Standard Companion Guide for the Vision Business Segment

Refers to the Implementation Guide Based on
X12 Version 005010X222A1
Health Care Claim: Professional (837)

Companion Guide Version Number: 1.8

Feb 11, 2025

Change Log

Version	Release date	Changes
1.0	03/27/2011	Initial Draft
1.1	2/16/2012	837 Transaction Specific Detail clarification
1.2	09/28/2015	VAS and ICD10 changes
1.3	01/20/2016	Minnesota MUCG Updates
1.4	01/02/2018	Added Minnesota MUCG website link
1.5	01/27/2020	Document Review – no updates
1.6	12/1/2020	Corrected Claim Submissions
1.7	04/01/2021	Updated Brand name
1.8	02/11/2025	Updated Minnesota MUCG website link

Preface

This companion guide (CG) to the Technical Report Type 3 (TR3) adopted under HIPAA clarifies and specifies the data content when exchanging transactions electronically with Spectera. Transactions 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 X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the 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.

Table of Contents

1. INTRODUCTION

This section describes how Technical Report Type 3 (TR3) Professional (837) ASC X12N/005010X222A1, also called Health Care Claim, adopted under HIPAA, will be detailed with the use of a table. The tables contain a row for each segment that Spectera has something additional, over and above, the information in the TR3. 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 TR3's 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, and composite or simple data element pertinent to trading electronically with Spectera

In addition to the row for each segment, one or more additional rows are used to describe Spectera usage for composite and simple data elements and for any other information. Notes and comments have been placed at the deepest level of detail. For example, a note about a code value has been placed on a row specifically for that code value.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that Spectera has something additional, over and above, the information in the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in: Section 8 – Transaction Specific Information.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
74	1000A	NM1	Submitter Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at **10%** and notes or comment about the segment itself goes in this cell.
122	2100BA	NM109	Subscriber Primary Identifier		**15**	This type of row exists to limit the length of the specified data element.
226	2300	HI01-2	Code List Qualifier Code	**BK**		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1. SCOPE

This document is to be used for the implementation of the Technical Report Type 3 (TR3) HIPAA 5010 Health Care Claim: Professional (837) (referred to Professional Claim in the rest of this document) and the Unsolicited Claim Acknowledgement (277CA) for the purpose of submitting Professional Claim(s) electronically and receiving a Claim Acknowledgement response. This companion guide (CG) is not intended to replace the TR3.

1.2. OVERVIEW

This CG will replace, in total, the previous Spectera Vision network business segment 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 that meet Spectera processing standards, by identifying pertinent structural and data related requirements and recommendations.

Our companion guide complies with the Minnesota Statutes, section 62J.536. The Minnesota Uniform Companion Guides (MUCGs) are state companions to HIPAA Implementation Guides and provide instructions and information for the standard, electronic exchange of health care administrative transactions pursuant to Minnesota Statutes, section 62J.536.
AUC Minnesota Uniform Companion Guides - MN Dept. of Health

1.3. REFERENCE

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 Washington Publishing Company web site at http://www.wpc-edi.com/.

1.4. ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator 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 SPECTERA

Spectera accepts electronic claims from virtually any clearinghouse!
Setting up electronic claims submission with us is easy. Simply contact your current clearinghouse or electronic billing partner and request transmission of your claims to Spectera through OptumInsight (formerly Ingenix). Our Payer ID is 00773.

If your clearinghouse or billing partner does not have a connection to OptumInsight and you are interested in establishing a connection, you may contact the OptumInsight EDI Sales Team at 1-800-341-6141, selecting option 2.

3. CONTACT INFORMATION

3.1. EDI SUPPORT

Providers/Clearinghouse

If you have questions related to transactions submitted please contact OptumInsight at support line is 1-866-678-8646 (1-866-OPTUMGO), opt #2

3.2. APPLICABLE WEBSITES / E-MAIL

Please visit the following web sites for more details:
General HIPAA Information – http://aspe.hhs.gov/admnsimp/
FAQ's about Transactions – http://aspe.hhs.gov/admnsimp/faqtx.htm
FAQ's about Code Sets – http://aspe.hhs.gov/admnsimp/faqcode.htm
Educational Materials & White Papers – http://wedi.org/

3.3. 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 Spectera Vision Networks 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.

TR3 Page #	LOOP ID	Reference	NAME	Codes	Notes/Comments
70	**None**	**ST**	**Transaction Set Header**		**Required Header**
70 (14 in Errata)		ST03	Implementation Convention Reference	**005010X222A1**	

3.4. 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

3.5. 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

3.6. FILE DELIMITERS

Spectera 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.
Data Segment: The recommended data segment delimiter is a tilde (~).

Data Element: The recommended data element delimiter is an asterisk (*).

Component-Element: ISA16 defines the 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 transactions. The recommended repetition separator is a carat (^).

4. ACKNOWLEDGEMENTS AND REPORTS

4.1. REPORT INVENTORY

999 - This file informs the submitter the acknowledgement of claims file.

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

5. TRADING PARTNER AGREEMENTS

5.1. TRADING PARTNERS

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

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.

6. CORRECTED CLAIM SUBMISSIONS

Spectera only accepts claim frequency code 7 for correction claims.

An example of the ANSI 837 CLM segment containing the Claim Frequency Code 7, along with the required REF segment and Qualifier in Loop ID 2300 – Claim Information, is provided below.

CLM*555555*80***11>B>7*Y*A*Y*Y*P~
REF*F8*(Enter the Original Payer Claim Control number for the corrected claim submission, if a second corrected submission is required please include the most recent Payer claim Control number beginning with 9000XXXXXXXXX)

7. TRANSACTION SPECIFIC INFORMATION

In 5010 837 transactions, Vision requires both a Rendering and Billing NPI to be submitted.

Providers must use-
ICD-10 Diagnosis codes for all services provided on or after October-1st 2015
ICD-9 Diagnosis codes for all services provided before October-1st 2015

Spectera does not coordinate benefits with other payers.The below table provides any Spectera specific requirements for claim construct and data values.

7.1. 837P – Professional Claim Transaction Set Detail

LOOP	SEGMENT ID	NAME	VALUES	NOTES
	ISA			
	ISA05		zz	Use the value zz.
	ISA06			Enter sender's tax identification number.
	ISA07		zz	Use the value zz.
	ISA08		Receiver's tax ID number.	Enter tax identification number of Receiver.
	GS			
	GS 02		Sender's tax ID number.	Enter exactly the same value as ISA06.
	GS 03			Enter exactly the same value as ISA08.
1000A	NM 1	Submitter Name		
1000A	NM109	Identification Code	Sender's tax ID number	Enter exactly the same value as ISA06.
1000B	NM 1	Receiver Name		
1000B	NM103	Receiver Name		Enter receiver's name
1000B	NM109	ReceiverPrimary Identifier		Enter exactly the same value as ISA08.
2010AA	NM 1	Billing Provider		
2010AA	NM101	Entity Identifier Code	85	85 - Billing Provider
2010AA	NM108	Identification Code Qualifi er	XX	XX - NPI

	SEGMENT ID	NAME	VALUES	NOTES
2010AA	NM109	Billing Provider Identifier	Provider's NPI number	Enter billing provider's NPI number
2010AA	REF	Billing Provider Tax Identification		
2010AA	REF01	Reference Identification Qualifier	EI	EI - Employer's Identification Number.
2000B	HL	Subscriber Hierarchical Level		
2000B	HL01	Hierarchical ID		Increments at each new hierarchical level
2000B	HL02	Hierarchical Parent ID Number		Poi nter to Parent (Billing Provider) hierarchical level
2000B	HL03	Hierarchical Level Number Code	22	22 - Subscriber Indicates beginning of a new subscriber level
2000B	HL04	Hierarchical Child Code	0, 1	0 - Patient is the subscriber; 1 - Patient is a dependent (a sub-level follows)

LOOP	SEGMENT ID	NAME	VALUES	NOTES
2000B	SBR	Subscriber Information		
2000B	SBR01	Payer Sequence Code	P, S, T	P - Primary payer S - Secondary Payer T – Tertiary payer Use P if only one payer is involved. Use S if another payer involved (information for payer identified as P must be submitted in loop 2320). Use T if two other prior Payers involved (information on P, S in loop 2320)
2000B	SBR02	Relationship Code	18	Required only when subscriber is the same person as the patient
2000B	SBR03	Insured Group or Policy Number		
2000B	SBR04	Insured Group Name		Required only if Payer identification includes name
2000B	SBR09	Claim Filing Code		One of the available codes for health care plan
2010BA	NM 1	Subscriber Name		

LOOP	SEGMENT ID	NAME	VALUES	NOTES
2010BA	NM108	Identification Code Qualifier	MI	If you are sending only the Subscriber ID in NM109, then enter MI in NM 108. If Number exceeds 9 characters the last two characters will be interpret as a relationship code
2010BA	NM109	Subscriber Primary Identifier		Enter either Subscriber ID or concatenated Subscriber ID and Member ID.
2010BB	NM 1	Payer Name		
2010BB	NM103	Payer Name		Enter payer's name
2010BB	NM109	Payer Identifier		Enter payer's ID
2300	CLM	Claim Information		
2000C	HL	Patient Hierarchical Level		
2000C	HL01	Hierarchical ID		Increments at each hierarchical level
2000C	HL02	Hierarchical Parent ID Number		Points to the main subscriber hierarchical level
2000C	HL03	Hierarchical Level Code	23	23 - dependent
2000C	HL04	Hierarchical Child Code	0	0 - No subordinate HL segment in this hierarchical structure.
2000C	PAT	Patient Information		

LOOP	SEGMENT ID	NAME	VALUES	NOTES
2000C	PAT01	Individual Relationship Code	01, 19, 20, 21,	01 - Spouse 19 - Child 20 - Employee 21 - Unknown
2300	CLM01	Claim Submitter's Identifier		Enter a unique claim submitter identifier: Patient Control Numb er or Patient's Account Number. Value must be unique f or each claim in the file. Maximum numb er of characters is 20.
2310A	NM 1	Referring Provider Name		
2310A	NM101	Entity Identifier Code	DN	DN - Referring Provider. This segment is not required , b ut should be sub mitted if available.
2310A	NM108	Identification Code Qualifi er	XX	XX - NPI
2310A	NM109	Code		Enter referring provider's NPI numb er.
2310B	NM 1	Rendering Provider Name		
2310B	NM101	Identification Entity Identifier Code	82	82 - Rendering

Provider

LOOP	SEGMENT ID	NAME	VALUES	NOTES
2310B	NM108	Identification Code Qualifi er	XX	XX - NPI
2310B	NM109	Identification Code		Enter rendering provider's NPI numb er.
2310B	REF	Rendering Provider Secondary Identification		
2310B	REF01	Reference Identification Qualifier	OB, 1G, G2,	0B - State License Number 1G - Provider UPIN Number G2 - Provider Commercial Number Enter the provider ID assigned by Enterprise System if known.
2310B	REF02	Reference Identification		
2310C	NM 1	Service Facility Location		
2310C	NM108	Identification Code Qualifier	XX	XX - NPI
2310C	NM109	Identification Code		

8. Additional Information

8.1. Identifying Facility location

The Enterprise System identifies and validates locations in electronic files during the claim import process. The system first attempts to identify locations and then attempts to identify providers. For some of the text-based identification methods described below, the Enterprise System uses a comparison function to evaluate text and detect phonetic similarities.

The Enterprise System uses the following methods to identify and validate Location IDs:

NPI (National Provider Identifier)

This identifier must be submitted in NM1*09 when NM1*01 in loop 2310E has a value of 77, or when NM1*01 in loop 2010AA has a value of 85. Loop 2310E takes precedence when a value is provided.

TAX ID

In Enterprise System versions 5.0 and later Tax ID is not supported as a primary identifier, and is not a valid identifier in loop 2310E. The Tax ID should be submitted in REF*EI as a secondary identifier in loop 2010AA.

INTERNAL LOCATOR NUMBER

Submit the Internal Location Number (assigned by the TPA) for REF*LU in loop 2310E. This qualifier is not used to identify a location in loop 2010AA.

NAME, ADDRESS1, CITY, STATE, ZIP

These identifiers are submitted in loop 2310E, loop 2010AA should be used if 2310E is not present. The Enterprise System can identify a location when the individual field similarity factor of NAME, ADDRESS1 and CITY ranges from 0.8 to 0.85; the overall confidence factor, combined with the overall similarity factor, is greater or equal to 1.44; and both State and zip are exact matches. The overall confidence factor is influenced by the number of records selected for look-up. If a small number of records are selected based on matching criteria, the overall confidence factor will be high. For example, if NAME, CITY, STATE, ZIP criteria match 100% in only a single record, then ADDRESS1 is less important because the overall confidence factor is very high, and the sum of overall confidence factor combined with the overall similarity factor will likely exceed the threshold of 1.44.

ADDRESS1, CITY, STATE, ZIP

The Enterprise System can identify a location if the individual field similarity factor of ADDRESS1 and CITY is greater than 0.85; the overall confidence factor, combined with the overall similarity factor, is greater than 1.5; and both State and zip are exact matches.

NAME, CITY, STATE, ZIP

The Enterprise System can identify a location if the individual field similarity factor of NAME and CITY is greater than 0.85; the overall confidence factor, combined with the overall similarity factor, is greater than 1.5; and both STATE and ZIP have exact matches.

8.2. Identifying Providers

The Enterprise System identifies and validates providers in electronic files during the claim import process. The system first attempts to identify locations and then attempts to identify providers. The sequence of steps to identify providers is fully controlled by end users, based on a set of priorities defined in a Provider Identification Profile.

Each client must define a Provider Identification Profile by listing qualifiers, in priority order, that are typically used in the client's electronic claim files to identify providers. For example, suppose 837I files from ABC Clearinghouse typically use a Tax ID to identify providers, but a few claims use a Professional State License ID or Provider Site Number instead. In this case, the Provider Identification Profile for ABC Clearinghouse can specify that the import process should first attempt to match against a provider Tax ID. If a Tax ID is not found, then match against a Professional State License ID. If a State ID is not found, then match against a Provider Site Number.

Behind the scenes, the system analyzes the defined priorities for identifying providers and processes provider identification using four different methods.

The Enterprise System follows three standard rules when identifying providers:

The system returns "Provider Not Found" and does not return a provider if it finds no matches or if it finds multiple matches.

- The system performs lookups in the order specified in the Provider Identification Profile.
- The system terminates the lookups as soon as a provider is found, even if additional qualifiers have not yet been checked. For example, suppose four potential qualifiers are defined in the Provider Identification Profile with the following priority: 1G - Provider UPIN Number, XX - NPI, EI - Provider Tax ID and
- 0B - Professional State License ID. Suppose the system identifies the provider after checking the second qualifier, where the number identified with the XX qualifier matches the provider's NPI number. Because it has found a single match, the system ends the provider identification process without checking the other defined qualifiers in the list.

Provider Identification Methods

The Enterprise System uses the following methods to identify and validate Provider IDs:

NPI (National Provider Identifier)

The NPI should be submitted as the primary identifier in segment NM1 for loop 2310A when the qualifier in NM1*02 is 71 and the Qualifier in NM1*08 is XX. The Enterprise System version 5.0 and later does not support Provider NPI in loop 2310E. When matching on the NPI, the Enterprise System requires a match of 75% or more of the Provider Last Name, 75% or more of Provider First Name, and a 100% match of the NPI.

XREF (0B or 1G)

The Enterprise System can cross reference provider license types and provider licenses. For example, suppose REF*0B*123456 is present in loop 2310A of the 837I file. The system looks up state licenses (Professional State License ID is defined as Qualifier 0B) and finds a single match for license number 123456. The system then maps the unique license number back to the provider.

NPI and XREF for Operating and Other Operating Physicians

Both NPI and XREF for operating and other operating physicians are the same as NPI and XREF for providers, and should be submitted in loop 2310B or 2310C.

LAST_NAME, FIRST_NAME, MIDDLE_NAME

- When LAST_NAME, FIRST_NAME, and MIDDLE_NAME are submitted in loop 2310A, the Enterprise System can identify a provider if the overall similarity factor is greater than or equal to 0.5, the overall confidence factor is greater than or equal to 0.6, and similarity of LAST_NAME is greater than or equal to 0.5; or if the overall similarity factor is greater than or equal to 0.4, the overall confidence factor is greater than or equal to 0.7, and an exact match exists for MIDDLE_NAME.

- When LAST_NAME, FIRST_NAME, and MIDDLE_NAME are submitted in loops 2310B and 2310C, the Enterprise System can identify a provider if the overall similarity factor is greater than or equal to 0.5, the overall confidence factor is greater than or equal to 0.6, and the similarity of LAST_NAME is greater than or equal to 0.5; or if the overall similarity factor is greater than or equal to 0.4, the overall confidence factor is greater than or equal to 0.7, and an exact match exists for MIDDLE_NAME.

- When the PROVIDER_ TYPE is greater than 0, the Enterprise System can identify a provider if the overall similarity factor is greater than or equal to 0.5, the overall confidence factor is greater than or equal to 0.6, and the similarity of LAST_NAME is greater than or equal to 0.5; or if the overall similarity factor is greater than or equal to 0.4, the overall confidence factor is greater than or equal to 0.7, and an exact match exists for MIDDLE_NAME.

LAST_NAME, FIRST_NAME

The Enterprise System can identify a provider if the overall similarity factor is greater than or equal to 0.5; the overall confidence factor is greater than or equal to 0.6; and the similarity of LAST_NAME, combined with the similarity of FIRST_NAME, is greater than or equal to 1.1.

8.3. Identifying Members

The Enterprise System identifies and validates members in electronic files during the claim validation process in the Claim Validation Module (CVM) and the authorization validation process in the Authorization ValidationModule(AVM).

The system performs eachsearch with andwithouta DATE_OF_SERVICE (DOS). Including the date of service restricts a member's eligibility based on the date services were performed. This is important because a member may have multiple eligibility spans or may not be eligible for coverage on the specified date of service. Dropping the DOS from the search allows the system to find newly subscribed members whose claims are submitted before their eligibility records are updated in the Enterprise System. The system performs a final check for date of service during the claim adjudication process to verify a member's eligibility and does not pay claimsif amember still is not eligible.

Member Identification Methods

The Enterprise System uses the following methods to identify and validate Member IDs, where DOB represents DATE_OF_BIRTH, DOS represents DATE_OF_SERVICE, SSN represents Social Security Number..

Patient Subscriber, plus

- DOB, DOS
- DOB
- Full Last Name, Full First Name, DOS
- Full Last Name, Full First Name
- First 3 characters of Last Name, first character of First Name, DOS
- First 3 characters of Last Name, first character of First Name
- DOB, First 3 characters of Last Name, DOS
- DOB, First 3 characters of Last Name

Insured Subscriber, plus

- DOB, DOS
- DOB
- Full Last Name, Full First Name, DOS
- Full Last Name, Full First Name
- First 3 characters of Last Name, first character of First Name, DOS
- First 3 characters of Last Name, first character of First Name
- DOB, First 3 characters of Last Name, DOS
- DOB, First 3 characters of Last Name

Insured SSN, plus
- DOB, DOS
- DOB
- Full Last Name, Full First Name, DOS
- Full Last Name, Full First Name
- First 3 characters of Last Name, first character of First Name, DOS
- First 3 characters of Last Name, first character of First Name
- DOB, First 3 characters of Last Name, DOS
- DOB, First 3 characters of Last Name

Insured SSN is Subscriber, plus
- DOB, DOS
- DOB
- Full Last Name, Full First Name, DOS
- Full Last Name, Full First Name
- First 3 characters of Last Name, first character of First Name, DOS
- First 3 characters of Last Name, first character of First Name
- DOB, First 3 characters of Last Name, DOS
- DOB, First 3 characters of Last Name

Patient SSN, plus
- DOB, DOS
- DOB
- Full Last Name, Full First Name, DOS
- Full Last Name, Full First Name
- First 3 characters of Last Name, first character of First Name, DOS
- First 3 characters of Last Name, first character of First Name
- DOB, First 3 characters of Last Name, DOS
- DOB, First 3 characters of Last Name

Patient SSN is Subscriber, plus
- DOB, DOS
- DOB
- Full Last Name, Full First Name, DOS
- Full Last Name, Full First Name
- First 3 characters of Last Name, first character of First Name, DOS
- First 3 characters of Last Name, first character of First Name
- DOB, First 3 characters of Last Name, DOS
- DOB, First 3 characters of Last Name

DOB, Full Last Name, plus
- Full First Name, DOS
- Full First Name
- First 3 characters of First Name, DOS
- First 3 characters of First Name

9. APPENDECIES

9.1. 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

9.2. 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.

9.3. 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.

9.4. FREQUENTLY ASKED QUESTIONS

1. ***What is HIPAA?***
   It is the acronym for the **H**ealth **I**nsurance **P**ortability & **A**ccountability **A**ct of 1996, Public Law 104-191. HIPAA is intended to improve the efficiency of the healthcare system by standardizing the electronic transmission of health information.

2. ***Who do the HIPAA standards apply to?***
   Health plans, health care providers, health care clearinghouses, employee benefits plans, dental & plans, public health authorities, life insurers, billing agencies, information system vendors are all considered covered entities. (Spectera is a covered entity.)

3. ***Does this Companion Guide apply to all Spectera Specialty Benefits payers?***
   No, only commercial and government business for **Spectera Vision Business Segment** using payer ID 00773.

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

5. Can we send multiple locations or companies in one file?

The processing of this type of combined file is possible. Please discuss processing requirements with the Spectera EDI coordinator to establish methods of distinguishing locations or companies on your file.

6. How often should I send my file?

Most of our providers send their claims files daily. However, this is directly related to the volume of claims involved. You may send your claims file less frequently depending on the amount of claims you have to submit.

7. How long will it take to go live in processing our claims electronically?

This process varies from trading partner to trading partner. Upon receiving your first test file, we will examine the file for HIPAA compliance and EDI Standards compliance. We will work with you in establishing any specific processing requirements for your file. Once a compliant file is received and any special processing programs are written and tested, we will agree on a date to start live processing of your claims file.

8. What is Data Encryption?

Encryption is a process that re-formats your data in to a format that can only be read by the receiver after the use of a decryption key. This protects the content of your file from anyone who may obtain it in an unauthorized fashion. Spectera strongly recommends encryption of files. PGP is an encryption/decryption product that is in use by Spectera.

9. What are my options for receiving acknowledgements?

Upon request, Spectera will return to you a Functional Acknowledgement 999 transaction set for acknowledging your transmission. A Functional Acknowledgment will indicate errors that were detected during syntax review by our translator.

We will also send an 'unsolicited' 277 transaction set which will indicate the status of each claim processed in your transmission. We will indicate a status of processed or error and include codes to indicate specifically which error caused the claim to not be processed.