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. 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 companion guide. 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. Effective January 1, 2007, Medicaid requires the reporting of the National Drug Code (NDC) in addition to the HCPCS/CPT code on all drugs identified by an NDC.

6. Transmit professional 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 may miss the adjudication cycle and will process the following weekend.

7. 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.

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

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

10. Utah Medicaid cannot accept a line with a negative amount (method used by Medicare for adjusting claims — Medicaid uses the void and replace method). A negative amount will generate the 484 error code (Business Application Currently Not Available).

11. EDI processing does not distinguish between the different Medicaid programs supported by Health Care Financing (HCF), e.g., Non-Traditional Medicaid, Primary Care Network, Select Access, Baby Your Baby, etc. Transmit claims for all the Medicaid programs to Medicaid Fee-For-Service (FFS), HT000004-001. Services not covered by Medicare should be billed to Medicaid FFS using the policy and procedures of Medicaid.

12. If transmitting a Medicare/Medicaid claim, submit to Medicare/Medicaid Crossovers, HT000004-005.

13. Please separate Fee-for-Service (FFS) claims to HT000004-001 and Crossover claims to HT000004-005 into separate transmissions. If both are included in one transmission then the last TPN in the transmission will be the ultimate destination of the transmission.

14. 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.

Page	Loop	Segment	Data Element	Values / Comments
65		BHT06	Claim or Encounter Identifier	"CH" - Used for claims with at least one chargeable item.
68	1000A	NM108	Electronic Transmitter Identification Number (ETIN)	"46" – ETIN
69	1000A	NM109	Submitter Identifier	Submitter's TPN
75	1000B	NM103	Receiver Name	"Medicaid FFS" OR "Medicaid Crossover"
75	1000B	NM108	Information Receiver Identification Number	"46" – ETIN
75	1000B	NM109	Receiver Primary Identifier	"HT000004-001" - Medicaid FFS "HT000004-005" - Crossover
80	2000A	PRV02	Reference Identification Qualifier	"ZZ" – Taxonomy Code
80	2000A	PRV03	Reference Identification	Provider Taxonomy Code required if multiple provider types/specialties under same NPI.
85	2010AA	NM101	Entity Identifier Code	"85" – Billing Provider
85	2010AA	NM102	Entity Type Qualifier	1 – Person 2 – Non-Person Entity
86	2010AA	NM108	Identification Code Qualifier	"XX" – NPI
86	2010AA	NM109	Identification Code	NPI
89	2010AA	N403	Billing Provider's Zip Code	Zip Code + 4 required if not using 12-digit provider number in REF02 below. Do not submit hyphens or spaces.
92	2010AA	REF01	Reference Identification Qualifier	"1D" – Medicaid Provider Number Not allowed on or after May 23, 2007, unless provider type is ineligible for NPI.
92	2010AA	REF02	Billing Provider Additional Identifier	Use the 12-digit identifier assigned by Medicaid.
109	2000B	HL04	Hierarchical Child Code	"0" – The subscriber is always the patient, there are no dependents in Medicaid.
112	2000B	SBR09	Claim Filing Indicator Code	"MC" – Medicaid

Page	Loop	Segment	Data Element	Values / Comments
118	2010BA	NM102	Entity Type Qualifier	"1" – Person
118	2010BA	NM103	Subscriber Last Name	Patient's last name. Match the name on the Medicaid Card.
118	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.
119	2010BA	NM108	Identification Code Qualifier	"MI" – Member Identification Number
119	2010BA	NM109	Subscriber Primary Identifier	Use the 10-digit identifier assigned by Medicaid. Do not submit hyphens or spaces.
131	2010BB	NM103	Payer Name	"Medicaid FFS" OR "Medicaid Crossover"
131	2010BB	NM108	Payer Identifier	"PI" – Payer Identification
131	2010BB	NM109	Payer Identifier	"HT000004-001" – Medicaid FFS "HT000004-005" – Crossover
152	2000C	HL	Patient Level	The subscriber is always the patient in Utah Medicaid. Do NOT use this loop.
171	2300	CLM01	Patient Account Number	Provider assigned number unique to this particular claim.
173	2300	CLM05-3	Claim Frequency Type Code	For original submission (or re-submission of <u>denied</u> claims) use value: "1" – Original Medicaid will allow for submission of electronic corrections or voids to a previously <u>paid</u> claim. Acceptable Values: "7" – Replacement "8" – Void The Provider Number must match. To correct a Provider Number, void out the <u>paid</u> claim, then submit an original claim using the correct Provider Number.
176	2300	CLM11	Accident/ Employment Related Causes	Use appropriate code to indicate type of accident.

Page	Loop	Segment	Data Element	Values / Comments
215	2300	PWK01	Attachment Report Type Code	Required if documentation is needed to support the claim. Claim may deny, however once documentation is received the claim is re-processed.
216	2300	PWK02	Report Transmission Code	“BM” – by mail “FX” – by fax “EM” – by e-mail
216	2300	PWK06	Identification Code	Provider assigned number unique to this attachment. Each attachment associated with the claim must display the same unique number and the Provider ID.
228	2300	REF01	Reference Identification Qualifier	“G1" – Prior Authorization Medicaid does not utilize referral numbers.
228	2300	REF02	Prior Authorization	Enter the 7-digit prior authorization number (Do not enter CLIA in this field).
230	2300	REF01	Reference Identification Qualifier	“F8” – Original Reference Number
230	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.
232	2300	REF01	Reference Identification Qualifier	“X4” – CLIA number
232	2300	REF02	CLIA Number	The first CLIA number will be used for processing.
283	2310A	NM101	Entity Identifier Code	“DN” – Referrals must be obtained from the Primary Care Provider listed on the Medicaid card.
284	2310A	NM108	Identification Code Qualifier	“XX” – NPI
284	2310A	NM109	Identification Code	NPI
286	2310A	PRV02	Reference Identification Qualifier	“ZZ” – Taxonomy Code

Page	Loop	Segment	Data Element	Values / Comments
286	2310A	PRV03	Reference Identification	Provider Taxonomy Code required if multiple provider types/specialties under same NPI.
288	2310A	REF01	Reference Identification Qualifier	"1G" – Unique Provider Identification Number (UPIN) Not allowed on or after May 23, 2007.
289	2310A	REF02	Referring Provider Secondary Identifier	Use the UPIN as supplied by the Primary Care Provider.
291	2310B	NM101	Entity Identifier Code	"82" – Rendering provider
291	2310B	NM102	Entity Type Qualifier	"1" – Person
292	2310B	NM108	Identification Code Qualifier	"XX" – NPI
292	2310B	NM109	Identification Code	NPI
294	2310B	PRV02	Reference Identification Qualifier	"ZZ" – Taxonomy Code
294	2310B	PRV03	Reference Identification	Provider Taxonomy Code required if multiple provider types/specialties under same NPI.
296	2310B	REF01	Reference Identification Qualifier	"1D" – Medicaid Provider Number Not allowed on or after May 23, 2007, unless provider type is ineligible for NPI.
297	2310B	REF02	Rendering Provider Secondary Identifier	Use the 12-digit identifier assigned by Medicaid.
318	2320	SBR	Other Subscriber Information	If the patient has Medicare or other coverage, repeat this loop for each payer. Do not put information about Medicaid coverage/payment in this loop.
326	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
326	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
327	2320	CAS03	Adjustment Amount – Claim Level	As reported by other payer.
332	2320	AMT01	Amount Qualifier Code	“D” – Payer Amount Paid
332	2320	AMT02	Payer Paid Amount	As reported by other payer.
334	2320	AMT01	Amount Qualifier Code	“B6” – Allowed - Actual
334	2320	AMT02	Allowed Amount	As reported by other payer.
335	2320	AMT01	Amount Qualifier Code	“F2” – Patient Responsibility - Actual
335	2320	AMT02	Patient Responsibility Amount	As reported by other payer.
367	2330B	DTP03	Adjudication or Payment Date	Report date claim paid by other payer.
368	2330B	REF01	Other Payer Identification Number	“F8” – Original Reference Number
369	2330B	REF02	Other Payer Secondary Identifier	Output the other payer claim number if known.
398	2400	LX	Line Counter	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	“UN” – Report services in units. “MJ” – Report anesthesia in minutes, including 41899 (Dental Anesthesia). 01996 is the only Anesthesia code reported as 1 unit, multiple units not allowed for this code.
472	2400	REF01	Reference Identification Qualifier	“6R” – Provider Control Number

Page	Loop	Segment	Data Element	Values / Comments
472	2400	REF02	Line Item Control Number	Provider assigned number unique to this line.
488	2400	NTE01	Note Reference Code	"ADD" – Additional Information
488	2400	NTE02	Line Note Text	Provide description of service rendered when utilizing a not otherwise classified procedure code, e.g., J7599, etc.
70A*	2410	LIN02	Identification Qualifier	"N4" – NDC
70A*	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.
72A*	2410	CPT03	Unit Price	Drug Unit Price
72A*	2410	CPT04	Quantity	National Drug Unit Count
72A*	2410	CPT05	Unit or Basis of Measurement	"GR" – Gram "ME" – Milligram "ML" – Milliliter "UN" – Unit
73A*	2410	REF01	Reference Identification Qualifier	"XZ" – Prescription Applicable if dispensing of the drug has been done with an assigned Rx number.
74A*	2410	REF02	Prescription Number	Pharmacy Prescription Number
554	2430	SVD	Line Adjudication Information	Use this loop if line level payment was received from another payer.
555	2430	SVD02	Service Line Paid Amount	As reported by other payer.
560	2430	CAS01	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.
560	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

Page	Loop	Segment	Data Element	Values / Comments
560	2430	CAS03	Adjustment Amount – Line level	As reported by other payer.

* Addenda page numbers