

Companion Document For
ANSI ASC X12N 837 4010A1 Professional Claim
Cahaba Government Benefit Administrators®, LLC
November 2009

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 ASC X12N 837 implementation guide has been established as the standard 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 ASC X12N 837 implementation guide. The table contains specific requirements to be used for processing data in the Medicare Part B MCS System of Cahaba Government Benefit Administrators®, LLC.

The use of this document is solely for the purpose of clarification. This document supplements, but does not contradict, any requirements in the ANSI ASC X12N 837 implementation guides. Additional companion documents will be developed for use with other HIPAA standards as they become available. You may obtain the most recent version of this Companion Document by visiting our web site at http://www.cahabagba.com/part_b/edi/hipaa_n3_companion_documents.htm.

Interchange Sender and Receiver ID

- The **Interchange Sender ID** data element within the ISA segment (ISA06) and the **Application Sender's Code** data element within the GS segment (GS02) must be populated with the applicable submitter ID assigned by Cahaba GBA.
- The **Interchange Receiver ID** data element within the ISA segment (ISA08) and the **Application Receiver's Code** data element within the GS segment (GS03) must be populated as follows:

Segment	Current Cahaba GBA Receiver ID	New Cahaba GBA MAC Workload Number (Receiver ID)	New Receiver ID Effective Date
Alabama – Part A	00010MA	10101	May 18, 2009
Alabama – Part B	00510MB*	10102	May 4, 2009
Georgia – Part A	N/A	10201	May 4, 2009
Georgia – Part B	00511	10202	August 1, 2009
Tennessee – Part A	N/A	10301	August 3, 2009
Tennessee – Part B	N/A	10302	August 29, 2009
Mississippi – Part B	00512	N/A	N/A
Home Health & Hospice	00011	N/A	N/A

*Alabama Part B Submitters – The current Receiver ID used in 1000B loop is 00510. This will also change to 10102 effective May 4, 2009.

ITEM #	LOOP	SEGMENT NAME	LANGUAGE
1.	-----	-----	The maximum number of characters to be submitted in a dollar amount field is seven characters. Claims in excess of 99,999.99 will be rejected.
2.	-----	-----	Claims that contain percentage amounts submitted with values in excess of 99.99 will be rejected.
3.	-----	-----	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.
4.	-----	-----	Cahaba GBA 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.
5.	-----	-----	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 cause the interchange (transmission) to be rejected at the carrier translator.
6.	-----	-----	The incoming 837 transactions should utilize delimiters from the following list: > (greater than), * (asterisk), ~ (tilde), : (colon), (pipe), and ^ (carat). Submitting delimiters not supported within this list will cause an interchange (transmission) to be rejected. The usage of these characters within text data elements in the incoming 837 transaction may cause problems with creation of subsequent transactions, including the

			outbound 837 and the 835. NOTE: Do Not use ^ (Karat) as a Segment Terminator.
7.			Effective May 23, 2008, the National Provider identifier (NPI) must be submitted in the NM109 segment (NM108 = XX). Failure to submit an NPI will result in your claim being rejected.
8			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.
9.			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 cause files to be rejected.
10.			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).
11.			Cahaba GBA 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).
12.			Cahaba GBA will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).
13.			Cahaba GBA 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.

14.			Cahaba GBA will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Professional Implementation Guide.
15.			Cahaba GBA will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.
16.			Cahaba GBA will reject an interchange (transmission) that is not submitted with a valid carrier code. Each individual Contractor determines this code.
17.			Cahaba GBA will reject an interchange (transmission) submitted with more than 9,999 loops.
18.			Cahaba GBA will reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.
19.			Cahaba GBA will reject an interchange (transmission) submitted with more than 9,999 segments per loop.
20.			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.
21.			Cahaba GBA will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997.
22.			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.
23.			Compression of files is supported for transmissions between the

			submitter and Cahaba GBA. Any compression software compatible with PKZIP by PKWARE, Inc. is supported.
24.			The format for submitting Cahaba GBA provider numbers can be up to 10 Alphanumeric digits.
25.			When submitting text in free format fields, any special character is acceptable with the exception of the delimiters specified in #6 of this companion document. Any names with special characters can be submitted with or without a space in the place of the special character.
26.		Interchange Control Header	<p>Cahaba GBA will reject an interchange (transmission) that does not contain a valid ID in ISA06. The Submitter ID reported in ISA06 must match the Submitter ID reported in GS02.</p> <p>For AL:</p> <p>Use your 8-character Submitter ID assigned by Cahaba GBA followed by 7 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA06 as the Interchange Sender ID. The Submitter ID reported in these records will be the directory in which the remittance and Electronic Report Files (ERF) will be returned.</p> <p>For GA:</p> <p>Use your 9-character Submitter ID assigned by Cahaba GBA. With the state code (i.e. GAXXX-XXX), followed by 6 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA06 as the Interchange Sender ID. The Submitter ID reported in these records (minus the hyphen in the 6th position) will be the directory in which the remittance and Electronic Report Files (ERF) will be returned.</p> <p>FOR MS:</p> <p>Use your 9-character Submitter ID assigned by Cahaba GBA (i.e. 007XXXXXX), followed by 6 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA06 as the Interchange Sender ID. The Submitter ID reported in these records ('00' will be</p>

			<p>replaced with the letter 'm' in the 1st two positions of the code) will be the directory in which the remittance and Electronic Report Files (ERF) will be returned.</p> <p>For TN:</p> <p>Use your 8-character Submitter ID assigned by Cahaba GBA followed by 7 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA06 as the Interchange Sender ID. The Submitter ID reported in these records will be the directory in which the remittance and Electronic Report Files (ERF) will be returned.</p>
27.		Interchange Control Header	Cahaba GBA will reject an interchange (transmission) that does not contain ZZ in ISA07.
28.		Interchange Control Header	Use the appropriate receiver ID based on the state followed by 10 spaces (to meet the minimum/maximum data element requirement of 15 bytes) in ISA08 as the Interchange Receiver ID. AL = 00510MB, GA = 00511, MS = 00512, TN = 10302. Effective May 4, 2009, AL will change from 00510MB to 10102, Effective August 3, 2009, GA will change from 00511 to 10202. Effective August 29, 2009, use 10302 for TN.
29.		Functional Group Header	Use your 8 or 9-character Submitter ID (for the appropriate state) assigned by Cahaba GBA in GS02 as the Application Sender's Code. The Submitter ID reported in this segment must match the Submitter ID submitted in ISA06.
30.		Functional Group Header	Use the appropriate Receiver Code (AL = 00510MB, GA = 00511, MS = 00512, TN = 10302) in GS03 as the Application Receiver's Code. Effective May 4, 2009, AL will change from 00510MB to 10102, Effective August 3, 2009, GA will change from 00511 to 10202. Effective August 29, 2009, use 10302 for TN.
31.		Functional Group	Cahaba GBA will reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the

		Header	carrier definition.
32.		Transaction Set Header	Cahaba GBA will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.
33.		Beginning Hierarchical Transaction of	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).
34.		Beginning Hierarchical Transaction of	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).
35.		Transmission Type Identification	The 837 Professional claim transaction will not be piloted. Claim files submitted with a Transmission Type Code value of 004010X098DA1 in REF02 will cause the file to be rejected.
36.	1000A	Submitter Name	Use your 8 or 9-character Submitter ID in NM109.
37.	1000B	Receiver Name	Use the appropriate Receiver Code (AL = 00510, GA = 00511, MS = 00512, TN = 10302) in NM109 as the Receiver Name Code. Effective May 4, 2009, AL will change from 00510 to 10102, Effective August 3, 2009, GA will change from 00511 to 10202, Effective August 29, 2009, use 10302 for TN.
38.	2010AA	Billing Provider name	Effective May 23, 2008, the National Provider identifier (NPI) must be submitted in the NM109 segment (NM108 = XX). Failure to submit an NPI will result in your claim being rejected.
39.	2010AB	Pay-To-Provider Name	Effective May 23, 2008, the National Provider identifier (NPI) must be submitted in the NM109 segment (NM108 = XX). Failure to submit an NPI will result in your claim being rejected.
40.	2000B	Subscriber	The HL segment must be in order from one, by one (+1) and must be

		Hierarchical Level	numeric.
41.	2010BB	Payer Name	Use the PI qualifier in NM108 followed by the appropriate Receiver Code AL = 00510, GA = 00511, and MS = 00512 as the Identification Code. Effective May 4, 2009, AL will change from 00510 to 10102, Effective August 3, 2009, GA will change from 00511 to 10202, Effective August 29, 2009, use 10302 for TN.
42.	2000C	Patient Hierarchical Level	For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used.
43.	Multiple (2010BD, 2300)	Various	Do not use Credit/Debit card information to bill Medicare AMT01=MA.
44.	Multiple (2300, 2320, 2400)	Various	Negative values submitted in the following fields will not be processed and will 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).
45.	2300	Claim Information	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).
46.	2300	Claim Information	The only valid value for CLM05-3 (Claim Frequency Type Code) of the Health Care Service Information data element is '1' (ORIGINAL). Claims with a value of other than '1' will be rejected.
47.	2300	Claim	Data submitted in CLM20 (Delay Reason Code) will not be used for

		Information	processing.
48.	2300	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.
49.	2300	Health Care Diagnosis Code	Diagnosis codes have a maximum size of five (5) bytes. Medicare does not accept decimal points in diagnosis codes.
50.	2310A, 2420F	Referring Provider Name	Effective May 23, 2008, the National Provider identifier (NPI) must be submitted in the NM109 segment (NM108 = XX). Failure to submit an NPI will result in your claim being rejected.
51.	2310B, 2420A	Rendering Provider Name	Effective May 23, 2008, the National Provider identifier (NPI) must be submitted in the NM109 segment (NM108 = XX). Failure to submit an NPI will result in your claim being rejected.
52.	2310C, 2420B	Purchased Service Provider Name	Effective May 23, 2008, the National Provider identifier (NPI) must be submitted in the NM109 segment (NM108 = XX). Failure to submit an NPI will result in your claim being rejected.
53.	2310E, 2420D	Supervising Provider Name	Effective May 23, 2008, the National Provider identifier (NPI) must be submitted in the NM109 segment (NM108 = XX). Failure to submit an NPI will result in your claim being rejected.
54.	2400	Professional Service	You may send up to four modifiers and all four modifiers will be considered for processing.
55.	2400	Professional Service	Service unit counts (units or minutes) cannot exceed 999.9 (SV104).
56.	2400		Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes will be rejected. (SV104).

57.	2400	Professional Service	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)
58.	2400	Professional Service	Negative values submitted in the fields will not be processed and will result in the claim being rejected. (SV104)
59.	2400	Professional Service	Negative values submitted in the fields will not be processed and will result in the claim being rejected. (PS102)
60.	2400	Professional Service	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.
61.	2420E	Ordering Provider Name	Effective May 23, 2008, the National Provider identifier (NPI) must be submitted in the NM109 segment (NM108 = XX). Failure to submit an NPI will result in your claim being rejected.
62.	2300	Paperwork	Any data submitted in the PWK (Paperwork) segment may not be considered for processing.
63.	Multiple (2300, 2400)		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 be rejected.
64.	Multiple (2300, 2400)		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.

SECONDARY CLAIM BILLING:

Note: Usage of the data elements below cause the 2330A and 2330B loops to be required.

65.	2300	Claim Total Submitted Charge	CLM02 Must be equal to the sum of the line items.
66.	2300	Claim OTAF Amount	CN102 where CN101 = 09. NOTE: If line item data is available, report this data at the line level.
67.	2320	Claim Primary Payer Paid Amount	AMT02, where AMT01=D. NOTE: If line item data is available, report this data at the line level
68.	2320	Claim Primary Payer Allowed Amount	AMT02, where AMT01=B6. NOTE: If line item data is available, report this data at the line level.
69.	2400	Line Submitted Charge	SV102, Monetary Amount.
70.	2400	Line OTAF Amount	CN102 where CN101 = 09. NOTE: If line item data is available, report this data at the line level.
71.	2400	Line Primary Payer Allowed Amount	AMT02, where AMT01=AAE. NOTE: If line item data is available, report this data at the line level.
72.	2430	Line Primary Payer Paid Amount	SVD02. NOTE: If line item data is available, report this data at the line level.