

837 v.4010A1 Professional Health Care Claim 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 Multi Carrier System of Wisconsin Physicians Service Contractor numbers: Wisconsin 00951, Illinois 00952, Michigan 00953, Minnesota 00954. The information in this document is subject to change. Changes will be communicated in the standard Communiqué (monthly news bulletin) and on Wisconsin Physicians Service Web site: www.wpsic.com/medicare. 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.

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Description		Language	Page
General Statements			
		The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 will be rejected	
		Claims that contain percentage amounts with values in excess of 99.99 will be rejected	
		Claims that contain percentage amounts cannot exceed two positions to the left or the right of the decimal. Percent amounts that exceed their defined size limit will be rejected.	
		Wisconsin Physicians Service 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	
		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	
		The incoming 837 transactions utilize delimiters from the following list: >, *, ~, ^, , and :. Submitting delimiters not supported within this list may cause an interchange (transmission) to be rejected	

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			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 may cause the interchange (transmission) to be rejected at the carrier translator	
			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 http://www.wpc-edi.com/codes . Claims submitted with invalid taxonomy codes will be rejected.	
			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)	
			Wisconsin Physicians Service may reject an interchange (transmission) submitted with more than 9,999 loops	
			Wisconsin Physicians Service will reject an interchange (transmission) submitted with more than 9,999 segments per loop	
			Wisconsin Physicians Service will reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.	
			Compression of files using PK Zip is supported for transmissions between the submitter and Wisconsin Physicians Service	
			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 cause the claim or the transaction to be rejected.	
			You may send up to four modifiers; however, the last two modifiers may not be considered. The Wisconsin Physician Service processing system may only use the first two modifiers for adjudication and payment determination of claims.	
Interchange Control Header				
	ISA06	Interchange Sender ID	Wisconsin Physicians Service will reject an interchange (transmission) that does not contain a valid ID in ISA06	B.4
	ISA08	Interchange Receiver ID	Wisconsin Physicians Service will reject an interchange (transmission) that does not contain (Wisconsin 00951, Illinois 00952, Michigan 00953, Minnesota 00954) in ISA08. Each individual Contractor determines this code.	B.5
Functional Group Header				

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			Wisconsin Physicians Service will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group)	
	GS03		Wisconsin Physicians Service will 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			
			Wisconsin Physicians Service 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 cause the transaction to be rejected	
	ST02	Transaction Control Set	Wisconsin Physicians Service 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	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL)	64
	BHT06	Claim/Encounter Identifier	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE)	65
1000A	NM109	Submitter ID	Wisconsin Physicians Service will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission	69
1000B	NM109	Receiver Primary Identifier	Wisconsin Physicians Service will reject an interchange (transmission) that is not submitted with a valid carrier code.(NM1) Each individual Contractor determines this code. Wisconsin Physicians Service Contractor number Wisconsin 00951, Illinois 00952, Michigan 00953, Minnesota 00954.	75
2000B	HL	Subscriber Hierarchical Level	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	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	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	Negative values submitted in CLM02 will not be processed and may result in the claim being rejected	172
2300	CLM02	Total Submitted Charges	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102)	172
2300	CLM05-3	Claim Frequency Type Code	The only valid value for CLM05-3 is '1' (ORIGINAL). Claims with a value other than "1" will be rejected	173
2300	CLM20	Delay Reason Code	Data submitted in CLM20 will not be used for processing	179
2300	PWK	Claim Supplemental Information	Any data submitted in the PWK (Paperwork) segment will not be considered for processing	214

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Description			Language	Page
2300	AMT01	Credit/Debit Card Maximum Amount	Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop)	219
2300	AMT02	Patient Amount Paid	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: AMT02	220
2300	AMT02	Total Purchased Service Amount	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: AMT02	221
2300	CR102, CR106	Ambulance Transport Information	Negative values submitted in the following fields may not be processed and will result in the claim being rejected: CR102, CR106	249,250
2300	HI	Health Care Diagnosis Code	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	Effective July 2004, all diagnosis codes submitted on a claim must be valid codes per the qualified code source. Claims that contain invalid diagnosis codes, pointed to or not, will be rejected.	265
2300	HI	Health Care Diagnosis Code	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.	265
2320	AMT02	Coordination of Benefits Amounts	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: AMT02	332 333
2400	SV102	Line Item Charge Amount	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: SV102.	402
2400	SV104	Professional Service	Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes may be rejected. (SV104)	403
2400	SV104	Professional Service	SV104 (Service unit counts) (units or minutes) cannot exceed 999.9	403
2400	SV104	Professional Service	Negative values submitted may not be processed and may result in the claim being rejected. (SV104)	403
2400	CR102, CR106	Ambulance Transport Information	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: CR102, CR106.	413, 414
2400	PS1	Purchased Service	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 may be rejected	489
2400	PS102	Purchased Service	Negative values submitted in PS102 may not be processed and may result in the claim being rejected	490
997 - Functional Acknowledgement				
			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

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			Wisconsin Physicians Service will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997.	