Utah Specific Transaction Instructions

837 Health Care Claim: **Institutional Long Term Care (LTC)**
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 837I Version 4010 implementation guide has been established as the standard of compliance. 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. For questions or suggestions about this companion guide, call (800) 662-9651 or (801) 538-6155 option 3, option 5, Operational Support and Development (OS&D). Go to http://health.utah.gov/hipaa/guides.htm to obtain the latest version of this guide. OS&D can help resolve issues on electronic transmissions.

2. All electronic data must pass through the Utah Health Information Network (UHIN), an independent, not-for-profit, value added network. Contact UHIN at www.UHIN.com or (801) 466-7705 x200. UHIN will assign a Trading Partner Number (TPN) for electronic data interchange.

3. Use your TPN and your Utah Medicaid Provider number to complete the Online Utah Medicaid EDI Enrollment Form at http://health.utah.gov/hcfenroll (do not mail or fax, simply click on submit). Without a successfully completed EDI enrollment, the Medicaid computer system cannot process or even acknowledge any transmission (e.g. no 997, no 277FE, etc).

4. Beginning October 1, 2006, register your National Provider Identifier (NPI) with Medicaid, 538-6155, option 3, option 4, or fax your NPI (include 12-digit provider number, taxonomy code, and zip code +4) to 536-0471. The 12-digit Medicaid Provider number will not be allowed on or after May 23, 2007, unless you are a provider type not eligible for the NPI. Submit both the NPI and 12-digit Medicaid Provider number on claims from October 1, 2006 to May 22, 2007. The Provider Taxonomy Code is required if there are multiple provider types/services under the same NPI. Zip Code + 4 is required if you are no longer using the 12 digit provider number.

5. Transmit Institutional LTC claims anytime 24 hours a day, 7 days a week. Electronic claims received before the End of Business on Thursday usually adjudicate that weekend. Transactions received after the End of Business on Thursday will miss the adjudication cycle and will process the following weekend.

6. Medicaid Customer Service agents are NOT able to see claims that have not processed through at least one weekend adjudication cycle. Use the 997 and 277FE reports to determine status of electronic submissions prior to a weekend adjudication cycle. After an adjudication cycle use the 276 for claim status; include the 17-digit Transaction Control Number (TCN) assigned to the claim by Medicaid.

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

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

9. Currently, Utah Medicaid accepts monthly billing for LTC, unless discharged. Charges may be billed at the time of discharge (claim must specify discharge date).

10. Do NOT use this Companion Guide for Crossover Claims. Follow the Institutional Companion Guide.

Page	Loop	Segment	Data Element	Values / Comments
59		BHT06	Claim or Encounter Identifier	"CH" – Used for claims with at least one chargeable item.
62	1000A	NM108	Electronic Transmitter Identification Number (ETIN)	"46" – ETIN
63	1000A	NM109	Submitter Identifier	Submitter's TPN
68	1000B	NM103	Receiver Name	"Medicaid FFS"
68	1000B	NM108	Information Receiver Identification Number	"46" – ETIN
68	1000B	NM109	Receiver Primary Identifier	"HT000004-001" – Medicaid FFS
72	2000A	PRV02	Reference Identification Qualifier	"ZZ" – Taxonomy Code
72	2000A	PRV03	Reference Identification	Provider Taxonomy Code required for swing bed facilities utilizing same NPI as hospital.
77	2010AA	NM101	Entity Identifier Code	"85" – Billing Provider
77	2010AA	NM102	Entity Type Qualifier	"2" – Non-Person Entity
77	2010AA	NM108	Code Qualifier	"XX" – NPI
78	2010AA	NM109	Identification Code	NPI

Page	Loop	Segment	Data Element	Values / Comments
81	2010AA	N403	ZIP Code	Zip Code + 4 required if not using 12-digit provider number in REF02 below. Do not submit hyphens or spaces.
83	2010AA	REF01	Reference Identification Qualifier	“1D” – Medicaid Provider Number Not allowed on or after May 23, 2007.
84	2010AA	REF02	Billing Provider Additional Identifier	Use the 12-digit identifier assigned by Medicaid.
100	2000B	HL04	Hierarchical Child Code	“0" – The subscriber is always the patient, there are no dependents in Medicaid.
104	2000B	SBR09	Claim Filing Indicator Code	“MC” – Medicaid
109	2010BA	NM102	Entity Type Qualifier	“1" – Person
109	2010BA	NM103	Subscriber Last Name	Patient’s last name. Match the name on the Medicaid Card.
109	2010BA	NM104	Subscriber First Name	Patient’s first name is required. Match the name on the Medicaid Card. See UHIN Standard #37 for additional guidance.
110	2010BA	NM108	Identification Code Qualifier	“MI” – Member Identification Number
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	“Medicaid FFS”
127	2010BC	NM108	Identification Code Qualifier	“PI” – Payer Identification
128	2010BC	NM109	Payer Identifier	“HT000004-001” - Medicaid FFS
139	2000C	HL	Patient Hierarchical Level	The subscriber is always the patient in Medicaid. Do NOT use this loop.
158	2300	CLM01	Patient Account Number	Provider assigned number unique to this particular claim.
159	2300	CLM02	Total Claim Charges	Total Claim Charges
159	2300	CLM05-1	Facility Type Code	Acceptable codes: “18", “21", “22", “23", “25", “26", “28", “65", “66", “68"

Page	Loop	Segment	Data Element	Values / Comments
159	2300	CLM05-3	Claim Frequency Code	For original submission (or re-submission of denied claims) use value: "1" – Original Medicaid will allow for submission of electronic corrections or voids to a previously paid claim. Acceptable Values: "7" – Replacement "8" – Void The Provider Number must match. To correct a Provider Number, void out the paid claim, then submit an original claim using the correct Provider Number.
165	2300	DTP01	Date/Time Qualifier	"096" – Discharge
165	2300	DTP02	Date Time Period Format Qualifier	"TM" – Hour
166	2300	DTP03	Discharge Hour	Use format HHMM
167	2300	DTP01	Date/Time Qualifier	"434" – Statement
167	2300	DTP02	Date Time Period Format Qualifier	"RD8" – Date Range
168	2300	DTP03	Statement From or To Date	Use format CCYYMMDD– CCYYMMDD
169	2300	DTP01	Date/Time Qualifier	"435" – Admission
169	2300	DTP02	Date Time Period Format Qualifier	"DT" – Date and time
170	2300	DPT03	Admission Date/Hour	Use format CCYYMMDDHHMM
171	2300	CL101	Admission Type Code	Type of admission
172	2300	CL102	Admission Source Code	Source of admission
172	2300	CL103	Patient Status Code	Discharge patient status
178	2300	AMT01	Amount Qualifier Code	"C5" – Claim Amount Due - Estimated
179	2300	AMT02	Estimated Claim Due Amount	Estimated Amount Due
180	2300	AMT01	Amount Qualifier Code	"F3" – Patient Responsibility - Estimated
181	2300	AMT02	Patient Responsibility Amount	Estimated Amount Due
191	2300	REF01	Reference Identification Qualifier	"F8" – Original Reference Number

Page	Loop	Segment	Data Element	Values / Comments
192	2300	REF02	Claim Original Reference Number	When codes “7" or “8" are submitted in Loop 2300 CLM05-3, the TCN assigned to the original claim must be reported. Do not submit hyphens or spaces. Do not submit replacement/void claims until the original TCN processes through a weekend cycle.
198	2300	REF01	Reference Identification Qualifier	“G1" – Pre-admission (10A)
199	2300	REF02	Prior Authorization	Use the 7-digit pre-admission (10A)
208	2300	NTE01	Note Reference Code	“ADD” – Additional Information
209	2300	NTE02	Billing Note Text	Additional claim level notes
228	2300	HI01-2	Principal Diagnosis	Primary diagnosis
228	2300	HI02 -2	Admitting Diagnosis	Admitting diagnosis
233	2300	HI01-2	Other Diagnosis	Additional diagnosis
257	2300	HI01-2	Occurrence Span Codes	“74” – Therapy Leave Days/Leave of Absence
257	2300	HI01-4	Occurrence Span Code Associated Date	Date range for Occurrence Span Code
268	2300	HI01-2	Occurrence Code	“42" – Date of Discharge
268	2300	HI01-4	Occurrence Code Associated Date	Date of Discharge
281	2300	HI01-2	Value Code	“D3” – Family Responsibility/Liability
281	2300	HI01-5	Monetary amount	Amount assigned by Medicaid as family responsibility for covered days. Amount should not exceed submitted charge.
306	2300	QTY	Claim Quantity	Used to report covered and non-covered days.
359	2320	SBR	Other Subscriber Information	If the patient has 3rd party coverage, repeat this loop for each payer. Do not put information about Utah Medicaid coverage/payment in this loop.
367	2320	CAS01	Claim Adjustment Group Code	As reported by other payer If other payer reported claim level patient responsibility, but did not provide a group code, use “PR” to report patient responsibility

Page	Loop	Segment	Data Element	Values / Comments
367	2320	CAS02	Adjustment Reason Code	As reported by other payer. If other payer reported claim level patient responsibility, but did not provide a reason code, use: “1" - deductible amount “2" - coinsurance amount
367	2320	CAS03	Adjustment Amount – Claim Level	As reported by other payer.
371	2320	AMT01	Amount Qualifier Code	“C4” – Prior Payment - Actual
371	2320	AMT02	Payer Paid Amount	As reported by other payer.
372	2320	AMT01	Amount Qualifier Code	“B6” – Allowed - Actual
372	2300	AMT02	Allowed Amount	As reported by other payer.
415	2330B	DTP03	Adjudication or Payment Date	As reported by other payer.
446	2400	SV201	Product/Service ID	Use appropriate 4-digit REV codes, for example: room and board (0120). Must have at least one REV Code.
448	2400	SV204	Unit or basis for measurement	“DA” – days “UN” – units
449	2400	SV205	Quantity	Number of days associated with charges or hospital/therapy leave days.
490	2400	SVD	Service Line Adjudication Information	Use this loop if line level payment was received from another payer.
491	2400	SVD02	Service Line Paid Amount	As reported by other payer.
37A*	2410	LIN02	ID Qualifier	“N4” – NDC
37A*	2410	LIN03	NDC Number	NDC is required on all drugs containing a NDC in addition to the HCPCS/CPT code, effective January 1, 2007. Enter 11 digits. Do not submit hyphens or spaces.
40A*	2410	REF01	Reference Identification Qualifier	“XZ” – Prescription Applicable if dispensing of the drug has been done with an assigned Rx number.
40A*	2410	REF02	Prescription Number	Pharmacy Prescription Number
491	2430	SVD02	Service Line Paid Amount	As reported by other payer.
495	2430	CAS01	Claim Adjustment Group Code	As reported by other payer. If other payer reported line level patient responsibility, but did not provide a group code, use “PR” to report patient responsibility.

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496	2430	CAS02	Adjustment Reason Code	As reported by other payer. If other payer reported line level patient responsibility, but did not provide a reason code, use: “1" - deductible amount “2" - coinsurance amount
496	2430	CAS03	Adjustment Amount – Line Level	As reported by other payer.

*Addenda page number