CMS Manual System

Pub. 100-20 One-Time Notification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 29 | **Date: DECEMBER 19, 2003**

CHANGE REQUEST 2900

I. SUMMARY OF CHANGES: The current companion document language is being revised to address corrections, as well as provide additional language to cover items not addressed in the current companion document. The summary of changes to the document are shown below:

- Removal of the REQUIRED statement "Currency code (CUR02) must equal USA". The CUR segment is situational and is only to be used when financial amounts submitted on the claim are for services provided in a currency that is not normally used by the receiver. The situation does not apply to Medicare;

- Revision to the statement "The only valid values for CLM05-3 (Claim Frequency Type Code) are '1' (ORIGINAL) and '7' (REPLACEMENT). Claims with a value of '7' will be processed as original claims and ***[will/may]*** result in duplicate claim rejection. The claims processing system does not process electronic replacements" to allow only 1 (ORIGINAL);

- Revision to the statement "Purchased diagnostic tests (PDT) amounts should be submitted at the detail line level (Loop 2400), not at the header claim level (Loop 2300). PDT amounts submitted at the header claim level (Loop 2300) ***[will/may]*** be ignored" which provides clarification that the PS1 segment is required at the 2400 loop for all purchased services;

- Revision to the statement "Claims that contain percentage amounts submitted with more than two positions to the left or the right of the decimal ***[will/may]*** be rejected." The language is being revised to be clear that percent values with less than two positions can be accepted;

- Addition of a new statement indicating that taxonomy codes are not required for Medicare;

- Addition of a new statement indicating that "D" (Pilot) in the REF02 is not a valid value for Medicare;

- Addition of three new statements related to the ISA;

- Addition of two new statements that provide clarification of the maximum value for the three service unit's qualifiers (UN units, MJ anesthesia minutes, and F2 international units);

- Addition of a new statement indicating that Medicare will only process anesthesia claims submitted with minutes.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 20, 2004
***IMPLEMENTATION DATE: January 20, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS:

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

*III. FUNDING:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

One-Time Notification

Pub. 100-20	Transmittal: 29	Date: December 19, 2003	Change Request 2900

SUBJECT: Revised American National Standards Institute X12N 837 Professional Health Care Claim Companion Document

I. GENERAL INFORMATION

A. Background: A revised 837 Professional companion document is provided due to errors and omissions in the previous companion document as well as changes in the implementation guide since publication of Change Request 1809.

A companion document is defined as a set of statements, which supplements the X12N 837 Professional Implementation Guide and clarifies the contractor expectations regarding data submission, processing, and adjudication. The specific language, which is provided in this companion document, is based on recommendations/decisions made by the Electronic Data Interchange Functional Workgroup (EDIFWG). The EDIFWG consists of members from CMS, Part B contractors, and shared system maintainers. You have the option to add specific items not contained in this companion document. However, these items must not contradict any other items in the companion document or X12N 837 Professional implementation guide.

The descriptions provided below indicates whether the statement usage is:

(R) Required-You must include this language in your companion document.
(O) Optional-You can choose to include this language in your companion document, if applicable.
(R/O) Selection required-You must choose one statement from the list of the statements provided. The choices will be labeled either (#a) or (#b) to identify the options for each statement. You should select the language that is applicable to your business situation.

B. Policy: N/A

C. Provider Education: Carriers and DMERCs shall inform affected providers by posting either a summary or relevant portions of this document on their Web site within 30 days. Also, carriers and DMERCs shall publish this same information in their next regularly scheduled bulletin. If they have a listserv that targets affected providers, they shall use it to notify subscribers that information about the **Revised American National Standards Institute X12N 837 Professional Health Care Claim Companion Document** is available on their Web site.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
	Publish the revised companion guide and required language in your contractor newsletter, on your contractor Web site, or post to your contractor list serve.	Carrier and DMERCs
	You are to include the following language in your X12N 837 companion document: "The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions. The implementation guides for each transaction are available electronically from the following Web site http://www.wpc-edi.com. The following information is intended to serve only as a companion document to the HIPAA X12N 837 implementation guides. The use of this document is solely for the purpose of clarification. The information describes specific requirements to be used for processing data in the [***Contractor system name***] system of [***Contractor name***] Contractor number [***contractor number***]. The information in this document is subject to change. Changes will be communicated in the standard [***Contractor newsletter name***] monthly news bulletin and on [***Contractor name***] Web site: [***Contractor URL***]. This companion document supplements, but does not contradict any requirements in the X12N 837 Professional implementation guide. Additional companion documents/trading partner agreements will be developed for use	Carrier and DMERCs

	with other HIPAA standards, as they become available".	
	For those statements that include the choice between option A or B, you must select the one option that meets your business needs and publish it in your finalized companion document.	Carriers and DMERCs
	For those statements that include the choice between [***will/may***], you must select either "will" or "may", depending on your business situation, in your finalized companion document.	Carriers and DMERCs

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
	The X12N 837 Professional companion document contains an optional statement regarding the PWK segment. The statement reads "Any data submitted in the PWK (Paperwork) segment [will/may] not be considered for processing". CMS has recently begun the preliminary analysis necessary to implement the PWK segment. Those contractors that have incorporated this statement into their companion documents will be required to remove that statement when the PWK segment processing is implemented.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 20, 2004 **Implementation Date: January 20, 2004** **Pre-Implementation Contact(s): Brian Reitz, 410-786-5001, breitz@cms.hhs.gov** **Post-Implementation Contact(s): Brian Reitz, 410-786-5001, breitz@cms.hhs.gov**	**These instructions should be implemented within your current operating budget.**

Attachment

Description				Language	Page
General Statements					
			R	The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 [will/may] be rejected	
			R	Claims that contain percentage amounts with values in excess of 99.99 [will/may] be rejected	
			R	Claims that contain percentage amounts cannot exceed two positions to the left or the right of the decimal. In certain circumstances, the percent can be less than two positions to the left or the right. Percent amounts that exceed their COBOL PIC clause will be rejected	
			R	[Contractor name] will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case	
			R	Only loops, segments, and data elements valid for the HIPAA Professional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected	
			O	The incoming 837 transactions utilize delimiters from the following list: >, *, ~, ^, |, and :. Submitting delimiters not supported within this list [will/may] cause an interchange (transmission) to be rejected	
			R	You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set [will/may] cause the interchange (transmission) to be rejected at the carrier translator	
			R	Medicare does not require taxonomy codes be submitted in order to adjudicate claims, but will accept the taxonomy code, if submitted. However, taxonomy codes that are submitted must be valid against the taxonomy code set published at www.wpc-edi.com/codes. Claims submitted with invalid taxonomy codes will be rejected	
			R	All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission)	
			O	[Contractor name] [will/may] reject an interchange (transmission) submitted with more than 9,999 loops	
			O	[Contractor name] will reject an interchange (transmission) submitted with more than 9,999 segments per loop	
			R/O	A. [Contractor name] will reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction -OR- B. [Contractor name] will reject an interchange (transmission) with more than [contractor supplies value] CLM segments (claims) submitted per transaction	

Description				Language	Page
			R/O	A. Compression of files is not supported for transmissions between the submitter and [Contractor name] -OR- B. Compression of files using [name of software] is supported for transmissions between the submitter and [Contractor name]	
			R/O	A. Only valid qualifiers for Medicare should be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing not defined for use in Medicare billing [will/may] cause the claim or the transaction to be rejected -OR- B. Only valid qualifiers for Medicare should be submitted for Medicare processing on incoming 837 claim transactions. Any qualifiers submitted not defined for use in Medicare billing [will/may] cause the claim to be rejected	
			R/O	A. You may send up to four modifiers; however, the last two modifiers [will/may] not be considered. The [Contractor name] processing system [will/may] only use the first two modifiers for adjudication and payment determination of claims. -OR- B. You may send up to four modifiers; however, the last two modifiers [will/may] not be considered. The [Contractor name] processing system [will/may] only use the first two modifiers for adjudication and payment determination of claims	
			O	[Contractor name] will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Professional Implementation Guides	
Interchange Control Header					
	ISA05	Interchange ID Qualifier	O	[Contractor name] will reject an interchange (transmission) that does not contain [qualifier] in ISA05	B.4
	ISA06	Interchange Sender ID	R	[Contractor name] will reject an interchange (transmission) that does not contain a valid ID in ISA06	B.4
	ISA07	Interchange ID Qualifier	O	[Contractor name] will reject an interchange (transmission) that does not contain [qualifier] in ISA07	B.4
	ISA08	Interchange Receiver ID	R	[Contractor name] will reject an interchange (transmission) that does not contain [carrier code]. Each individual Contractor determines this code	B.5
Functional Group Header					
			O	[Contractor name] will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange)	
			O	[Contractor name] will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group)	

Description				Language	Page
	GS03		O	[Contractor name] [will/may] reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the carrier definition	B.8
Loop	**Transaction Set**				
			O	[Contractor name] will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) [will/may] cause the transaction to be rejected	
	ST02	Transaction Control Set	O	[Contractor name] will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements	62
	BHT02	Transaction Set Purpose Code	O	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL)	64
	BHT06	Claim/Encounter Identifier	O	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE)	65
	REF02	Transmission Type Identification	O	The 837 Professional claim transaction will not be piloted. Claim files submitted with a Transmission Type Code value of 004010X098DA1 in REF02 [will/may] cause the file to be rejected	66
1000A	NM109	Submitter ID	R	[Contractor name] will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission	69
1000B	NM103	Receiver Name	O	[Contractor name] [will/may] reject an interchange (transmission) that is not submitted with a valid carrier name.(NM1)	75
1000B	NM109	Receiver Primary Identifier	O	[Contractor name] [will/may] reject an interchange (transmission) that is not submitted with a valid carrier code.(NM1) Each individual Contractor determines this code	75
2000B	HL	Subscriber Hierarchical Level	O	The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric	108
2000B	SBR02, SBR09	Subscriber Information	R	For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used	111
2010BD		Credit/Debit Card Information	R	Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop)	150
Loop	**Claim Information**				
2300	CLM02	Total Submitted Charges	R	Negative values submitted in CLM02 [will/may] not be processed and [will/may] result in the claim being rejected	172
2300	CLM02	Total Submitted Charges	R	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102)	172
2300	CLM05-3	Claim Frequency Type Code	R	The only valid value for CLM05-3 is '1' (ORIGINAL). Claims with a value other than "1" [will/may] be rejected	173
2300	CLM20	Delay Reason Code	R	Data submitted in CLM20 will not be used for processing	179
2300	PWK	Claim Supplemental Information	O	Any data submitted in the PWK (Paperwork) segment [will/may] not be considered for processing	214

Description				Language	Page
2300	AMT01	Credit/Debit Card Maximum Amount	R	Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop)	219
2300	AMT02	Patient Amount Paid	R	Negative values submitted in the following fields [will/may] not be processed and [will/may] result in the claim being rejected: AMT02	220
2300	AMT02	Total Purchased Service Amount	R	Negative values submitted in the following fields [will/may] not be processed and [will/may] result in the claim being rejected: AMT02	221
2300	REF02	Prior Authorization and Referral Number	O	Peer Review Organization (PRO) information should be submitted at the header claim level (Loop 2300). PRO information submitted at the detail line level (Loop 2400) will be ignored	227
2300	CR102, CR106	Ambulance Transport Information	R	Negative values submitted in the following fields [will/may] not be processed and [will/may] result in the claim being rejected: CR102, CR106	249,250
2300	HI	Health Care Diagnosis Code	R	Diagnosis codes have a maximum size of five (5). Medicare does not accept decimal points in diagnosis codes	265
2300	HI	Health Care Diagnosis Code	R/O	A. You may send up to eight diagnosis codes per claim. If diagnosis codes are submitted, you must point to the primary diagnosis for each service line. -OR- B. You may send up to eight diagnosis codes per claim; however, the last four diagnosis codes [will/may] not be considered in processing	265
2320	AMT02	Coordination of Benefits Amounts	R	Negative values submitted in the following fields [will/may] not be processed and [will/may] result in the claim being rejected: AMT02	332 333
2400	SV104	Professional Service	O	The max value for anesthesia units (qualifier MJ) cannot exceed 4 bytes numeric. Claims for anesthesia services that exceed this value will be rejected. (SV104)	400
2400	SV104	Professional Service	R (for Carriers)	Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes [will/may] be rejected. (SV104)	403
2400	SV104	Professional Service	O	The max value for units (qualifier UN) cannot exceed three bytes numeric with one decimal place. Claims for medical services that exceed this value will be rejected. (SV104)	403
2400	SV104	Professional Service	R	SV104 (Service unit counts) (units or minutes) cannot exceed 999.9	403
2400	SV104	Professional Service	R	Negative values submitted [will/may] not be processed and [will/may] result in the claim being rejected. (SV104)	403
2400	PS1	Purchased Service	O	Purchased diagnostic tests (PDT) require that the purchased amounts be submitted at the detail line level (Loop 2400). Claims for PDT services that are submitted without the PS1 segment data at the 2400 loop [will/may] be rejected	489
2400	PS102	Purchased Service	R	Negative values submitted in PS102 [will/may] not be processed and [will/may] result in the claim being rejected	490
2410	CTP04	Professional Service	O	The max value for international units (qualifier F2), in the CTP segment, cannot exceed seven bytes numeric with three decimal places. Claims for drugs that exceed this value will be rejected.	403

Description				Language	Page
997 - Functional Acknowledgement					
			R/O	We suggest retrieval of the ANSI 997 functional acknowledgment files on or before the first business day after the claim file is submitted, but no later than five days after the file submission OR We suggest retrieval of the ANSI 997 functional acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission	B.15
			R/O	A. [Contractor name] will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997 -OR- B. [Contractor name] will return [X] as the version in GS08 (Version/Release/Industry Identifier Code) of the 997	
			O	Dates that are submitted on an inbound 837 transaction must be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit valid calendar dates will result in the rejection of the applicable interchange (transmission)	