

## Companion Document for ANSI ASC X12N 837: Institutional 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 Medicare Contractor number 52280.

The information in this document is subject to change. Changes will be communicated in the provider newsletter and on the WPS Website (<http://www.wpsmedicare.com>).

This companion document supplements, but does not contradict any requirements in the X12N 837 Institutional Implementation Guide.

Please contact us at 866-734-6656 if you have any questions.

S.No	WPS Medicare Specifications
1	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 will cause the interchange (transmission) to be rejected at the intermediary's translator.
2	For Medicare, the subscriber is always the same as the patient (SBR02 = 18, SBR09 = MA). Claims containing data in the Patient Hierarchical Level (2000C loop) will not be processed.
3	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 – Medicare.
4	The maximum size for dollar amount fields in the Medicare system is 10 characters. Claims submitter with dollar amounts in excess of 99,999,999.99 will be RTP'd or will be errored back to the submitter by WPS – Medicare.
5	Claims submitter with attending, other, or operating physician UPIN data exceeding 6 positions will be RTP'd or will be errored back to the submitter by WPS Medicare.
6	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 Medicare. 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 Medicare.)
7	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 Medicare. Claims submitted with decimal data will be rounded to the closest whole number before being processed.
8	The Medicare System does not process decimal points in diagnosis codes or ICD-9-CM procedure codes. Medicare will strip out decimal points submitted in valid diagnosis before processing. Medicare will strip out decimal points submitted in valid procedure codes before processing.

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9	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.
10	Hospital (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 Medicare.
11	Do not use Credit/Debit card information to bill Medicare Credit/Debit card information will be ignored.
12	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 Medicare.
13	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 Medicare.
14	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.
15	Medicare will process only HL structures as described in the implementation guide front matter (Billing Provider HL (parent) followed by appropriate Subscriber HL (child)).
16	WPS Medicare will reject an interchange (transmission) that uses the following character as a delimiter: ' '.
17	WPS Medicare will reject an interchange (transmission) that uses the following character as a delimiter: \.
18	WPS Medicare will only process one transaction type (records group) per interchange (transmission). A submitter can submit more than one GS-GE (Functional Group) within an ISA – IEA (Interchange) when submitting claims to WPS Medicare.
19	WPS Medicare will validate individual identifiers submitted within the ISA and GS envelope segments in addition to the verifying the format requirements defined in the IG. Claims submitted with invalid Medicare identifiers will be RTP'd or will be errored back to the submitter by WPS Medicare.
20	WPS Medicare will not process an interchange (transmission) that is not submitted with a valid receiver/submitter code (each individual Contractor determines this code)).
21	WPS Medicare 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.
22	WPS Medicare will process more than one (ST–SE) Transaction Set within a (GS–GE) Functional Group. A Submitter Cannot submit one ST–SE for each claim.
23	WPS Medicare will accept and process transmissions with a Claim or Encounter Indicator (BHT06) of 'CH' (Chargeable).
24	Compression of files using a vendor's software is supported for transmissions between the submitter and WPS Medicare.
25	For all outpatient claims, all line items must contain a date or dates of service for each revenue code or it will be rejected.
26	Any outpatient claims containing Covered Days (QTY Segment) will be rejected.
27	All claims will be edited to ensure all Health Insurance Prospective Payment System (HIPPS) Rate Codes used with a "ZZ" qualifier are accepted (not just HIPPS SNF rate codes). A complete list of valid HIPPS codes may be found at <a href="http://www.cms.hhs.gov/providers/hippscodes">http://www.cms.hhs.gov/providers/hippscodes</a> .
28	All claims containing a NPP000 UPIN will be rejected.
29	All claims containing an invalid E-Code (an E-Code not listed in the external code source reference by the HIPAA 837 Institutional implementation guide) will be rejected. Note that Medicare does not require or use E codes, but if they are sent, they must be valid.
30	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 <a href="http://www.wpc-edi.com/codes/taxonomy">http://www.wpc-edi.com/codes/taxonomy</a> . Claims submitted with invalid taxonomy codes will be rejected.
31	All HIPAA X12N 837 claims that contain revenue code 045X, 0516, or 0526 must also contain an HI02 – 1 code of 'ZZ' along with a HIPAA – compliant "Patient Reason for Visit" diagnosis code or it will be rejected.

<b>S.No</b>	<b>WPS Medicare Specifications</b>
32	All inpatient claims must contain the admission date, admitting diagnosis, admission type code, patient status code, and admission source code or the claim will be rejected. Medicare previously did not require these elements on 12X or 22X bill types, but now they will be required.
33	WPS Medicare 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.
34	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.
35	The incoming 837 transactions utilize delimiters from the following list: >, *, ~, ^,  , and:. Submitting delimiters not supported within this list will cause an interchange (transmission) to be rejected.
36	Effective January 1, 2008, your Medicare fee-for-service claims must include an NPI in the primary provider fields on the claim (i.e., the billing and pay-to provider fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI. The secondary provider fields (i.e., attending, operating and other) may continue to include only your legacy number, if you choose. Failure to submit an NPI in the primary provider fields will result in your claim being rejected, beginning January 1, 2008.
37	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).
38	WPS Medicare will reject an interchange (transmission) submitted with more than 9,999 loops.
39	WPS will reject an interchange (transmission) submitted with more than 9,999 segments per loop.
40	WPS Medicare will reject an interchange (transmission) with more than 5000 CLM segments (claims) submitted per transaction.
41	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 will cause the claim or the transaction to be rejected.
42	We suggest retrieval of the ANSI 997 functional acknowledgement files on the first business day after the claim file is submitted, but no later than 5 days after the file submission.
43	WPS Medicare will return (X) as the version in GS08 (Version/Release/Industry Identifier Code) of the 997.
44	WPS Medicare will reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the intermediary definition

<b>Helpful Hints</b>	
1	Please use your Tax Id number in ISA06 and GS02
2	GS03 should be WPS Fiscal Intermediary Number, which is 52280.
3	The file version in the REF02 segment should appear like this: 004010X096A1, not 004010X096DA1.
4	Do not include the discharge hour on the following TOB's: 212, 23X, 24X, 71X, 72X, 74X, 75X, 76X, 83X as the translator will reject the claims. For all other TOB's, the system will accept the discharge hour; however it must be in the proper format (0000 is a valid time; however 00000000 is not a valid date)
5	Do not report covered days or DRG information on outpatient claims.
6	As of March 8, 2004, all AMT segments with a valid qualifier will be allowed to contain a zero dollar amount.
7	Patient Relation Code (from FL57 of the UB92) must be present on each claim and dependent to subscriber is amount.
8	Use the Employer's EIN number for the value in the NM109 segment of Loop 2310A of the Physician's SS# is unknown.
9	837 Transactions to WPS Medicare should contain no more than 5,000 claims per ISA / IEA.
10	Test files should only be submitted to designated HIPAA test mailboxes, not to production mailboxes. Please contact Medicare Systems at 866 – 734 – 6656.

Helpful Hints	
11	<p>Here is what CMS feels are Inpatient Vs. Outpatient bill types for HIPAA editing purposes.            Inpatient: 11X, 12X, 18X, 21X, 22X, 41X.            Outpatient: 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, 85X.</p>
12	<p>Submitters sending file for multiple states in the same file should send on GS/ST – GE/SE for each provider number within each ISA/IEA segment in order to ensure all claims are successfully loaded into the FISS system. Failure to do so could cause claims for some providers not to get loaded into the FISS system. For example, if claims would get loaded but the Nebraska claims would not because the provider numbers are maintained in different claims processing regions.</p>
13	<p>How our Translator Check for Duplicate Transmissions:</p> <p>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 this key, the key is then ran 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.</p> <p><b>Key Information:</b></p> <ul style="list-style-type: none"> <li>• APPL-SENDER-CD GS 02</li> <li>• CLAIM-CNT CALCULATED FIELD – NUMBER 500 RECORDS</li> <li>• SRVC-LN-CNT CALCULATED FIELD - NUMBER OF 600 RECORDS</li> <li>• REC-CNT CALCULATED FIELD - TOTAL RECORDS IN THE ST</li> <li>• TOTAL-CHG. 2400 SV2 03</li> <li>• FST-SBR-LST-NAME 2010BA NM1 03</li> <li>• FST-SBR-FST-NAME 2010BA NM1 04</li> <li>• FST-SBR-PAT-CTRL 2300 CLM 01</li> <li>• FST-SBR-TOT-CHG 2400 SV2 02</li> <li>• FST-SBR-STMT-FROM-DT 2300 DTP 03 QUAL 434</li> <li>• LST-SBR-LST-NAME 2010BA NM1 03</li> <li>• LST-SBR-FST-NAME 2010BA NM1 04</li> <li>• LST-SBR-PAT-CTRL 2300 CLM 01</li> <li>• LST-SBR-TOT-CHG 2400 SV2 03</li> <li>• LST-SBR-STMT-FROM-DT 2300 DTP 03 QUAL 434</li> </ul>

Interchange Control Header		
ISA05	Interchange Qualifier	WPS will reject an interchange (transmission) that does not contain a 29 in ISA05
ISA06	Interchange Sender ID	WPS Medicare will reject an interchange (transmission) that does not contain a valid ID in ISA06.
ISA07	Interchange ID Qualifier	WPS Medicare will reject an interchange (transmission) that does not contain 28 qualifier in ISA07
ISA08	Interchange Receiver ID	WPS will reject an interchange (transmission) that does not contain 52280 in ISA08. Each individual contractor determines this code.

<b>Loop Transaction Set</b>			
	BHT02	Transaction Set Purpose Code	Transaction Set Purpose Code(BHT) must equal '00' (ORIGINAL).
1000A	NM109	Submitter ID	WPS Medicare will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.
1000B	NM109	Receiver Primary Identifier	WPS Medicare will reject an interchange (transmission) that is not submitted with a valid intermediary code (NM1). Each individual contractor determines this code
2000A	PRV	Billing/Pay to Provider Specialty Information	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.

<b>Loop Claim information</b>			
2300	CLM02	Total Submitted Charges	Negative values submitted in CLM02 will not be processed and will 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 Code	Data submitted in CLM20 will not be used for processing.
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 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.