Program Memorandum Carriers

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

Transmittal B-01-71 **Date: NOVEMBER 8, 2001**

CHANGE REQUEST 1809

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

This Program Memorandum (PM) is to provide carriers and Durable Medical Equipment Regional Carriers (DMERCs) with language to include in a companion document. A companion document is defined as a set of statements, which supplements the X12N 837 Professional implementation guides 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 standard system maintainers. Contractors have the option to add specific items not contained in this PM. However, these items must not contradict any items in this PM. Contractors are to communicate this companion document information to their EDI submitters using their current methods of communication or an alternate method, if deemed more effective.

X12N 837 Professional Companion Document

The table provided below indicates whether the 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 each option. You should select the language that is applicable to your business situation.

For those statements that include the choice between [***will/may***], you should use either "will" or "may", depending on your business situation, in your finalized companion document.

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 ANSI X12N 837 implementation guides have been established as the standards of compliance for claim transactions. The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion document to the HIPAA ANSI 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 with other HIPAA standards, as they become available.

USAGE	LANGUAGE
R	Negative values submitted in the following fields ***[will/may]*** not be processed and ***[will/may]*** result in the claim being rejected: Total Claim Charge Amount (2300 Loop, CLM02), Patient Amount Paid (2300 Loop, AMT02), Patient Weight (2300 and 2400 Loop, CR102), Transport Distance (2300 and 2400 Loop, CR106), Payer Paid Amount (2320 Loop, AMT02), Allowed Amount (2320 Loop, AMT02), Line Item Charge Amount (2400 Loop, SV102), Service Unit Count (2400 Loop, SV104), Total Purchased Service Amount (2300 Loop, AMT02), and Purchased Service Charge Amount (2400 Loop, PS102).
R	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.
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 submitted with values in excess of 99.99 ***[will/may]*** be rejected.
R	Claims that contain percentage amounts submitted with more than two positions to the left or the right of the decimal ***[will/may]*** be rejected.
R	Data submitted in CLM20 (Delay Reason Code) ***[will/may]*** not be used for processing.
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	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	The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.
R	Currency code (CUR02) must equal 'USA'.
R	Diagnosis codes have a maximum size of five (5). Medicare does not accept decimal points in diagnosis codes.
USAGE	**LANGUAGE**
R	Total submitted charges (CLM02) must equal the sum of the line item charge

	amounts (SV102).
R	Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).
R	Service unit counts (units or minutes) cannot exceed 999.9 (SV104).
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.
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.
O	Only loops, segments, and data elements valid for the HIPAA Institutional or Professional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide ***[will/may]*** cause files to be rejected.
O	Only loops, segments, and data elements valid for the HIPAA Institutional or Professional Implementation Guides will be translated. Non-implementation guide data ***[will/may]*** not be sent for processing consideration.
O	Any data submitted in the PWK (Paperwork) segment ***[will/may]*** not be considered for processing.
O	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.
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/may]*** be ignored.
O	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/may]*** result in rejection of the claim or the applicable interchange (transmission).
O	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).
O	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).
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/may]*** edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Institutional or Professional Implementation Guides.
O	[***Contractor name***] ***[will/may]*** reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.
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.
USAGE	**LANGUAGE**
O	[***Contractor name***] ***[will/may]*** reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number)

	elements.
O	[***Contractor name***] ***[will/may]*** reject an interchange (transmission) that is not submitted with a valid carrier code. Each individual Contractor determines this code.
O	[***Contractor name***] ***[will/may]*** reject an interchange (transmission) submitted with more than 9,999 loops.
O	[***Contractor name***] ***[will/may]*** reject an interchange (transmission) submitted with more than 9,999 segments per loop.
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.
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).
O	[***Contractor name***] ***[will/may]*** reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.
O	[***Contractor name***] ***[will/may]*** reject an interchange (transmission) with more than [***X(X=>5000)***] CLM segments (claims) submitted per transaction.
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.
R/O (b)	You may send up to eight diagnosis codes per claim; however, the last four diagnosis codes ***[will/may]*** not be considered in processing.
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.
R/O (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.
R/O (b)	You may send up to four modifiers; however, the last modifier ***[will/may]*** not be considered. The [***Contractor name***] processing system ***[will/may]*** only use the first three modifiers for adjudication and payment determination of claims.
R/O (a)	[***Contractor name***] will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997.
R/O (b)	[***Contractor name***] will return [X] as the version in GS08 (Version/Release/Industry Identifier Code) of the 997.
R/O (a)	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.
R/O (b)	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.

R/O (a)	Compression of files is not supported for transmissions between the submitter and [***Contractor name***].
R/O (b)	Compression of files using [*name of software*] is supported for transmissions between the submitter and [***Contractor name***].

The *effective date* for this PM is November 8, 2001.

The *implementation date* for this PM is November 23, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 16, 2002.

If you have any questions, contact Brian Reitz, on (410) 786-5001 or e-mail breitz@cms.hhs.gov**.**