

Utah Specific Transaction Instructions ENCOUNTER RECORD

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. For encounter records, 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.

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 encounter records. 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 encounter records may be sent anytime 24 hours a day, 7 days a week.

Page	Loop	Segment	Element No.	Data Element	Values / Comments
HEADER					
65		BHT06	640	Claim or Encounter Identifier	"RP"
SUBMITTER					
69	1000A	NM109	67	Submitter Primary Identification Number	Electronic Address – Trading Partner Number (TPN)
RECEIVER					
75	1000B	NM103	1035	Receiver Name	"Utah Medicaid – MCO"
75	1000B	NM109	67	Receiver Primary Identifier	"HT000004-002"
BILLING PROVIDER					
85	2010AA	NM101	98	Entity Identifier	85 – Billing Provider
85	2010AA	NM102	1065	Entity Type Qualifier	1- Person 2- Non Person
85	2010AA	NM103	1035	Billing Prov Last Name	This would be the info of the provider rendering service. PMHP – if person rendering the service is on staff, this should be the PMHP info. To report who the rendering staff member is, use the 2310B loop with the identifier code of 82 (see page 290 of the implementation guide) in addition to the 2010AA. HMO – if the billing provider is a clinic, the rendering provider number needs to be supplied in the 2310 B loop (REF01 = '1D', REF02 = Medicaid ID) see pg. 296 of guide

Page	Loop	Segment	Element No.	Data Element	Values / Comments
85	2010AA	NM104	1036	Billing Prov First Name	
85	2010AA	NM105	1037	Billing Prov Middle Name	
86	2010AA	NM108	66	ID Code Qualifier	24- EIN 34 SSN
86	2010AA	NM109	67	ID Code	
92	2010AA	REF01	128	Reference ID Qualifier	"1D" – Medicaid Provider Number
92	2010AA	REF02	127	Billing Provider Secondary ID Number	Medicaid assigned number for the billing provider.
PATIENT INFORMATION					
118	2010BA	NM102	1065	Entity Type Qualifier	"1"
118	2010BA	NM103	1035	Subscriber Last Name	
118	2010BA	NM104	1036	Subscriber First Name	
118	2010BA	NM105	1037	Subscriber Middle Name	
119	2010BA	NM108	66	Identification Code Qualifier	"MI"
119	2010BA	NM109	67	Subscriber Primary Identifier	Use the 10 digit identifier assigned by Utah Medicaid. Do not submit hyphens or spaces.
125	2010BA	DMG02	1251	Subscriber Birth Date	
125	2010BA	DMG03	1068	Subscriber Gender Code	Valid codes are F, M, U
131	2010BB	NM108	66	Payer ID Type	USE 'PI'

Page	Loop	Segment	Element No.	Data Element	Values / Comments
131	2010BB	NM109	67	Payer ID	MCO State Assigned Medicaid ID
CLAIM INFORMATION					
171	2300	CLM01	1028	Patient Account Number	
172	2300	CLM02	782	Total Claim Charge Amount	Usual and customary amount charged by provider for service.
172	2300	CLM05-1	1331	Place of Service	
173	2300	CLM05-3	1325	Claim Submission Reason Code	1 – Original 7 – Replacement 8 – Void
175	2300	CLM09	1363	Release of info from client	
217	2300	CN1	1166	Contract Information	Use '05' when the plan has a capitated arrangement with the billing provider
247	2300	NTE01	363	Claim Note	Use 'Add' for all reasons
247	2300	NTE02	352	Claim Note Information (for entire claim)	<p>Claim Entry Date (date claim entered MCO system) -- Start with 'E' and enter date in format CCYYMMDD</p> <p>Claim Paid/Adjudicated Date – Start with 'A' and enter date in format CCYYMMDD</p> <p>SPMI/SED Status – Start with 'S' and enter 'Y' or 'N' (PMHP only, SPMI is adults, SED is child)</p> <p>Payment Amount – Start with 'P' and enter amount. Use explicit decimal.</p> <p>Denial Reason – Start with 'D' and enter denial reason</p>

Page	Loop	Segment	Element No.	Data Element	Values / Comments
222	2300	REF02	127	Claim Original Reference Number	Original Transaction Control Number (TCN) if correcting, replacing or voiding a record.
265	2300	HI01-2	1271	Principal Diagnosis	
266	2300	HI02-2 thru HI08-2	1271	Other Diagnoses	
296	2310B	REF01	128	Reference Identification	1D
297	2310B	REF02	127	ID	Only use if REF01 is used. This will be used when the billing provider is a clinic to identify the rendering provider.
COORDINATION OF BENEFITS INFORMATION - Repeat loop for each payer.					
This segment is only required If there is TPL and the TPL Primary payer is Medicare.					
326	2320	CAS01	1033	Patient Responsibility	If SBR05 and SBR01 indicates Medicare, use PR to indicate the patient responsibility
326	2320	CAS02	1034	Reason Code	1 – Deductible 2 - Coinsurance
327	2320	CAS03	782	Monetary Amount	Amount client is responsible to pay after Medicare
This segment is not required as the MCO Paid amount is in the note segment on the claim level above.					
326	2320	CAS01	1033	MCO Paid Amount	Use CO – Contractual Obligation
326	2320	CAS02	1034	Reason Code	Use 42
327	2320	CAS03	782	Monetary Amount	Amount MCO paid for this claim
320	2320	SBR01	1138	Payer Responsibility Sequence Number Code	P - Primary payer S – Secondary Payer T – Tertiary Payer If Medicare is Primary put P in SBR01 and MP or MB in SBR05.

Page	Loop	Segment	Element No.	Data Element	Values / Comments
321	2320	SBR05	1336	Insurance Type Code	Use 'MP' if Medicare is primary
332	2320	AMT01	522	Amount Qualifier Code	Use 'D' to indicate Payor Amount Paid and put COB amount in AMT02.
332	2320	AMT02	782	COB Payer Paid Amount	Amount paid by other payer for service.
334	2320	AMT01	522	Amount Qualifier Code	Use 'B6' to indicate Allowed Amount in AMT02.
334	2320	AMT02	782	Allowed Amount	Amount allowed for service by other payer (if available).
LINE INFORMATION (MAX 6 LINES PER CLAIM)					
400	2400	SV101	C003	Product or Service Code and Modifiers	HCPCS codes and modifiers for service rendered.
402	2400	SV102	782	Line Item Charge Amount	Usual and customary amount charged by provider for service.
403	2400	SV103	355	Units or Basis for Measurement Code	F2 – International Unit MJ – Minutes (for anesthesia only) UN – Unit
403	2400	SV104	380	Service Unit Count	
405	2400	SV107-1 (through 5)	1328	Diagnosis Code Pointer	1-4
406	2400	SV111	1073	EPSDT Indicator	Y/N
406	2400	SV112	1073	Family Planning Indicator	Y/N
436	2400	DTP02	1250	Date Time Period Format – Date of Service	If single date "D8", if range "RD8" in CCYYMMDD format
436	2400	DTP03	1251	Service Date	
485	2400	AMT01	522	Approved/Allowed Amount	Use AAE

Page	Loop	Segment	Element No.	Data Element	Values / Comments
485	2400	AMT02	782	Dollar Amount	Enter the Approved or Allowed amount. On the PMHPS if this field is blank the usual and customary charges (SV102) will be loaded here.
488	2400	NTE01	363	Line Note	Use 'Add' for all reasons
488	2400	NTE02	352	Line Note Information	Payment Amount – Start with 'P' and enter amount Denial Reason – Start with 'D' and enter denial reason

LINE TPL INFORMATION(COB) -- This is needed to send through the Pricing system, if it is not sent in the TPL total amount is sent in at claim level and if there are more than 6 lines the TPL may affect amount that prices.

555	2430	SVD01	67	ID Code	Use MCO Payer ID
555	2430	SVD02	782	TPL Amount	TPL Amount for this Line
560	2430	CAS01	1033	MCO Paid Amount	Use CO – Contractual Obligation
560	2430	CAS02	1034	Reason Code	Use 42
560	2430	CAS03	782	Monetary Amount	Amount MCO paid for this line.

ERRORS THAT WILL RETURN ON THE 277

Professional HMO Edits					
Status Category Code	Status Code	Status Entity Code	Reject Encounter	MMCS Status Description	WPC -EDI Status Description(Standard)
A6	26	1E	Y	Recipient ID missing (not submitted on encounter)	Entity not found.
A7	26	1E	Y	Recipient ID not on file	Entity not found.
A4	35	1E	Y	No match found on history for replacement	Claim/encounter not found.
A4	35	1E	Y	No match found on history for replacement	Claim/encounter not found.
A4	35	1E	Y	No match found on history for void	Claim/encounter not found.
A6	35	1E	Y	Previous TCN not present for replacement/void code	Claim/encounter not found.
A3	54	1E	Y	Possible duplicate encounter.	Duplicate of a previously processed claim/line.

Professional HMO Edits					
Status Category Code	Status Code	Status Entity Code	Reject Encounter	MMCS Status Description	WPC -EDI Status Description(Standard)
A2	86	1E	N	Diagnosis to sex mismatch	Diagnosis and patient gender mismatch.
A3	88	1E	Y	Recipient ineligible during service period	Entity not eligible for benefits for submitted dates of service.
A3	97	1E	Y	Recipient enrolled with another plan during service Period	Patient eligibility not found with entity.
A3	97	1E	Y	Recipient enrollment not reflected on system	Patient eligibility not found with entity.
A7	122	1E	Y	Invalid Claim frequency code	Missing/invalid data prevents payer from processing claim.
A6	122	1E	Y	Missing claim frequency code	Missing/invalid data prevents payer from processing claim.
A6	122	1E	Y	Replacement/void code not present for previous TCN	Missing/invalid data prevents payer from processing claim.
A3	122	1E	Y	TCN has already been replaced	Missing/invalid data prevents payer from processing claim.
A3	122	1E	Y	TCN has already been voided	Missing/invalid data prevents payer from processing claim.
A7	125	1E	Y	Recipient name does not match file name	Entity's name.
A6	125	1E	Y	Recipient name missing	Entity's name.
A2	126	1E	N	Zip code is invalid	Entity's address.
A2	126	1E	N	Zip code is missing	Entity's address.
A6	153	1E	Y	Rendering Provider ID missing	Entity's id number.
A1	153	1E	N	Invalid/Missing State Assigned Medicaid ID	Entity's id number
A7	158	1E	Y	Month and year does not match file month and year	Entity's date of birth
A6	158	1E	Y	Recipient DOB missing	Entity's date of birth
A6	178	1E	Y	Charges missing	Submitted charges.
A6	178	1E	Y	Total Charges missing	Submitted charges.
A6	183	1E	Y	Other payer amount missing	Amount entity has paid.
A6	183	1E	Y	Plan Paid Amount missing	Amount entity has paid.
A3	187	1E	Y	From date after submit date	Date(s) of service.
A6	187	1E	Y	From date of service missing	Date(s) of service.
A3	188	1E	Y	Encounter is greater than 12 months FROM_DOS	Statement from-through dates.
A3	188	1E	N	From-through service dates cannot span more than one month	Statement from-through dates.
A7	188	1E	Y	Service through date after submit date	Statement from-through dates.
A7	188	1E	Y	Service through date prior to service from date	Statement from-through dates.
A3	247	1E	Y	Must contain at least one service line	Line information.
A7	249	1E	Y	Place of service invalid	Place of service.

Professional HMO Edits					
Status Category Code	Status Code	Status Entity Code	Reject Encounter	MMCS Status Description	WPC -EDI Status Description(Standard)
A6	249	1E	Y	Place of service missing	Place of service.
A7	254	1E	Y	Primary Diagnosis code Invalid	Primary diagnosis code.
A6	254	1E	Y	Primary Diagnosis code Missing	Primary diagnosis code.
A7	255	1E	Y	Diagnosis code not on file	Diagnosis code.
A7	453	1E	Y	Modifier invalid	Procedure Code Modifier(s) for Service(s) Rendered
A7	453	1E	Y	Modifier invalid for procedure code	Procedure Code Modifier(s) for Service(s) Rendered
A7	454	1E	Y	Procedure code invalid	Procedure code for services rendered.
A6	454	1E	Y	Procedure code missing	Procedure code for services rendered.
A2	474	1E	N	Procedure to sex mismatch	Procedure code and patient gender mismatch
A7	476	1E	N	Max units exceeded	Missing or invalid units of service
A6	476	1E	Y	Units missing	Missing or invalid units of service
A6	477	1E	Y	Diagnosis code x-ref missing	Diagnosis code pointer is missing or invalid
A7	477	1E	Y	Diagnosis code x-ref Invalid	Diagnosis code pointer is missing or invalid
A2	478	1E	N	Patient account number is missing	Claim submitter's identifier (patient account number) is missing

Professional PMHP Edits					
Status Category Code	Status Code	Status Entity Code	Reject Encounter	MMCS Status Description	WPC -EDI Status Description(Standard)
A6	21	1E	N	Missing SPMI indicator	
A6	26	1E	Y	Recipient ID missing (not submitted on encounter)	Entity not found.
A7	26	1E	Y	Recipient ID not on file	Entity not found.
A4	35	1E	Y	No match found on history for replacement	Claim/encounter not found.
A4	35	1E	Y	No match found on history for replacement	Claim/encounter not found.
A4	35	1E	Y	No match found on history for void	Claim/encounter not found.
A6	35	1E	Y	Previous TCN not present for replacement/void code	Claim/encounter not found.
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A4	35	1E	Y	No match found on history for void	Claim/encounter not found.
A6	35	1E	Y	Previous TCN not present for replacement/void code	Claim/encounter not found.
					mismatch.
A3	88	1E	Y	Recipient ineligible during service period	Entity not eligible for benefits for submitted dates of service.
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A7	188	1E	Y	Service through date after submit date	Statement from-through dates.
A7	188	1E	Y	Service through date prior to service from date	Statement from-through dates.
A6	188	1E	N	MCO's Paid Date Missing	
A6	188	1E	N	MCO's Entry Date Missing	
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A6	35	1E	Y	Previous TCN not present for replacement/void code	Claim/encounter not found.
A6	477	1E	Y	Diagnosis code x-ref missing	Diagnosis code pointer is missing or invalid
A7	477	1E	Y	Diagnosis code x-ref Invalid	Diagnosis code pointer is missing or invalid
A2	478	1E	N	Patient account number is missing	Claim submitter's identifier (patient account number) is missing