Utah Specific Transaction Instructions

837 Health Care Claim: Institutional
ASCX12N 837 (004010X096A1)

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, and all health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for healthcare as established by the Secretary of Health and Human Services. The ANSI ASC X12N 837P Version 4010 implementation guide has been established as the standard of compliance. Utah Medicaid will implement the Addenda corrections for the Health Care Claim: Institutional (004010X096A1). The implementation guide is available electronically at www.wpc-edi.com. The following supplemental requirements are specific to Utah Medicaid and are intended to serve as a companion guide to the HIPAA ANSI X12N implementation guide. For clarification regarding submission of encounter records, refer to the encounter provider manual. Further billing instructions and policy are published in the Utah Medicaid Provider Manual and the Utah Uniform Billing Instruction Manual (UB92 Manual).

Requirements:

1. An Electronic Commerce Agreement must be in place. The form is available at www.UHIN.com.

2. A Utah Medicaid EDI Enrollment form must be completed and on file prior to the submission of claims. The form is available at http://www.health.utah.gov/hipaa/medicaid_pcn.htm . Transactions submitted without an Electronic Transmitter Identification Number (ETIN) or Trading Partner Number (TPN) on file with Medicaid will be rejected back to the sender.

3. 837 claims may be sent anytime 24 hours a day, 7 days a week. Transactions sent after noon on Friday will not be included in the following week remittance.

4. Utah Medicaid recommends submitting 60 or fewer service lines for each Institutional claim. Claims submitted with more than 60 service lines will be split and may encounter processing delays.

5. An 837 transaction will be rejected if the monetary amounts do not balance.

6. A 997 Functional Acknowledgment will be created for all 837 transactions.

7. A 277 Health Care Claim Status Notification - Front End Acknowledgment will be created for all 837 transactions.

8. All references to Medicaid are used for simplicity, but other programs supported by Health Care Financing (HCF) are also included, e.g., Non-Traditional Medicaid, Primary Care Network, IHC Access, Baby Your Baby, etc.

9. Units must be reported in full units. No decimals will be accepted. When procedure codes contain time increments in the definition, Health Care Financing's policy is to round to the nearest unit or procedure code.

   Example: T1002 - RN services, up to 15 minutes.
   20 minutes of service, units billed = 1.
   28 minutes of service, units billed = 2.

Page	Loop	Segment	Data Element	Values / Comments
59		BHT06	Claim or Encounter Identifier	"CH"
63	1000A	NM109	Submitter Identifier	Trading partner number
68	1000B	NM103	Receiver Name	"Utah Medicaid FFS"
68	1000B	NM109	Receiver Primary Identifier	"HT000004-001"
82	2010AA	REF01	Reference Identification Qualifier	"1D"
83	2010AA	REF02	Billing Provider Additional Identifier	Use the 12 digit identifier assigned by Utah Medicaid.
100	2000B	HL04	Hierarchical Child Code	"0" – The subscriber is always the patient. There are no dependents in Utah Medicaid.
104	2000B	SBR09	Claim Filing Indicator Code	"MC"
109	2010BA	NM102	Entity Type Qualifier	"1"
110	2010BA	NM108	Identification Code Qualifier	"MI"

Page	Loop	Segment	Data Element	Values / Comments
110	2010BA	NM109	Subscriber Primary Identifier	Use the 10 digit identifier assigned by Utah Medicaid. Do not submit hyphens or spaces.
127	2010BC	NM103	Payer Name	“Utah Medicaid FFS”
128	2010BC	NM109	Payer Identifier	“HT000004-001”
139	2000C	HL	Patient Hierarchical Level	The subscriber is always the patient in Utah Medicaid. It is not necessary to complete this loop.
158	2300	CLM01	Patient Account Number	Provider assigned account number to identify claim.
159	2300	CLM02	Total Claim Charge Amount	Total Claim Charge. REV Code 0001 to report total claim charge is only used on paper claims.
159	2300	CLM05-1	Facility Type Code	Use appropriate codes as identified in the UB92 Manual.
159	2300	CLM05-3	Claim Frequency Code	Medicaid will allow for submission of electronic corrections and voids to a previously paid claim. However, a code “6" or “7" in this data sub-element will be treated as a “replacement” for the original claim.
161	2300	CLM11	Property & Casualty Related Cause Codes	Use appropriate code to indicate type of accident
166	2300	DTP03	Discharge Hour	Report discharge hour.
168	2300	DTP03	Statement From or To Date	Statement Date
170	2300	DTP03	Admission Date and Hour	Date of admission and hour.
171	2300	CL101	Admission Type Code	Type of Admission
172	2300	CL102	Admission Source Code	Source of Admission

Page	Loop	Segment	Data Element	Values / Comments
172	2300	CL103	Patient Status Code	Discharge patient status.
174	2300	PWK01	Attachment Report Type	Required if documentation is needed to support the claim. Claims may deny, however once documentation is received the claim will be re-processed.
174	2300	PWK02	Attachment Transmission Code	“BM”, “EM” or “FX”
175	2300	PWK06	Attachment Control Number	Must be unique with each claim and each attachment associated to the claim. Attachment control number and provider Medicaid ID must be submitted on attachment
179	2300	AMT02	Estimated Claim Due Amount	Net claim charge.
180	2300	AMT02	Patient Responsibility Amount	Report patient responsibility amount applicable to this claim.
192	2300	REF02	Claim Original Reference Number	When codes “6", “7" or “8" are submitted in 2300 CLM05-3, the Transaction Control Number (TCN) assigned to the original claim must be reported.
198	2300	REF01	Reference Identification Qualifier	“G1” for prior authorizations. Medicaid does not utilize referral numbers.
199	2300	REF02	Prior Authorization or Referral Number	Use the 7 digit prior authorization number assigned by Medicaid.
205	2300	NTE	Claim Note	Provide necessary claim information.
230	2300	HI01-2	Diagnosis Related Group (DRG) Information	Medicaid calculates the DRG for payment and does not utilize this field.
233	2300	HI	Other Diagnosis Information	The first 5 diagnoses will be used for claims processing (principal diagnosis and 4 others).

Page	Loop	Segment	Data Element	Values / Comments
242	2300	HI	Procedure Information and Date	The first 3 surgical procedure codes will be used for claims processing (principal procedure and 2 others). Report date of procedure.
256	2300	HI	Occurrence Span Information	Nursing Homes should utilize span code “74” to report visit leave days.
267	2300	HI	Occurrence Information	Information from the first 5 occurrence codes will be used for claims processing.
280	2300	HI	Value Information	Information from the first 3 value codes will be used for claims processing. When using value code “68”, a revenue code and units must also be submitted (units should be rounded to full units).
290	2300	HL	Condition Information	Information from the first 5 condition codes will be used for claims processing.
306	2300	QTY	Claim Quantity	Utilize to report covered and non-covered days.
326	2310A	REF01	Reference Identification Qualifier	“1D”
327	2310A	REF02	Attending Physician Secondary Identifier	Use the 12 digit identifier assigned by Medicaid.
333	2310B	REF01	Reference Identification Qualifier	“1D”
334	2310B	REF02	Operating Physician Secondary Identifier	Use the 12 digit identifier assigned by Medicaid.
359	2320	SBR	Other Subscriber Information	If the patient has Medicare or other coverage, repeat this loop for each payer. Do not put information about Utah Medicaid coverage/payment in this loop.

Page	Loop	Segment	Data Element	Values / Comments
367	2320	CAS02	Adjustment Reason Code	Report standard codes as received on EOB. Use adjustment reason code “1” to report deductible amount and “2” to report coinsurance amount.
371	2320	AMT02	Payer Paid Amount	Report amount received from other payer.
372	2320	AMT02	Allowed Amount	For Medicare Coordination of Benefits (COB), report amount.
377	2320	AMT02	Medicare Paid Amount	For Medicare COB, report amount.
392	2320	MIA	Medicare Inpatient Adjudication Information	Report Medicare remark codes (inpatient).
397	2320	MOA	Medicare Outpatient Adjudication Information	Report Medicare remark codes (outpatient).
415	2330B	DTP03	Adjudication or Payment Date	Date claim paid by other payer.
445	2400	SV2	Institutional Service Line	Report all service information. Reference the UB92 Manual and Medicaid Provider Manual for specific instructions.
453	2400	PWK01	Attachment Report Type	Required if documentation is needed to support the line. Claims may deny, however once documentation is received the claim will be re-processed.
454	2400	PWK02	Attachment Transmission Code	“BM”, “EM” or “FX”
454	2400	PWK06	Attachment Control Number	Must be unique with each claim and each attachment associated to the claim. Attachment control number and provider Medicaid ID must be submitted on attachment

Page	Loop	Segment	Data Element	Values / Comments
456	2400	DTP	Service Line Date	Report line level date of service as appropriate. Required for home health providers.
491	2430	SVD02	Service Line Paid Amount	Report amount paid by other payer.
496	2430	CAS02	Adjustment Reason Code	Report standard code as received on EOB. Use adjustment reason code “1” to report deductible amount and “2” to report coinsurance amount.
496	2430	CAS03	Adjustment Amount	Report amount relating to adjustment reason code.