

Mutual of Omaha Medicare HIPAA Reject Report Guide

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1. Overview

ANSI ASC X12N 837 Health Care Claims (837) transaction can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. Payers will process these transactions by performing different types of edits and generating different reports.

This document was created to provide detailed instructions on how to analyze the reject reports and the 997 functional acknowledgement.

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2. Types of Edits

Once Medicare receives the file from providers, the file will be validated for different levels before being processed by the claims system. Following are different levels of edits.

Level I – ISA Edits (Submitter / Receiver Information)

- Interchange Control Header Segment (ISA) editing will be done prior to translating the transmission.
- If the transmission fails at the Level 1 ISA edits the file will be rejected.

Level II – 997

- If the transmission passes the Level 1 ISA edits X12 997 Functional Acknowledgement will be generated at Level II.
- The 997 transaction is explained in detail on Page No.5

Level III GS edits (These edits ensure ISA and GS segments match)

Functional Group Header Segment (GS) editing will be performed if the transmission passes the ISA edits. The GS edits validate data in the transmitted GS segment against the implementation guide.

- If the file fails at the GS level the entire functional group will be rejected.
- If the transmission has only one functional group the transaction will be rejected.
- If the transmission has more than one transaction only the functional group with the errors will be rejected.
- IG edits will not be performed on any segments within that functional group.
- The submitters should correct the errors and resubmit just that functional group.

Note: If one transaction set is rejected just send only that transaction set not the entire batch. Our program captures the key information below from the first claim in each ST/SE loop of every successful file in order to create a

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key. The key is then stored in a library of the dup. program. All files that are transmitted to Mutual 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.

- If the file passes the GS level edits IG edits will be performed (Level IV)

Level IV – IG Edits (HIPAA Implementation Guide Edits)

- All segments in the file including the ST segments (ST – SE) will be validated for IG edits.
- All the segments, elements and composite elements will be edited for usage, field sizes, qualifiers and situational notes defined in the ANSI X12 837 format. The ST/SE transaction set will be processed successfully by the translator but had implementation edit errors, then the transaction will be entered in to the claim system without the claims in error.

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3.Reject Report Analysis

Providers will receive an acknowledgement 997 and rejection / acceptance reports once the file is processed. The file or claim rejections can be analyzed in two ways.

- Using the Functional Acknowledgement 997 (ANSI format).
- Analyzing the error reports.

3.1 Analyzing Functional Acknowledgement

Functional acknowledgement transaction helps to identify the acceptance or rejection of the functional group, transaction sets or segments or the data elements. Table1 gives the detail of all the different elements used in an ANSI 997 (Acknowledgment). Each element within a segment gives the detail of acceptance or rejection at different levels.

*Most commonly referenced segments are in **Red**.

Table1

Loop ID	Seg. ID	Name	Example	Segment analysis
	ST	Transaction set header	This indicates the start of a transaction set and to assign a control number. ST*997*1234~ ST01 ST02	ST01 – 997 (ID) ST02 – Transaction set control number 1234
	AK1	Functional Group Response Header	AK1*HC*1~ AK101 AK102	AK101 – HC Healthcare Claim 837 AK102 – Functional group control number in the GS segment of the 837 file submitted.
AK2				
	AK2	Transaction Set Response Header	AK2*837*0000123~ AK201 AK202	AK201 -837 Healthcare claim AK202 – Transaction set control number in the ST segment of the 837 for the function group in the AK1012

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AK2/ AK3				
	AK3	Data segment Note	AK3*NM1*3*2010BB*7~ AK301 AK303 AK304 AK302	<p>AK301 – This identifies the data segment in error.</p> <p>AK302 – This is the position count of the segment in error starting with ST as count 1.</p> <p>AK303 – Loop in which the segment with error is present.</p> <p>AK304 – This code identifies the type of error.</p> <p>1 – Unrecognized segment ID</p> <p>2 – Unexpected segment</p> <p>3 – Mandatory segment missing</p> <p>4 – Loop occurs Over maximum limit</p> <p>5 - Segment exceeds maximum use</p> <p>6-Segment not in defined transaction set</p> <p>7 – Segment not in proper sequence</p> <p>8- Segment has data element errors.</p>
	AK4	Data element note	AK4*1*46*6~ AK401 AK403 AK402	<p>AK401 – AK401 has two sub fields.</p> <p>AK401 – 1 – Errored Element position in the Segment</p> <p>AK402 – 2 – This gives the position of the data element if the data element is composite.</p> <p>AK402 – Data element reference number. All the reference numbers are found with the segment descriptions</p>

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				<p>in the implementation guide.</p> <p>AK403 – Data element error code. Gives the brief information for the type of error.</p> <p>1 – Mandatory data element missing.</p> <p>2 – Conditional required data element missing.</p> <p>3 – Too many data elements</p> <p>4 – Data element is too short.</p> <p>5 – Data element too long</p> <p>6 – Invalid character in data element</p> <p>7 – Invalid code value</p> <p>8 – Invalid date</p> <p>9 – Invalid time</p> <p>10 – Exclusion Condition Violated.</p> <p>AK404 – This is the copy of the data element in error.</p>
	AK5	Transaction set response trailer	<p>AK5*E*5~</p> <p style="margin-left: 40px;"> </p> <p style="margin-left: 40px;">AK502</p> <p style="margin-left: 20px;">AK501</p>	<p>AK501 – This code indicates that the transaction set is accepted or not.</p> <p>A – Accepted</p> <p>E – Accepted but errors were noted.</p> <p>M Rejected, Message Authentication code (MAC) Failed.</p> <p>R – Rejected</p> <p>W – Rejected, Assurance Failed</p> <p>Validity tests</p> <p>X – Rejected, Content after decryption could not be analyzed.</p> <p>AK502 , AK503, AK504, AK505, AK506 – Transaction</p>

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				<p>errors were noted M, R, W, X – Rejected P – Partially accepted. AK902 – No of transaction sets included in the functional group AK903 – Number of Received transaction sets AK904 – Number of accepted transaction sets. AK905 – This indicates if an error is present in the functional group. 1 – Functional group not supported 2 – Functional group version not supported 3 – Functional group trailer missing 4 – Group control number in the functional group header and trailer do not agree 5 – Number of included transactions sets does not match the actual count 6 – Group control number violates syntax. 10 – Authentication key name unknown 11 – Encryption key name unknown 12 – requested service (Authentication or Encryption) not available 13 – Unknown security recipient 14 – Unknown security originator 15 – Syntax error in</p>
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3.2.4 SAMPLE REPORT (4)

This report is an example for a complete transaction set, which has been rejected. This type of errors might be caused if the submitters the resubmits the same transaction set or if issues are fixed and submits the transaction set with the same patient in the beginning as previously submitted.

- Once the file is rejected totally then provider should send the entire file again after the issues are fixed. Change the order of the claims in the transaction set (ST / SE).
- If one functional group is rejected just send only that functional group and not the entire batch. Change the order of the claims.
- If one transaction set is rejected just send only that transaction set not the entire batch. Our program captures the key information below from the first 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 dup. program. All files that are transmitted to Mutual 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.

Key information:

Patient Last Name

Patient Control numbers

Total Charges

Total Non-Covered Charges

Statement From and Thru date

SAMPLE REPORT WITH A TOTAL TRANSACTION SET REJECTED (Duplicate Transaction).

```
REPORT ID: HB997ZRJ-A                                MUTUAL OF OMAHA                                PAGE: 3
RUN DATE: 05/05/04                                MEDICARE PART A INBOUND REJECT REPORT        RUN TIME: 19:56:46
RECEIVED:
SUBMITTER: B71111959-                                PROVIDER: -
SUBMITTER QUALIFIER  ISA CTRL NBR  GS SUBMITTER  GS CTRL NBR  TXNSET ID  ST CTRL NBR
29 MED PROV NUMBER    41261735    B71111959    41261735    837        41261735
-----
LAST NAME  FIRST NAME  HIC  TOB  PATIENT CTL NBR  MEDICAL REC NBR  ADMIT  FROM  THRU  TOTAL
CHARGES
-----
PROGRAM  LOOP  SEG  ELE  SUB  SEG  POS  DATA  REF  ERR  CD  ERROR MESSAGE  QUALIFIER
BAD DATA
-----
HB837BDC  0000  ISA  00  99 THIS IS A DUPLICATE SUBMISSION FOR SENDR
```

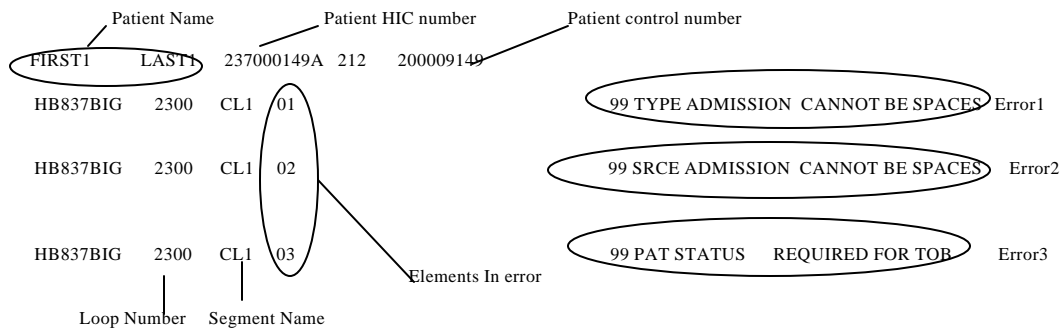
THIS ST LOOP HAD ERRORS AND THIS ENTIRE ST LOOP WILL NOT BE ENTERED INTO CLAIMS SYSTEM

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3.2.5 SAMPLE REPORT (5)

In this report some of the individual claims are rejected. This means that transaction set will be processed but the claims with errors will not be processed. Those claims should be checked for the cause and then fixed and send those back again for processing.

For example the patient First1 Last1 has 3 errors one of which is “TYPE ADMISSION CANNOT BE SPACES”. This should be analyzed as follows. This report gives the patients HIC number. If the HIC number is located in the file the segments and the elements in error can be located for that patient around that HIC number.



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SAMPLE REPORT OF THE FILE WITH THE ERRORS (File processed without the errored claims)

REPORT ID: HB997ZRJ-A
 RUN DATE: 05/05/04
 RECEIVED: 05/05/04

MUTUAL OF OMAHA
 MEDICARE PART A INBOUND REJECT REPORT

PAGE: 1
 RUN TIME: 19:56:46

SUBMITTER: B000003409 - XXXXXXXXXXXXXXXXXXXXXXXXXXXX PROVIDER: 440000 -
 XXXXXXXXXXXXXXXXXXXXXXXXXXXX
 SUBMITTER QUALIFIER ISA CTRL NBR GS SUBMITTER GS CTRL NBR TXNSET ID ST CTRL NBR
 29 MED PROV NUMBER 13 B000003409 13 837 000000013

LAST NAME	FIRST NAME	HIC	TOB	PATIENT CTL NBR	MEDICAL REC NBR	ADMIT	FROM	THRU	TOTAL
CHARGES									

PROGRAM	LOOP	SEG	ELE	SUB	SEG POS	DATA REF	ERR CD	ERROR MESSAGE	QUALIFIER
BAD DATA									

FIRST1	LAST1	237000149A	212	200009149				04/28/2004 04/28/2004 04/30/2004	496.06
HB837BIG	2300	CL1	01				99	TYPE ADMISSION CANNOT BE SPACES	
HB837BIG	2300	CL1	02				99	SRCE ADMISSION CANNOT BE SPACES	
HB837BIG	2300	CL1	03				99	PAT STATUS REQUIRED FOR TOB	
FIRST	LAST2	409000000D	212	409600009					
HB837BIG	2300	CL1	01				99	TYPE ADMISSION CANNOT BE SPACES	
HB837BIG	2300	CL1	02				99	SRCE ADMISSION CANNOT BE SPACES	
HB837BIG	2300	CL1	03				99	PAT STATUS REQUIRED FOR TOB	
FIRST3	LAST3	410000084A	212	410000384					
HB837BIG	2300	CL1	01				99	TYPE ADMISSION CANNOT BE SPACES	
HB837BIG	2300	CL1	02				99	SRCE ADMISSION CANNOT BE SPACES	
HB837BIG	2300	CL1	03				99	PAT STATUS REQUIRED FOR TOB	
HB837BIG	2310A	NM1	04				99	ATTN FST NAME CANNOT BE SPACES	

|
|
|
|
|

NOTE: THIS ST / SE TRANSACTION SET HAS BEEN PROCESSED SUCCESSFULLY BY THE TRANSLATOR
 BUT HAD IMPLEMENTATION EDIT ERRORS.
 THIS TRANSACTION WILL BE ENTERED IN TO THE CLAIM SYSTEM WITHOUT THE ERRORED CLAIM(S)
 SHOWN ON THIS REPORT.

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4. Most Common Errors

Use the patients Medicare Number (HIC#) to find the claim in error.

4.1 HI Errors

The following information about the HI segments help to understand the cause of the error. All the HI segments are present in the Loop 2300 of the 837 file. (These errors can be invalid Diagnosis codes, procedure codes, DRG is required for the patient type etc.,)

Examples:

```

HB837BIG 2300 HI 04          99 DRG INVALID FOR OUTPATIENT DR
HB837BIG 2300 HI 01          99 OCCUR SPAN THR INVALID/MISSING DATE BI
HB837BIG 2300 HI 01          99 PRINC PROC CD INVALID FOR TOB BR
    
```

Qualifier /Format	Description	Errors	Resolution
BK HI*BK:9976~ HI*BK:6826*BJ:68 26~ HI*BK:5690*ZZ:5 690~	Principal, Admitting, E- code and patient reason for visit diagnosis information.	<ul style="list-style-type: none"> Invalid diagnosis code. Princ Diag Ql required Princ Diag Required Admitting diag required Patient reason for visit reqd. for Revcd. 	Please verify the diagnosis codes or reason codes are sent with the qualifier and if is a correct code. The codes should be at the current release level.
DR HI*DR:123~	DRG Information	<ul style="list-style-type: none"> Invalid DRG. Invalid for outpatients DRG information missing. 	DRG information is required for all the inpatients and should not be reported for the outpatients.
BF HI*BF:V9782~	Other diagnosis conditions	<ul style="list-style-type: none"> Invalid other diagnosis code (ICD – 9 – CM) 	This is required when other conditions co-exist with the principal diagnosis at the time of admission and should be a valid code.
BP, BR HI*BR:92795:D8:1 9980321~	Principal procedure codes (ICD –9 CM)	<ul style="list-style-type: none"> Invalid procedure code 	This is required on inpatient claims or Home IV therapy claims / encounters when a procedure was performed.
BQ, BO HI*BO:92795:D8:1	Other procedure Information (ICD – 9 – CM)	<ul style="list-style-type: none"> Invalid other procedure information 	This is required on inpatient claims or Home IV therapy

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9980321~	codes).		claims / encounters when a procedure was performed
BI HI*BI:70:RD8:199 81202-19981212~	Occurrence span	<ul style="list-style-type: none"> • Occurrence span thru Invalid / Missing. 	Required when occurrence span applies to the claim / encounter
BH HI*BH:42:d8:1998 1208~	Occurrence codes.	<ul style="list-style-type: none"> • Occurrence codes Invalid/ Missing 	Required when occurrence information applies to the claim / encounter
BE HI*BE:08:::1740~	Value information	<ul style="list-style-type: none"> • Value information required • Value code cannot be spaces 	Required when value information applies to the claim / encounter.
BG HI*BG:67~	Condition codes	<ul style="list-style-type: none"> • Condition code missing • Invalid condition code 	The code should be valid and is required when it applies to the claim / encounter.
TC	Treatment code		

4.2 Other Errors

Error	Resolution
When should the loop 2000C be reported?	Loop 2000C should only be reported when patient is not the same as the subscriber. This loop should not be used for Medicare because patient is always the same as the subscriber.
Where are non-covered charges reported?	Non – Covered charges should be reported in SV207.
Why is the SBR02 in the loop 2000B cannot be spaces?	With Medicare patient is always the same as the subscriber. '18' should be reported in SBR 02 to report this information. If it is not reported the claim will be rejected.
Loop 2300 Segment CL1 01 – Type Admission cannot be spaces 02 – SRCE Admission cannot be spaces 03 – Pat Status required for TOB	CL1 is a required segment for all the inpatient and Medicare outpatient claims / encounters. CL1 01 is required for all the inpatients CL1 02 is required for all inpatient admissions and Medicare outpatient Registrations. CL1 03 This is required for all inpatient claims / encounters.
Transaction is receiving different error codes. Don't know what it means.	AK4 01 – Mandatory data element missing. – This is the error caused because some data element is missing in the file, Segment is present and the required element is missing Etc. AK4 02 – Conditional required data element missing. AK4 03 – Too many data elements AK4 04 – Data element is too short. AK4 05 - Data element too long

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	<p>AK4 06 – Invalid character in data element – This is caused if there are special characters in the file.</p> <p>AK4 07 – Invalid code value – If the qualifier reported in the 837 file do not match the valid qualifiers in the Implementation Guide</p> <p>AK4 08 – Invalid date – This is caused if the date is not in the valid format specified in the implementation guide or if zeros were used for the date or if there are some special characters included in the date.</p> <p>AK4 09 – Invalid time – This is caused if the time is not in the valid format specified in the Implementation Guide.</p>
Dischrg hour QL required for final TOB	DTP segment is missing for the Discharge hour Qualifier for the patient in the 2300 loop. This is required for all final inpatient claim / encounters.
SBR Zip invalid	This error is reported if the zip code is missing or does not have the required number of digits or if it is zeros.
SBR Birth date invalid. Oth SBR birth date invalid.	The Date of Birth is greater than the current date. The date of birth can never be greater than the current date.
Other SBR sex cannot be spaces. Other SBR FMT BDY cannot be spaces. Other SBR B-Date is Invalid / Missing	For the other subscriber if an SBR segment is reported a DMG segment should be reported for that SBR segment. These errors are caused because the DMG segment is missing for Other Subscriber.
Covered days invalid for outpatient CA	QTY segment is required only on inpatient claims or encounters when covered, co-insured, life – time reserved or non – covered days are being reported.
Patient reason for visit required for REVC.D.	In the HI segment with the qualifier BK, the Patient reason for visit should be reported with the ZZ qualifier. Example: HI*BK:5690*ZZ:5690~
Admitting Diag. required for the TOB	In the HI segment with the qualifier BK, the Admitting Diagnosis code should be reported with the BJ qualifier. Example: HI*BK:5690*ZZ:5690~
SBR04 INS group name should be spaces.	If the subscriber group number is reported in the element SBR03 Group name should not be reported in the SBR04. Either Group number or the group name should be reported and not both.
REF02 Attn. Physician UPIN required	REF segment with the qualifier 'IG' (Used for reporting the UPIN number) should be reported for the attending physician.
SV204 Unit qualifier cannot be spaces.	Units should always be reported with a qualifier.
N301 SBR address cannot be blanks.	N301 should be reported when the patient is the same as the subscriber.
OI01 Oth Ins asgn BN cannot be blank OI06 Oth Ins rel cd cannot be spaces	OI segment is required and is missing
2000B SBR 09 Payment srce code not equal to 'MA'	For the primary subscriber 'MA' should be reported in the SBR09 field. (For Medicare)
SE 01 not equal to the	The segment count should be the total number of segments from

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segment count.	ST to SE including ST and SE.
N4 04 Billing provider country invalid.	Valid country codes are available at http://www.oasis-open.org/cover/country3166.html
Attending Physician required for this TOB	The attending physician segment is missing in the file. The NM1 (2310A) with the qualifier 71 should be reported.
Dashes in the HIC# not allowed.	FISS system does not allow dashes in the HIC#. Providers should resubmit the claims for processing.

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5.Summary

Level I ISA – Re-send the entire file + Change the order of the claims

Level III GS – Re-send the Functional Group + Change the order of the claims

Level IV IG – Can reject the entire file or only a few claims can be effected.

- Once the file is rejected totally then provider should send the entire file again after the issues are fixed. Change the order of the claims in the transaction set (ST / SE).
- If one functional group is rejected just send only that functional group and not the entire batch.
- If one transaction set is rejected just send only that transaction set not the entire batch. Our program captures the key information below from the first 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 dup. program. All files that are transmitted to Mutual 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.

Key information:

Patient Last Name

Patient Control numbers

Total Charges

Total Non-Covered Charges

Statement From and Thru date

If you have any questions feel free to contact Mutual of Omaha - Medicare at **866-734-6656**.

This document is created to help providers understand different reject reports they receive once they submit their claims to Mutual of Omaha Medicare.