

ANSI X12N 8371 V4010A1

Health Care Claim

Institutional

Revised 05/23/08 for Nebraska Part A

Companion Document
Version 4010A1

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The X12N 837 Implementation Guides have been established as the standards of compliance for submission of claims for all services, supplies, equipment, and health care other than retail pharmacy prescription drug claims. The implementation guides for each X12 transaction adopted as a HIPAA standard are available electronically at <http://www.wpc-edi.com>.

The following information is intended to serve only as a companion document to the HIPAA X12N 837 institutional claim implementation guide. The use of this document is solely for the purpose of clarification.

The information describes specific requirements to be used for processing data in the FISS System of WPS, contractor number 05401. The information in this document is subject to change. Changes will be communicated in the standard Wisconsin Physicians Service (WPS) provider news bulletin and on the WPS Corporate Web site: www.wpsic.com. This companion document supplements, but does not contradict any requirements in the X12N 837 Institutional Implementation Guide.

Health Care Claim Companion Guide

Institutional: Medicare

ANSI X12N 8371 V4010A1

General Statements

The maximum size for the fields containing number of days information (covered, lifetime reserve, etc.) in the Medicare system is four characters. Claims submitted with data that exceed will be returned to the provider (RTP'd) or will be errored back to the submitter by WPS.

The maximum size for dollar amount fields in the Medicare system is 10 characters. Claims submitted with dollar amounts in excess of 99,999,999.99 will be RTP'd or will be errored back to the submitter by WPS.

Claims with external code set data that does not conform to the format requirements of the external code set maintainer will be RTP'd or will be errored back to the submitter by WPS. Data elements referencing external code sets are limited to the size of the data as defined by the code set maintainer. For example, the element in the Implementation Guide designated for HCPCS information may contain up to 30 positions but the HCPCS external code list allows only 5 positions (claims with more than 5 positions of HCPCS data in this element would be RTP'd or will be errored back to the submitter by WPS).

The maximum size for the service unit count field in the Medicare system is 7 characters. Claims submitted with data that exceeds this limit will be RTP'd or will be errored back to the submitter by WPS. Claims submitted with decimal data will be rounded to the closest whole number before being processed.

The Medicare system does not process decimal points in diagnosis codes or ICD9-CM procedure codes. Medicare will strip out decimal points submitted in valid diagnosis codes before processing. Medicare will strip out decimal points submitted in valid procedure codes before processing.

You may send as many diagnosis codes as allowed in the implementation guide. However, only the primary/principal and first 8 other diagnosis codes will be considered for adjudication and payment determination.

Hospital other (14X) claims that lack diagnosis information when required for CMS adjudication (2300 HI Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information) will be RTP'd or will be errored back to the submitter by WPS.

Claims that lack a patient status code when required for CMS adjudication will be RTP'd or will be errored back to the submitter by WPS.

Claims that lack an admission source code when required for CMS adjudication will be RTP'd or will be errored back to the submitter by WPS.

Inpatient claims that lack HCPCS when required for CMS adjudication will be RTP'd or will be errored back to the submitter by WPS.

Medicare will process only HL structures as described in the implementation guide front matter [Billing Provider HL (parent) followed by the appropriate Subscriber HL (child)].

WPS will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.

Only loops, segments, and data elements valid for the HIPAA Institutional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.

The incoming 837 transactions utilize delimiters from the following list: >, *, ~, ^, |, and:. Submitting delimiters not supported within this list may cause an interchange (transmission) to be rejected.

You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Institutional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set may cause the interchange (transmission) to be rejected at the intermediary's translator.

Effective May, 23, 2008, the National Provider Identifier (NPI) must be submitted in all NM109 data elements (NM108 = XX) where NM109 is required and in the Service Facility (2310E) NM109 if known.

Medicare does not require taxonomy codes be submitted in order to adjudicate claims, but will accept the taxonomy code, if submitted. However, taxonomy codes that are submitted must be valid against the taxonomy code set published at <http://www.wpc-edi.com/codes/taxonomy>. Claims submitted with invalid taxonomy codes will be rejected.

All dates that are submitted on an incoming 837 claim transaction must be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission).

WPS may reject an interchange (transmission) with more than 5000 CLM segments (claims) submitted per transaction.

Compression of files using a vendor's software is supported for transmissions between the submitter and WPS.

Only valid qualifiers for Medicare must be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing which are not defined for use in Medicare billing may cause the claim to the transaction be rejected.

Do not use Credit/Debit card information to bill Medicare. Credit/Debit card information will be ignored.

WPS will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE and IEA) beyond the requirements defined in the Institutional Implementation Guides. Claims submitted with invalid Medicare identifiers may be RTP'd or may be errored back to the submitter by WPS.

WPS will reject an interchange (transmission) that uses the following character as a delimiter: ‘ ‘.

WPS will reject an interchange (transmission) that uses the following character as a delimiter: ‘/’.

WPS will validate individual identifiers submitted within the ISA and GS envelope segments in addition to verifying the format requirements defined in the IG. Claims submitted with invalid Medicare identifiers may be RTP'd or may be errored back to the submitter by WPS.

WPS will not process an interchange (transmission) that is not submitted with a valid receiver/submitter code (each individual Contractor determines this code).

For all outpatient claims, all line items must contain a date or dates of service for each revenue code or it will be rejected.

All inpatient claims must contain the admission date, admitting diagnosis, admission type code, patient status code, and admission source code or the claim may be rejected. Medicare previously did not require these elements on 12X or 22X bill types, but now they will be required.

WPS will only process one transaction type (records group) per interchange (transmission). A submitter can submit one GS-GE (Functional Group) within an ISA-IEA (Interchange) when submitting claims to WPS.

Interchange Control Header

ISA05	Interchange ID Qualifier	WPS will reject an interchange (transmission) that does not contain ZZ in ISA05.
ISA06	Interchange Sender ID	WPS will reject an interchange (transmission) that does not contain a valid ID in ISA06.
ISA07	Interchange ID Qualifier	WPS will reject an interchange (transmission) that does not contain ZZ in ISA07.
ISA08	Interchange Receiver ID	WPS will reject an interchange (transmission) that does not contain [05401] in ISA08. Each individual contractor determines this code.

Functional Group Header

WPS will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange).

WPS will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).

GS03	Application Receiver's Code	WPS may reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the intermediary definition.
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Loop Transaction Set

WPS will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) may cause the transaction to be rejected.

ST02	Transaction Control Set	WPS will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.
BHT02	Transaction Set Purpose Code	Transaction Set Purpose Code (BHT) must equal '00' (ORIGINAL).
BHT06	Claim/Encounter Identifier	WPS will accept and process transmissions with a Claim or Encounter Indicator (BHT06) of 'CH' (Chargeable).
1000A	NM109 Submitter ID	WPS will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.
1000B	NM103 Receiver Name	WPS may reject an interchange (transmission) that is not submitted with a valid intermediary name (NM1).
1000B	NM109 Receiver Primary Identifier	WPS may reject an interchange (transmission) that is not submitted with a valid intermediary code (NM1). Each individual contractor determines this code.
2000A	PRV	Providers shall be in compliance with CR 5243: Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims.
2000B	HL Subscriber Hierarchical Level	The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.
2000B	SBR02, SBR09 Subscriber Information	For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MA). The Patient Hierarchical Level (2000C loop) is not used.

Loop Claim Information

2300	CLM02 Total Submitted Charges	Negative values submitted in CLM02 may not be processed and may result in the claim being rejected.
2300	CLM02 Total Submitted Charges	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV203).

2300	CLM20	Delay Reason	Data submitted in CLM20 will not be used for processing.
2300	HI	Health Care Diagnosis Code Code	Effective October 2004, all diagnosis codes submitted on a claim must be valid codes per the qualified code source. Claims that contain invalid diagnosis codes will be rejected.
2410	LIN03	Drug Identification	The format for National Drug Codes (NDC) is 5-4-2 (11 positions). Claims that contain NDC codes in any other Format will be rejected.

997 - Functional Acknowledgement

We suggest retrieval of the ANSI 997 functional acknowledgment files on the first business day after the claim file is submitted, but no later than 5 days after the file submission.

WPS will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997.

Helpful Hints

Please use your WPS submitter Id in ISA06 and GS02

The file version in the REF02 segment should appear like this: 004010X096A1, not 004010X096DA1.

Do not report covered days or DRG information on outpatient claims.

How our Translator Checks for Duplicate Transmissions:

Our duplicate program captures the key information below from the first and last claim in each ST/SE loop of every successful file in order to create a key. The key is then stored in a library of the program. All files that are transmitted to WPS create a key; the key is then run against the keys that are already stored in the library from previous files received from the same submitter. If a match is found, then the system duplicates the file out. If a match is not found the batch of claims continues in the claims processing job stream.

Key Information:

- APPL-SENDER-CD GS 02
- CLAIM-CNT CALCULATED FIELD – NUMBER 500 RECORDS
- SRVC-LN-CNT CALCULATED FIELD – NUMBER OF 600 RECORDS
- REC-CNT CALCULATED FIELD – TOTAL RECORDS IN THE ST
- TOTAL-CHG.2400 SV2 03
- FST-SBR-LST-NAME 2010BA NM1 03
- FST-SBR-FST-NAME 2010BA NM1 04
- FST-SBR-PAT-CTRL- 2300 CLM 01
- FST-SBR-TOT-CHG 2400 SV2 02
- FST-SBR-STMT-FROM-DT 2300 DTP 03 QUAL 434
- LST-SBR-LST-NAME 2010BA NM1 03
- LST-SBR-FST-NAME 2010BA NM1 04
- LST-SBR-PAT-CTRL 2300 CLM 01
- LST-SBR-TOT-CHG 2400 SV2 03
- LST-SBR-STMT-FROM-DT 2300 DTP 03 QUAL 434