTH FIELDS

The new fields for Home Health Services fall into two categories:

1. The fields below are required depending on provider configuration

    a. Facility Type Code
    b. Claim Frequency Code for Initial Claims
    c. Admission Date/Patient Certification
    d. Patient Status Code
    e. Attending Provider

For the fields listed above, providers will be required to go into the CareBridge Provider Portal and select whether they want to have these fields populated statically by CareBridge or dynamically by being supplied on the inbound EVV Visit Data file. If providers select that they want this to be supplied by their EVV Vendor, these fields are **required** for any visits that are sent to CareBridge with the ClaimAction field populated for that Tax ID with a Date of Service on or after the required date for these fields (10/1/2024). Vendors should work with their providers to determine which (if any) fields are expected to be transmitted to CareBridge on the inbound EVV Visit Data file. It is highly recommended that all fields are tested, in case a provider decides they would like to change their configuration to manage these after 10/1/2024.

Finally, you should work with your providers to ensure that they have made their configurations in the CareBridge system prior to 10/1/2024. If providers do not complete their configuration selections within the CareBridge system by this date, all home health visits will receive prebilling rejections indicating that these configurations must be set.

2. Optional fields

    a. Referring Provider
    b. Condition Codes
    c. Value Code

The optional fields listed above do not have configuration requirements, but will be passed onto the claim if included in the inbound EVV Visit Data file.

HOME HEALTH CLAIM ELEMENT ROLLOUT DETAILS

- CareBridge's technical specifications will be updated on 7/1/2024.
    - Vendors should begin working with their provider agencies to determine which fields they would like to begin transmitting to CareBridge, and then begin any development work necessary to start sending these fields to CareBridge. When vendors have coordinated with their providers to determine which fields they will need to begin sending, they should complete the Home Health Claim Element Attestation Form.
- On 8/9/2024, these fields will be enabled in the CareBridge staging environment for vendors to begin testing. At this point, vendors should begin testing all the fields that any of their providers have indicated they will be configuring to manage directly. CareBridge recommends testing the ability to send all the fields, but vendors may use their discretion if none of their providers indicate that they intend to leverage this functionality or only intend to leverage a subset of these fields.
- On 9/13/2024, providers can begin setting their configurations in the CareBridge provider portal. **All providers must set these configurations prior to 10/1/2024.** Additionally, after this date, if vendors send any of the new fields in production, CareBridge will utilize them on claims, even if they are configured to continue to use static values identified by CareBridge.
    - The rationale for this is that if, in most situations, a provider prefers to use static values, but in specific cases would like to override those values with values submitted by their vendor, they may do so without changing their configurations. However, this means that if providers do not want to use vendor submitted values on claims, vendors should not send them on the inbound visit file.
    - During this period (9/13/2024 – 10/1/2024), CareBridge will generate warnings if visits are received without the new claim elements for providers who are configured to send them via their third-party vendor. These warnings will not block claim generation but are intended to inform vendors that they will be required on 10/1/2024.
- On 10/1/2024, the new claim element fields will be required for providers who are configured to send them for all visits with dates of service on or after 10/1/2024.
    - If a visit is submitted after 10/1/2024 with a date of service prior to 10/1/2024 without the new claim elements, it will still be claimed using the current, static values.
    - If a visit is submitted after 10/1/2024 with a date of service prior to 10/1/2024 with the new claim elements, the claim will be generated with the vendor submitted values.

FACILITY TYPE CODE - DETAILS

- This field is required if the provider has selected that they want this to be managed by their EVV Vendor. Otherwise, this field should be left null.
- Facility Type Code will be included on the claim at Loop 2300 – CLM05-1
- This field is used to identify the Facility Code Value as part of Health Care Service Location Information.
- This field includes two digits (see the Facility Type Codes table in the CareBridge Technical Specification)
    - First digit = Type of facility
        - '3' = Home health agency
    - Second digit = Bill classification
        - '2' = Hospice (hospital based)
        - '3' = Outpatient hospital, or outpatient SNF
        - '4' = Hospital referenced laboratory services, home health agency, rehabilitation agency
- This value should align for all visits completed with the same Tax ID and NPI combination.
    - If there are visits that should be included on the same claim, but do not have the same facility type code value, a prebilling alert will be generated blocking claim generation.

CLAIM FREQUENCY CODE FOR INITIAL CLAIMS - DETAILS

- This field is required for **initial** claims if the provider has been selected that they want this to be managed by their EVV Vendor. Otherwise, this field should be left null.
- Claim Frequency Code will be included on the claim at Loop 2300 – CLM05-3
- This field should only be populated for initial claims. For corrected and voided claims, this field should be left null; however, if this field is populated and the CareBridge claim engine rolls up visits to generate a corrected claim, the value supplied in this field will not be used and '7' will be used instead.
- If there are multiple visits that would roll up together on the same claim with different claim frequency codes, CareBridge will generate a prebilling alert.
- Allowable values for this field include the following digits (see the Initial Claim Frequency Codes table in the CareBridge Technical Specification):
    - '1' Admit through discharge claim
    - '2' Interim – first claim
    - '3' Interim – continuing claim
    - '4' Interim – last claim
- MCOs may have adjudication denial logic related to the claim frequency code and other values such as patient status code (e.g. Claim Frequency Code '2' is submitted with Patient Status Code other than '30'). If providers are configured to send this field, they should review MCO expectations for transmitting this data to CareBridge to avoid denials.

ADMISSION DATE - DETAILS

- This field is required if the provider has selected that they want this to be managed by their EVV Vendor. Otherwise, this field should be left null.
- Admission Date will be included on the claim at Loop 2300 – DTP03 Admission Date
- This field corresponds to the beginning of the member's certification period.
    - The same value should be transmitted for all visits for the same member that are part of the same claim and should be dated prior to the date of service for the visit. If there are visits that the CareBridge Claim engine rolls up together to the same claim with different Admission Dates or containing an Admission Date after the date of service for the visit, CareBridge will generate a prebilling alert.
- The data should be transmitted in ISO 8601 date format (YYYY-MM-DD)

PATIENT STATUS CODE – DETAILS

- This field is required if the provider has selected that they want this to be managed by their EVV Vendor. Otherwise, this field should be left null.
- Patient Status Code will be included on the claim at Loop 2300 – CL103
- This code indicates the member's status at the end of service.
- Values transmitted in this field should correspond to valid Patient Status Codes as defined by Iowa Medicaid in the IA Medicaid UB-04 Claim Form Instructions.
- CareBridge will not enforce any validations related to invalid combinations of Patient Status Code and Claim Frequency Code. Providers that have selected that they want this to be managed by their EVV Vendor are responsible for understanding MCO adjudication logic with respect to these fields and submitting the data in this field appropriately.

ATTENDING PROVIDER – DETAILS

- These fields are required if the provider has selected that they want this to be managed by their EVV Vendor. Otherwise, these fields should be left null.
- These fields correspond to the provider responsible for the patient.
- Attending Provider fields will be included on the claim at Loop 2310A in the following segments:

EVV Visit Data File Field Name	837i Segment	837i Segment Description
AttendingProviderName	NM103	Provider Full Name / Organization Name
AttendingProviderNPI	NM109	Attending Provider Primary Identifier (NPI)
AttendingProviderTaxonomyCode	PRV03	Provider Taxonomy Code

- CareBridge expects the value in the AttendingProviderNPI field to satisfy the requirements for a valid NPI; however, CareBridge will not enforce validations that ensure the attending provider is listed in the Iowa State Provider Master File (PMF). MCOs may have adjudication logic that will deny claims if the Attending Provider is not active on the Iowa State PMF.
- The same values should be transmitted for all visits for the same member that are part of the same claim. If there are visits that the CareBridge Claim engine rolls up together to the same claim with different Attending Providers, CareBridge will generate a prebilling alert.

REFERRING PROVIDER – DETAILS

- These fields are optional. CareBridge's inbound EVV Visit File data specification does not require them, but will include them on claims if provided.
- These fields correspond to the provider who referred the patient for Home Health Services.
- Attending Provider fields will be included on the claim at Loop 2310F in the following segments:

EVV Visit Data File Field Name	837i Segment	837i Segment Description
ReferringProviderName	NM103	Provider Full Name / Organization Name
ReferringProviderNPI	NM109	Referring Provider Identifier (NPI)

- CareBridge expects the value in the ReferringProviderNPI field to satisfy the requirements for a valid NPI; however, CareBridge will not enforce validations that ensure the referring provider is listed in the Iowa State Provider Master File (PMF). MCOs may have adjudication logic that will deny claims if the Referring Provider is not active on the Iowa State PMF.
- The same values should be transmitted for all visits for the same member that are part of the same claim. If there are visits that the CareBridge Claim engine rolls up together to the same claim with different Referring Providers, CareBridge will generate a prebilling alert.

CONDITION CODES– DETAILS

- These fields are optional. CareBridge's inbound EVV Visit File data specification does not require them but will include them on claims if provided.
- These codes are used to identify condition(s) relating to the claim or the member.
- Condition Codes will be included on the claim at Loop 2300 – Condition Information
    - HI01-2
    - HI02-2
    - HI03-2
    - HI04-2
    - HI05-2
    - HI06-2
    - HI07-2
    - HI08-2
    - HI09-2
    - HI10-2
    - HI11-2
    - HI12-2
- If multiple condition codes are transmitted, they should be sent as a tilde (~) delimited list.
- The maximum number of condition codes that can be sent for a single visit is 24.

VALUE CODES – DETAILS

- These fields are optional. CareBridge's inbound EVV Visit File data specification does not require them, but will include them on claims if provided.
- These fields supply information related to the delivery of care.
- Value Codes will be included on the claim at Loop 2300 – Value Information at the following segments:
    - Value Code - HI01-2
    - Value Code Amount - HI01-5
- If the ValueCode field is sent, ValueCodeAmount is a required field.