Utah Specific Transaction Instructions

837 Health Care Claim: Professional
ASCX12N 837 (004010X098A1)

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: Professional (004010X098A1). 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.

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 6 or fewer service lines for each Professional claim. Claims submitted with more than 6 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
65		BHT06	Claim or Encounter Identifier	"CH"
69	1000A	NM109	Submitter Identifier	Trading partner number
75	1000B	NM103	Receiver Name	"Utah Medicaid FFS"
75	1000B	NM109	Receiver Primary Identifier	"HT000004-001"
92	2010AA	REF01	Reference Identification Qualifier	"1D"
92	2010AA	REF02	Billing Provider Additional Identifier	Use the 12 digit identifier assigned by Utah Medicaid.
99	2010AB	NM1	Pay-to Provider	Medicaid's claims processing utilizes billing provider information.
109	2000B	HL04	Hierarchical Child Code	"0" - The subscriber is always the patient, there are no dependents in Utah Medicaid.
112	2000B	SBR09	Claim Filing Indicator Code	"MC"
118	2010BA	NM102	Entity Type Qualifier	"1"

Page	Loop	Segment	Data Element	Values / Comments
119	2010BA	NM108	Identification Code Qualifier	“MI”
119	2010BA	NM109	Subscriber Primary Identifier	Use the 10 digit identifier assigned by Utah Medicaid. Do not submit hyphens or spaces.
131	2010BB	NM103	Payer Name	“Utah Medicaid FFS”
131	2010BB	NM109	Payer Identifier	“HT000004-001"
152	2000C	HL	Patient Level	The subscriber is always the patient in Utah Medicaid. It is not necessary to complete this loop.
174	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.
176	2300	CLM11	Accident/ Employment Related Causes	Use appropriate code to indicate type of accident.
215	2300	PWK01	Attachment Report Type Code	Required if documentation is needed to support the claim. Claims may deny, however once documentation is received the claim will be re-processed.
216	2300	PWK02	Attachment Transmission Code	“BM”, “FX” , “EM”
216	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.
228	2300	REF01	Reference Identification Qualifier	“G1" for prior authorizations. Utah Medicaid does not utilize referral numbers.

Page	Loop	Segment	Data Element	Values / Comments
228	2300	REF02	Prior Authorization or Referral Number	Use the 7 digit prior authorization number assigned by Utah Medicaid.
230	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.
232	2300	REF02	CLIA Number	The first CLIA number will be used for claims processing.
266	2300	HI01-HI08	Diagnosis Code	The first 4 diagnosis codes will be used for claims processing.
283	2310A	NM101	Entity Identifier Code	“DN” - Referrals must be obtained from the Primary Care Provider listed on the Medicaid card.
288	2310A	REF01	Reference Identification Qualifier	“1G”
289	2310A	REF02	Referring Provider Secondary Identifier	Use the Unique Provider Identification Number (UPIN) as supplied by the Primary Care Provider.
291	2310B	NM101	Entity Identifier Code	“82” – Rendering provider
296	2310B	REF01	Reference Identification Qualifier	“1D”
297	2310B	REF02	Rendering Provider Secondary Identifier	Use the 12 digit identifier assigned by Utah Medicaid.
318	2320	SBR	Other Subscriber Information	If the patient has Medicare or other coverage, repeat this loop for each other payer. Do not put information about Utah Medicaid coverage/payment in this loop.
326	2320	CAS02	Adjustment Reason Code	Output adjustment codes as reported by other payer.

Page	Loop	Segment	Data Element	Values / Comments
327	2320	CAS03	Adjustment Amount	Report amount relating to adjustment reason code.
332	2320	AMT02	Payer Paid Amount	Report amount received from other payer.
334	2320	AMT02	Allowed Amount	Report allowed amount as reported by other payer.
335	2320	AMT02	Other Payer Patient Responsibility Amount	Report amount as reported by other payer.
367	2330B	DTP03	Adjudication or Payment Date	Report date claim paid by other payer.
369	2330B	REF02	Other Payer Secondary Identifier	Use qualifier “F8” and output the other payer claim number if known.
398	2400	LX	Service Line	Utah Medicaid recommends submitting 6 or fewer service lines for each Professional claim. Claims submitted with more than 6 service lines will be split and may encounter processing delays.
401	2400	SV101-3 to SV101-6	Procedure Modifier	The first 2 modifiers will be used for claims processing.
403	2400	SV103	Unit or Basis for Measurement Code	Services are reported in units “UN”, except anesthesia procedures which will report minutes “MJ” (see provider manual).
472	2400	REF02	Line Item Control Number	It is recommended that providers submit a unique line item control number for each line submitted.
488	2400	NTE01	Note Reference Code	“ADD”
488	2400	NTE02	Line Note Text	Provide description of service rendered when utilizing a not otherwise classified procedure code, e.g., J9999, etc.

Page	Loop	Segment	Data Element	Values / Comments
554	2430	SVD	Line Adjudication Information	For Coordination of Benefits, report adjudication information using this loop.
555	2430	SVD02	Service Line Paid Amount	Report amount received from other payer.
560	2430	CAS01	Adjustment Group Code	Report standard group code as received on EOB. Use “PR” for patient responsibility as reported by other payer.
560	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.
560	2430	CAS03	Adjustment Amount	Report amount relating to adjustment reason code.