

**837 v. 4010A1 Inbound Professional Claim
Companion Document**

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Description		Language	Page																		
General Statements																					
		The Wisconsin Physician Service (WPS) production cutoff time is 4 p.m. cst; that is, claims received and processed by the EDI front end, before 4 p.m will be sent down to the adjudication system for prepass editing. Batch Detail Control Listing (aka prepass reports) will be available the next business day.																			
		The WPS assigned submitter ID should be present in the ISA06, GS02, 1000A/NM109.																			
		The WPS receiver ID (aka carrier code) should be present in the ISA08, GS03, 1000B/NM109 and 2010BB/NM109. WPS carrier codes for Medicare Part B:																			
		<table border="1"> <thead> <tr> <th>WI</th> <th>IL</th> <th>MI</th> <th>MN</th> <th>IA</th> <th>KS</th> <th>E. MO</th> <th>W. MO</th> <th>NE</th> </tr> </thead> <tbody> <tr> <td>00951</td> <td>00952</td> <td>00953</td> <td>00954</td> <td>05102</td> <td>05202</td> <td>05392</td> <td>05302</td> <td>05402</td> </tr> </tbody> </table>	WI	IL	MI	MN	IA	KS	E. MO	W. MO	NE	00951	00952	00953	00954	05102	05202	05392	05302	05402	
WI	IL	MI	MN	IA	KS	E. MO	W. MO	NE													
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		The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 may be rejected.																			
		Claims that contain percentage amounts with values in excess of 99.99 may be rejected.																			
		Claims that contain percentage amounts cannot exceed two positions to the left or the right of the decimal. Percent amounts that exceed their defined size limit may be rejected.																			
		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 Professional 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.																			
		Segments should be terminated by a ~ and should not use separators as place holders for not used data elements. Example: PER*IC*MARY*TE*6085551212***~ <== incorrect PER*IC*MARY*TE*6085551212~ <== correct																			
		You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional 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 carrier translator.																			
		When applicable, the National Provider Identifier (NPI) must be submitted in the NM109 segment																			

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		(NM108 = XX).																				
		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) submitted with more than 9,999 loops.																				
		WPS may reject an interchange (transmission) submitted with more than 9,999 segments per loop.																				
		WPS may reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.																				
		Compression of files using PK Zip is supported for transmissions between the submitter and WPS.																				
		Only valid qualifiers for Medicare should be submitted for Medicare processing on incoming 837 claim transactions. Any qualifiers submitted which are not defined for use in Medicare billing may cause the claim to be rejected.																				
		You may send up to four modifiers; however, the last two modifiers may not be considered. The WPS processing system may only use the first two modifiers for adjudication and payment determination of claims.																				
Interchange Control Header																						
	ISA05	Interchange ID Qualifier	WPS recommends use of qualifier ZZ in ISA05.	B.4																		
	ISA06	Interchange Sender ID	WPS will reject an interchange (transmission) that does not contain a valid ID in ISA06.	B.4																		
	ISA07	Interchange ID Qualifier	WPS recommends use of qualifier ZZ in ISA07.	B.4																		
	ISA08	Interchange Receiver ID	WPS will reject an interchange (transmission) that does not contain correct code in ISA08. Each individual Contractor determines this code. WPS carrier codes for Medicare Part B: <table border="1" data-bbox="655 1058 1749 1123"> <tr> <td>WI</td> <td>IL</td> <td>MI</td> <td>MN</td> <td>IA</td> <td>KS</td> <td>E. MO</td> <td>W. MO</td> <td>NE</td> </tr> <tr> <td>00951</td> <td>00952</td> <td>00953</td> <td>00954</td> <td>05102</td> <td>05202</td> <td>05392</td> <td>05302</td> <td>05402</td> </tr> </table>	WI	IL	MI	MN	IA	KS	E. MO	W. MO	NE	00951	00952	00953	00954	05102	05202	05392	05302	05402	B.5
WI	IL	MI	MN	IA	KS	E. MO	W. MO	NE														
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	ISA15		The value in the ISA15 is returned in the Batch Detail Control Listing (aka prepass report). It is recommended the value in the ISA15 be unique or incremented.																			
	ISA16		Use of the component element separator (aka subelement separator) as defined in ISA16, in elements that do not have subelements will cause the file to reject.																			
Functional Group Header																						
			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	WPS will reject an interchange (transmission) that is submitted with an invalid value in GS03	B.8																		

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		Code	(Application Receivers Code) based on the carrier definition. WPS carrier codes for Medicare Part B: <table border="1"> <tr> <td>WI</td> <td>IL</td> <td>MI</td> <td>MN</td> <td>IA</td> <td>KS</td> <td>E. MO</td> <td>W. MO</td> <td>NE</td> </tr> <tr> <td>00951</td> <td>00952</td> <td>00953</td> <td>00954</td> <td>05102</td> <td>05202</td> <td>05392</td> <td>05302</td> <td>05402</td> </tr> </table>	WI	IL	MI	MN	IA	KS	E. MO	W. MO	NE	00951	00952	00953	00954	05102	05202	05392	05302	05402	
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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) will 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.	62																		
	BHT02	Transaction Set Purpose Code	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).	64																		
	BHT06	Claim/Encounter Identifier	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).	65																		
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.	69																		
1000B	NM109	Receiver Primary Identifier	WPS may reject an interchange (transmission) that is not submitted with a valid carrier code (NM1). Each individual Contractor determines this code. WPS carrier codes for Medicare Part B: <table border="1"> <tr> <td>WI</td> <td>IL</td> <td>MI</td> <td>MN</td> <td>IA</td> <td>KS</td> <td>E. MO</td> <td>W. MO</td> <td>NE</td> </tr> <tr> <td>00951</td> <td>00952</td> <td>00953</td> <td>00954</td> <td>05102</td> <td>05202</td> <td>05392</td> <td>05302</td> <td>05402</td> </tr> </table>	WI	IL	MI	MN	IA	KS	E. MO	W. MO	NE	00951	00952	00953	00954	05102	05202	05392	05302	05402	75
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2000B	HL	Subscriber Hierarchical Level	The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.	108																		
2000B	SBR02, SBR09	Subscriber Information	For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used.	111																		
2010BD		Credit/Debit Card Information	Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).	150																		
Loop	Claim Information																					
2300	CLM02	Total Submitted Charges	Negative values submitted in CLM02 will not be processed and will result in the claim being rejected.	172																		
2300	CLM02	Total Submitted Charges	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).	172																		
2300	CLM05-3	Claim Frequency Type Code	The only valid value for CLM05-3 is '1' (ORIGINAL). Claims with a value other than "1" will be rejected.	173																		
2300	CLM20	Delay Reason Code	Data submitted in CLM20 will not be used for processing.	179																		
2300	PWK	Claim Supplemental Information	Any data submitted in the PWK (Paperwork) segment may not be considered for processing.	214																		
2300	AMT01	Credit/Debit Card	Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD	219																		

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		Maximum Amount	loop).	
2300	AMT02	Patient Amount Paid	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: AMT02.	220
2300	AMT02	Total Purchased Service Amount	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: AMT02.	221
2300	REF02	Prior Authorization and Referral Number	Peer Review Organization (PRO) information should be submitted at the header claim level (loop 2300). PRO information submitted at the detail line level (loop 2400) will be ignored.	227
2300	CR102, CR106	Ambulance Transport Information	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: CR102, CR106.	249,250
2300	HI	Health Care Diagnosis Code	Diagnosis codes have a maximum size of five (5). Medicare does not accept decimal points in diagnosis codes.	265
2300	HI	Health Care Diagnosis 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, pointed to or not, will be rejected.	265
2300	HI	Health Care Diagnosis Code	You may send up to eight diagnosis codes per claim. If diagnosis codes are submitted, you must point to the primary diagnosis for each service line (SV107-1).	265
2320	AMT02	Coordination of Benefits Amounts	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: AMT02.	332 333
2400	SV102	Line Item Charge Amount	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: SV102.	402
2400	SV104	Professional Service	Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes may be rejected. (SV104)	403
2400	SV104	Professional Service	The max value for anesthesia minutes (qualifier MJ) cannot exceed 4 bytes numeric. Claims for anesthesia services that exceed this value may be rejected. (SV104)	403
2400	SV104	Professional Service	The max value for units (qualifier UN) cannot exceed three bytes numeric with one decimal place. Claims for medical services that exceed this value may be rejected. (SV104)	403
2400	SV104	Professional Service	SV104 (Service unit counts) (units or minutes) cannot exceed 999.9.	403
2400	SV104	Professional Service	Negative values submitted in the following fields will not be processed and may result in the claim being rejected: SV104.	403
2400	CR102, CR106	Ambulance Transport Information	Negative values submitted in the following fields will not be processed and may result in the claim being rejected: CR102, CR106.	413, 414
2400	PS1	Purchased Service	Purchased diagnostic tests (PDT) require that the purchased amounts be submitted at the detail line level (Loop 2400). Claims for PDT services that are submitted without the PS1 segment data at the 2400 loop will be rejected.	489
2400	PS102	Purchased Service	Negative values submitted in the following fields will not be processed and will result in the claim	490

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	being rejected: PS102.	
997 - Functional Acknowledgement		
	We suggest retrieval of the ANSI 997 functional acknowledgment files on or before the first business day after the claim file is submitted, but no later than five days after the file submission.	B.15
	WPS will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997 .	