Utah Specific Transaction Instructions

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

The Health Insurance Portability and Accountability Act (HIPAA) require all health insurance payers in the United States to 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 is the standard of compliance -- available at www.wpc-edi.com. The following supplemental information is specific to Utah Medicaid and serves as a companion guide to the implementation guide. Utah Medicaid Provider Manuals are available at http://www.health.utah.gov/medicaid/manuals/directory.php?p=Medicaid%20Provider%20Manuals/.

Electronic Claims:

1. Telephone number for Medicaid EDI customer support (OS&D) is 801-538-6155 or 800-662-9651 menu 3, menu 5, menu 2. Hours of operation are Monday through Wednesday (7 am to 6 pm) and Thursday (11 am to 6 pm). Telephones are down between 12 noon and 1 pm.

2. AccessNow, telephone automated system for member eligibility, is available from 6 am to 12 midnight Monday through Saturday and 12 noon to 12 midnight on Sundays.

3. Medicaid companion guides are available at https://health.utah.gov/hipaa/guides.htm.

4. All EDI must pass through the Utah Health Information Network (UHIN), an independent, not-for-profit, value added network serving all payers in Utah. Contact UHIN at www.uhin.org or call 801-466-7705 x200. UHIN will assign a Trading Partner Number (TPN) for EDI.

5. Use your TPN and your National Provider Identifier (NPI)** to complete the online EDI Enrollment Form at https://mmcs.health.utah.gov/hcfenroll2/index.jsp. The TPN in the 835 field of the EDI Enrollment will receive the 835 electronic remittance advice.

6. “Atypical” providers are providers who bill for non-medical services, e.g. medical alert systems, meals on wheels. Providers who have been setup by the Medicaid Provider Enrollment team as atypical must bill with their Medicaid 12-digit Contract number. Atypical providers must submit their EDI transmissions to and receive their EDI transmissions from the Trading Partner Number (TPN) of HT000004-801.

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7. The NPI and Tax ID (or SSN) must match to a single Medicaid contract. If a provider affiliates their NPI to more than one Medicaid Contract, a unique Taxonomy Code or unique address must be affiliated to their Contract. Update contract information with the Medicaid Provider Enrollment team at 801-538-6155 or 800-662-9651, menu 3, menu 4, or fax to 801-536-0471.

8. Providers, billers, and clearinghouses must separate batches by receiving TPN (HT000004-001, HT000004-005 and HT000004-801). If submitted as one batch, claims will be applied to the first receiver TPN on the submission.

9. Medicaid requires the reporting of the National Drug Code (NDC) in addition to the HCPCS/CPT code on provider administered drugs. The drug list requiring NDC is available at http://health.utah.gov/medicaid/pdfs/NDC_required4-08.pdf .

10. Transmit claims anytime 24 hours a day, 7 days a week. Medicaid's cut-off for claims acceptance is before the end of business on Thursday. Transactions received after the end of business on Thursday may miss the adjudication cycle and will process the following weekend.

11. A 997 Functional Acknowledgment will be available for pickup (download) within two hours of transmission for all 837 transactions. If you find no 997, contact OS&D.

12. A 277FE Health Care Claim Status Notification - Front End Acknowledgment will usually be available for pickup (download) the next business day after the transmission of the 837. If you find no 277FE, contact OS&D. This transmission assigns a 17-digit Transaction Control Number (TCN) to any claim that is accepted into the Medicaid Management Information System (MMIS). The lack of a TCN indicates a claim was rejected. Use the Claim Status Codes http://www.wpc-edi.com/content/view/715/1 to determine why the claim was rejected. Make corrections and resubmit.

13. Medicaid Customer Service agents are **unable** 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 transaction for claim status.

14. Utah Medicaid cannot accept a line with a negative submitted charge (method used by Medicare for adjusting claims). A negative amount will generate the 484 error code (Business Application Currently Not Available). For adjustments, Medicaid requests submission of a void or replace claim (see instructions below).

15. Transmit claims for all Medicaid programs (Non-Traditional Medicaid, Primary Care

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Network, Select Access, Baby Your Baby, etc.) to Medicaid Fee-For-Service (FFS), HT000004-001 or Medicare/Medicaid Crossover claims to HT000004-005. Atypical providers must use HT000004-801 for all transactions. Services not covered by Medicare should be billed to Medicaid FFS using the policy and procedures of Medicaid.

16. Units must be reported in full units. Utah Health Care Financing's policy is to round to the nearest unit. No decimals will be accepted.

17. Providers should submit their own corrections by submitting either a replacement or void claim. If the original claim was denied, submit claim as an original claim. Medicaid will allow for submission of electronic corrections or voids to a previously paid claim. Acceptable Values: "7" – Replacement "8" – Void. The TCN of the claim to be replaced or voided must be reported. Do not submit hyphens or spaces.
The following is information about replacement/void claims:
    - The provider number on the original claim must match the provider number being submitted on the replacement claim, or the claim will reject.
    - If the TCN of the original claim cannot be identified in the Medicaid system, or the claim has already been reprocessed, the replacement/void claim will be rejected.
    - Replacement claim(s) void the original claim. The replacement claim is then processed in the Medicaid system as an original claim.
    - If there is a line item that did not pay on the original claim, it is not necessary to submit a replacement claim. You may submit a new claim for only the services not paid on the original claim. However, if additional units are being added to an already paid procedure code, or you are changing procedure codes, a replacement claim must be submitted.
    - If wanting to replace an original claim that was split by Medicaid for processing, it is necessary to submit a void claim for each of the split claims. A new original claim would then be submitted for processing.
    - If a claim was paid under the wrong provider number, submit a void claim with the provider number of the original claim and a new original claim with the correct provider number.
    - If the original claim was denied, do not submit a replacement claim. Make the necessary correction(s) and resubmit the claim as an original claim.

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" – Electronic Transmitter Identification Number (ETIN)

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69	1000A	NM109	Submitter Identifier	Submitter's TPN
75	1000B	NM103	Receiver Name	"Medicaid"
75	1000B	NM108	Information Receiver Identification Number	"46" – ETIN
75	1000B	NM109	Receiver Primary Identifier	"HT000004-001" – Medicaid FFS "HT000004-005" – Crossover "HT000004-801" – Medicaid atypical
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. Not used when Billing Provider is a group and taxonomy is coded for Rendering Provider in loop 2310B.
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* "24" – Tax ID (For atypical only)
86	2010AA	NM109	Identification Code	NPI* Tax ID (For atypical only)
88	2010AA	N301	Billing Provider Address Line	Address that coordinates with Medicaid Contract Service Location
89	2010AA	N401	Billing Provider City Name	City that coordinates with Medicaid Contract Service Location
90	2010AA	N402	Billing Provider State	State that coordinates with Medicaid Contract Service Location
90	2010AA	N403	Billing Provider's Zip Code	Zip Code+4 Do not submit hyphens or spaces.
92	2010AA	REF01	Reference Identification Qualifier	"1D" – Medicaid Contract Number "EI" – Tax ID

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92	2010AA	REF02	Billing Provider Additional Identifier	Use the 12-digit identifier assigned by Medicaid. (atypical only) Tax ID (non atypical)
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
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.
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 "HT000004-801" – Medicaid atypical
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.

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173	2300	CLM05-3	Claim Frequency Type 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 TCN assigned to the claim voiding or replacing must be reported in REF02.
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. Claim may deny, however once documentation is received the claim will be reprocessed. Write number reported in 2300 PWK06 (Identification Code) or TCN of accepted claim as reported in the 277FE on documentation before sending to Medicaid.
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 use referral numbers.
228	2300	REF02	Prior Authorization	Use the 7-digit prior authorization number (Do not enter CLIA in this field).
230	2300	REF01	Reference Identification Qualifier	"F8" – Original Reference Number

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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
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 required if multiple provider types/specialties under same NPI.
294	2310B	PRV03	Reference Identification	Provider Taxonomy Code
296	2310B	REF01	Reference Identification Qualifier	"24" – Tax ID
297	2310B	REF02	Rendering Provider Secondary Identifier	Tax ID
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.

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326	2320	CAS01	Claim Adjustment Group Code	As reported by other payer. Report Patient Responsibility in Loop 2320 AMT Segment.
326	2320	CAS02	Adjustment Reason Code	As reported by other payer.
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

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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. Do not enter NDC information in this field.
72[A]	2410	LIN02	Identification Qualifier	"N4" – NDC
72[A]	2410	LIN03	NDC Number	NDC is required on physician administered drugs in addition to the HCPCS/CPT code. Enter 11 digits (5-4-2). Zero fill if not 5-4-2 format (example: 186-868-44 report as 00186086844) in first field if Do not submit hyphens or spaces.
74[A]	2410	CTP03	Unit Price	Drug Unit Price
74[A]	2410	CTP04	Quantity	National Drug Unit Count Numeric value of Quantity
74[A]	2410	CTP05	Unit or Basis of Measurement	"GR" – Gram "F2" – International Unit "ME" – Milligram "UN" – Unit
75[A]	2410	REF01	Reference Identification Qualifier	"XZ" – Prescription Applicable if dispensing of the drug has been done with an assigned Rx number.
76[A]	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.

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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
560	2430	CAS03	Adjustment Amount – Line level	As reported by other payer.

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