EDI Companion Guide

Repricing EDI Data Return

There are two standard segments in an 837 file which can be used to send repricing information. 6 Degrees Health works with partners which require one or the other in their claims systems and we are happy to support your company with either format.

To simplify the process of matching repriced claims data with the original data, the 6 Degrees Health claims processor returns all of the data that you send. This includes the REF D9 (Claim Number), REF F8 (Original Reference Number), and any other information that you send. We will simply add to the claim a new HCP or CAS segment after repricing.

Repricing segment options:

- Health Care Pricing (HCP) Segment
- Claims Adjustment (CAS) Segment

Repricing Using HCP Segment

The HCP segment consists of up to 4 data values that we provide to inform how we've completed the repricing. We will provide an HCP segment for each Professional (SV1) or Institutional (SV2) service in the claim as well as a summary HCP segment for the claim as a whole. Values we populate are:

HCP01 – Pricing Methodology

If an item is repriced per Medicare, it will receive a code of "10". If it is rejected for any reason, it will receive a code of "00" for zero pricing. When a claim is rejected or if there is something unusual about a particular item, we will also include a NTE segment to provide additional information.

Code	X12.org 837 Definition	6 Degrees Usage
00	Zero Pricing (Not Covered Under Contract)	Need more information to reprice
00	Zero Pricing (Not Covered Under Contract)	Not allowed per Medicare (available on request)
10	Other Pricing	Repriced per Medicare multiple

HCP02 – Repriced Allowed Amount

This is the total amount that a claim is repriced to (on claim-level HCP) or the amount that a service (on line-level HCP) is repriced to.

As an example, if 6 Degrees Health determines that the plan multiple * Medicare reimbursement = $25 then HCP02 will be set to “25”

HCP03 – Repriced Saving Amount

This is the savings amount for a claim (on claim-level HCP) or a service (on line-level HCP) after repricing.

As an example, if an item were originally priced at $100 and it was repriced to $25 (HCP02), then HCP03 will be set to “75” since there is a $75 savings.

HCP04 – Repricing Organization Identifier

6 Degrees can either send a single organization identifier for all repricing, or several in order to better explain our repricing. The default for HCP04 is to send multiple in order to provide more information for placement on the EOB. These codes should be placed with each line-item. A key at the bottom of the EOB should include the full text or similar language as adjusted for the plan.

Code	Text	On EOB	Purpose and explanation
DEG	Repriced as a percentage of Medicare	Line, Claim	Standard RBP pricing methodology. Most HCP04 codes will be this
NRP	Not repriced per TPA request	No	Only used on request of the TPA when they do not want us to reprice a particular claim
CON	Repriced according to Direct Contract	Line, Claim	Clarifies that repricing was done according to a contract between 6 Degrees Health and the provider
NTA	Not allowed by CMS	Line	Line item that would be denied by CMS, and hence is also denied in an RBP plan
AAH	Allowed amount higher than billed	No	This is an explanation for the TPA that the RBP reimbursement would be higher than billed, but was limited to the billed amount
PKG	Packaged or bundled	Line	Line item is packaged or bundled into another service and hence is repriced to $0
CAP	Reimbursement capped at plan allowance	Line, Claim	Used when a service agreement is made with a provider and bill is over the agreed rate. The bill is "capped" at agreed amount
IFO	Need more info	Line, Claim	Additional information is needed in order to reprice a claim or service item. Additional information is provided in the accompanying NTE or K3 segment
STA	Status indicator	Line	CMS has status codes for different types of procedures that affect repricing. We will send what the status code is and any explanation in the NTE
MEA	Measurement code not priced	Line	CMS doesn’t allow providers to charge for measurements like height and weight
OTH	CMS uses other code for this service	Line	Unable to reprice because the code that the provider has selected is incorrect
COV	Non-covered service	Line	Plan doesn’t cover this service
EXC	Excluded code	Line	Code must be excluded in certain billing situations
PRO	Professional component only code	Line	Some codes only allow a professional component modifier under CMS guidelines

TEC	Technical component only code	Line	Some codes only allow a technical component modifier under CMS guidelines
PTC	Professional/Technical component does not apply	Line	Adding a professional or technical component to a procedure may not be allowed under CMS guidelines for some procedures
CNR	Code not recognized when submitted on this bill type	Line	Certain codes are only allowed on particular bill types.
INO	Inpatient only procedure	Line	Inpatient procedure was billed on an outpatient or professional bill
APC	Repriced using composite APC	Line	When certain procedures appear together on the same bill, a composite APC is used for CMS repricing
MPR	Multiple procedure reduction applies	Line	Reimbursement is affected when multiple procedures are performed during the same session
BNR	Bilateral procedure reduction applies	Line	Reimbursement is affected when both sides of the body are repriced during the same session

If a TPA cannot support multiple repricing identifiers, we will send a single ID of 814242649. This is our Tax ID #.

HCP13 – Reject Reason Code

In the event that an item is to be rejected, we will send an HCP01 of "00" (Zero Pricing) and also send the reject reason. When a claim is rejected, it will also include a NTE segment to explain why the claim was rejected.

Code	X12.org 837 Definition	6 Degrees Usage
T1	Cannot Identity Provider as TPO (Third Party Organization) Participant	Not allowed per Medicare (available on request)
T6	Claim does not contain enough information for repricing	Need more information to be able to accurately reprice

HCP Segment Examples

HCP Segment	Explanation
HCP*10*25*75*DEG	standard repricing. Original price of 100 has been adjusted to $25. There is a savings of $75
HCP*00*100*0*IFO*********T6	additional information is required in order to reprice this item
HCP*00*100*0*NTA*********T1	Not allowed per Medicare (available on request)

Additional Service Level Information Using NTE Segment

In the event that additional information is needed to understand why 6 Degrees Health repriced a service item as it did, we will send an NTE segment to explain.

NTE01 – Note Reference Code

Code	X12.org 837 Definition	6 Degrees Usage

TPO	Third Party Organization Notes (used at service level)	Any additional information which 6 Degrees Health wishes to convey
SPH	N/A	TPA-specific code for special handling (available upon request)

NTE02 - Description
Free-form text used to provide additional information

NTE Segment Examples

HCP Segment	Explanation
NTE*TPO*NTA Other code used for reporting of service	First 3 characters will always be HCP04 code (see above). Description follows.
NTE*SPH*IFO Need Chart notes	First 3 characters will always be IFO (see HCP04 table above). Description follows. (available upon request)

Additional Claim Level Information

We can send claim-level notes using either the NTE segment or the K3 segment

- NTE segment. Works great for systems that support the segment so this is our default place to send claim level information.
- K3 segment. This segment was not originally designed for additional information from a repricing organization, but the specification has recently been relaxing to allow this type of usage.
- No claim-level information. This is NOT the preferred approach since we do need to send claim level information, but can be enabled if your system cannot support either the NTE or K3 segment.

Additional Claim Level Information using NTE segment

When enabled, we send a claim level NTE in the same way as a service level NTE. See "Additional Service Level Information Using NTE Segment" for more information.

Additional Information Using K3 Segment (available on request)

In the event that additional information is needed to understand why 6 Degrees Health repriced a service item as it did, we can send a K3 segment to explain.

K301 – Fixed Format Information
Free-form text used to provide additional information

K3 Segment Examples

HCP Segment	Explanation
K3*IFO Need chart notes	First 3 characters is our repricing code (see HCP04 table above). Description follows. In this case, we need chart notes in order to reprice

Repricing Using CAS Segment

CAS01 – Claim Adjustment Group Code
6 Degrees Health will always send a group code of "OA" to indicate that this is an "Other Adjustment"

CAS02 – Claim Adjustment Reason Code
6 Degrees Health currently only sends 2 different codes to indicate the reason why the claim was adjusted.

Code	X12.org 837 Definition	6 Degrees Usage
AU	N/A	TPA-specific code for "Audit"
DC	N/A	TPA-specific code for "Denied Claim"

CAS03 – Adjustment Amount
This is the total amount that a claim is repriced to (on claim-level CAS) or the amount that a service (on line-level CAS) is repriced to.

As an example, if 6 Degrees Health determines that the plan multiple * Medicare reimbursement = $25 then CAS03 will be set to "25"

CAS Segment Examples

CAS Segment	Explanation
CAS*OA*AU*25	standard repricing to $25
CAS*OA*DC*0	Line-item denied