

EDI Support Services

Trading Partner Agreement Companion Document

For Medicare Part B Providers and CAP Vendors

Last Updated 03/03/2009

The Health Insurance Portability and Accountability Act (HIPAA) requires that EDI Support Services (EDISS), and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N 837 4010A1 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 4010A1 implementation guides. This companion document supplements, but does not contradict any requirements in the X12N 837 Professional 4010 Addenda implementation guide. 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 Medicare Part B Multi-Carrier System (MCS). **The information in this document is subject to change.** Changes will be communicated on the EDISS Email Distribution and the EDISS website: www.edissweb.com.

Item No.	Loop ID - Loop Description	Element - Element Description	IG Page #	Medicare Specifications
1	General - Sequencing of the HL segment	HL01 - Hierarchical ID Number, HL02 - Health Care Code Information, HL03 - Health Care Code Information, HL04 - Health Care Code Information	77, 108, 152	The subscriber hierarchical level (HL segment) must be in order from one, increased by one, and must be numeric
2	General - Compression	General	NA	Compression of files using PKZIP and WINZIP compression software is supported for transmissions between the submitter and EDISS.

3	General - National Provider Identifier (NPI)	General	NA	The National Provider Identifier (NPI) must be submitted in the NM109 segment. (NM108 = XX) (2010AA, 2010AB, 2310A, 2310B, 2310C, 2310D, 2310E, 2420A, 2420B, 2420C, 2420D, 2420E, 2420F)
4	General - Case Conversion	General	NA	EDISS 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 (COB) will be submitted in upper case.
5	General - 9999 Segments per Loop	General	NA	EDISS may reject an interchange (transmission) submitted with more than 9,999 segments per loop.
6	General - Must pick up a 997	General	NA	EDISS suggests 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.
7	General - Delimiters Allowed	ISA16 - Component Element Separator	NA	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.

8	General - Qualifiers to use for Medicare	General	NA	Only valid qualifiers for Medicare should be submitted for Medicare processing on incoming 837 claim transactions. Any qualifiers submitted which are not defined for use in Medicare billing may cause the claim to be rejected.
9	General - Files Invalid in Syntax and Structure	All Segments and Elements	NA	Only loops, segments, and data elements valid for the HIPAA Professional Implementation (004010x098A1) Guide will be translated. Non-implementation guide data will be dropped or will not be considered in processing.
10	General - 9999 Loops per Transaction	General	NA	EDISS may reject an interchange (transmission) submitted with more than 9,999 loops
11	General - Extended character set	General	NA	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 by the EDISS translator.

12	General - Interchange Control Number (997)	TA1 Segment, ISA13	B.11- B.13, B.3-B.6	EDISS' claims translator generates the TA101 value in the Functional Acknowledgment Report (997). This value will match the interchange control number of the originally submitted file (ISA13).
13	Envelopes - Group Control Number	GS06 - Group Control Number, GE02	B.8 - B.9	When multiple functional groups (GS-GE) are sent within one ISA-IEA the GS06 and GE02 values must be unique within each functional group.
14	Envelopes - Interchange Control Number	ISA13 - Interchange Control Number, IEA02	B.5, B.7	When multiple interchanges (ISA-IEA) are sent in one day, the ISA13 and IEA02 values must be unique within each Interchange.
15	Envelopes - Multiple Transactions within an Interchange	ISA - Interchange Control Header, GS - Functional Group Header, GE - Functional Group Trailer, IEA - Interchange Control Trailer	B.3 - B.10	EDISS will handle multiple GS-GE's within one ISA-IEA.
16	Envelopes - Envelope Segments	ISA - Interchange Control Header, GS - Functional Group Header, ST - Transaction Set Header, SE - Transaction Set Trailer, GE - Functional Group Trailer, IEA - Interchange Control Trailer	B.3 - B.10	EDISS will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Professional Implementation Guide. (Ex. GS03 - see Carrier Code Listing)

17	Envelopes - Interchange Sender ID	ISA06 - Interchange Sender ID	B.3 - B.10	EDISS may reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.
18	Envelopes - Application receiver's code	GS03 - Application Receiver's Code	B.3 - B.10	EDISS may reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the carrier definition. (See Carrier Code Listing)
19	Envelopes - Line Of Business	ST - Transaction Set Header SE - Transaction Set Trailer	B.3 - B.10	EDISS will only accept claims for one line of business per transaction set. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) may cause the transaction to be rejected.
20	Envelopes - GS08 value in 997	GS08 - Version / Release / Industry Identifier Code	B.3 - B.10	EDISS will return 004010 as the version in GS08 (Version/Release/Industry Identifier Code) of the 997.
21	Envelopes - Unique ST02	ST02 - Transaction Set Identifier Code	B.3 - B.10	If multiple transaction sets (ST-SE) are sent within a functional group (GS-GE), the Transaction Set Control Number in ST02 and the corresponding SE02 must be unique and increment within that functional group and interchange (ISA-IEA). An occurrence of an ST02/SE02 within a functional group cannot be less than or equal to that of a preceding ST02/SE02.

22	Envelopes - ISA08 Value - EDISS ID to use	ISA08 - Interchange Receiver ID	B.3 - B.10	EDISS may reject an interchange (transmission) that is not submitted with a valid Interchange Receiver ID. The Interchange Receiver ID is a contractor defined field. As such, EDISS requests the Interchange Receiver ID match the state represented in the file (see Carrier Code Listing). Clearinghouses and Billing Services may send 33477 as the Interchange Receiver ID if multiple states are represented in one file.
23	Envelopes - Transaction Type	GS - GE (Functional Group) ST - SE (Transaction Set)	B.3 - B.10	EDISS will only process one transaction set per functional group.
24	Envelopes - Transaction Set Purpose Code	BHT02 - Transaction Set Purpose Code	B.3 - B.10	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).

25	Envelopes and 1000A	GS02 and NM109	B.8, 67	The values in the ISA06, GS02, and NM109 (1000A loop) are used by EDISS' front-end claim processor to verify that each Trading Partner is authorized to send claims for each provider represented within the transaction. The value in the GS02 also aids in report delivery. When testing begins, a unique ID is assigned by EDISS for each provider, clearinghouse, billing service, and billing group. If these IDs are not submitted in the correct elements it will cause the file to be rejected. If you are unable to comply with this requirement, contact EDISS for assistance in interpreting the requirement and potentially explore other alternatives.
26	Envelopes - Claim or Encounter Indicator	BHT06 - Transaction Type Code	B.3 - B.10	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).
27	General - 1000B and 2010BB	NM109	NA	All Medicare Part B claims must be submitted with a valid carrier number. EDISS requires the values submitted in 1000B NM109 and 2010BB NM109 be equal. (see Carrier Code Listing)

28	2300 - Claim Information, 2320 - Other Subscriber Information, 2400 - Service Line	CLM02 - Total Claim Charge, AMT02 - Patient Paid Amount, CR102 - Patient Weight, CR106 - Transport Distance, SV102 - Line Item Charge Amount, SV104 - Service Unit Count, PS102 - Purchased Service Charge Amount	NA	Negative values submitted may not be processed and may result in the claim being rejected.
29	2300 - Claim Information, 2320 - Other Subscriber Information, 2400 - Service Line, 2430 - Line Adjudication Information	CLM02 - Total Claim Charge, PS102 - Purchased Service Charge Amount, (CAS03, CAS06, CAS09, CAS12, CAS15, CAS18, CN102, HCP02, HCP03, HCP07, MOA02, MOA08, MOA09, HI01-5, HI02-5, HI 03-5, HI04- 5, HI05-5, HI06-5, SV119) - Monetary Amount	NA	The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 may be rejected.
30	2400 - Service Line	CR102, CR106	413, 414	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: CR102, CR106
31	2300 - Claim Information, 2400 - Service Line	CN103 - Percent, CN105 - Terms Discount Percent	217, 466	Claims that contain percentage amounts with values in excess of 99.99 may be rejected.

32	2300 - Other Subscriber Information	(HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2) - Industry Code	266 - 270	Effective October 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.
33	2300 - Claim Information, 2400 - Service Line	CN103 - Percent, CN105 - Terms Discount Percent	217, 466	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.
34	2300 - Claim Frequency Code	CLM05-3	173	The only valid value for CLM05-3 is '1' (ORIGINAL). Claims with a value other than "1" may be rejected
35	2300 - Other Subscriber Information	CLM20 - Delay Reason Code	179	Data submitted as a delay reason code in CLM20 may not be used for processing.
36	2400 - Service Line	SV101-3 Procedure Modifier, SV101-4 Procedure Modifier, SV101-5 Procedure Modifier, SV101-6 Procedure Modifier, SV101-7 Description	401, 402	You may send up to four modifiers; however, the last two modifiers may not be considered. The Medicare processing system may only use the first two modifiers for adjudication and payment determination of claims.

37	2000B - Subscriber Hierarchical Level, 2010BA - Subscriber Name, 2000C - Patient Hierarchical Level, 2010CA - Patient Name, 2300 - Claim Information, 2320 - Other Subscriber Information, 2330B - Other Payer Name, 2400 - Service Line, 2430 Line Adjudication Information, 2440 - Form Identification Code	ISA09 - Interchange Date, GS04 - Date, BHT04 - Date, PAT06 - Date Time Period, DMG02 - Date Time Period, DTP03 - Date Time Period, HI02-4 Date Time Period, HI03-4 Date Time Period, HI04-4 Date Time Period, HI05-4 Date Time Period, HI06-4 Date Time Period, HI07-4 Date Time Period, HI08-4 Date Time Period	NA	All dates that are submitted on an incoming 837 claim transaction must be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date may result in rejection of the claim or the applicable interchange (transmission).
38	2300 - 5000 CLM segments	CLM Segment	170 - 271	EDISS may reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.
39	2300 - Claim Information	PWK05 - Identification Code Qualifier, PWK06 - Identifier Code	216	Any data submitted in the PWK (Paperwork) segment will not be considered for processing.
40	2300 - Claim Information	(HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2) - Industry Code	266 - 270	Diagnosis codes have a maximum size of five (5). Medicare does not accept decimal points in diagnosis codes.
41	2300 - Claim Information	CLM02 - Monetary Amount	172	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).

42	2010 BD - Credit/Debit Card Holder Name, 2300 - Claim Information	AMT01 - Amount Qualifier Code, NM1 - Individual or Organizational Name, N2 - Additional Name Information, REF - Reference Identification	146 - 151, 219 - 220	Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).
43	2410 - Drug identification	CTP04 - Quantity	75	The National Drug Unit Count (CTP04) cannot exceed 9999999.999 .
44	2000B - Subscriber Hierarchical Level	SBR02 - Individual Relationship Code, SBR09 - Claim Filing Indicator Code	110	For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used.
45	2400 - Service Line	All Elements	398 - 495	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) may be ignored.
46	2300 - Claim Information	All Elements	170, 271	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) may be ignored.
47	Beginning of Hierarchical Transaction	REF02	66	For 4010A1 version of the 837P claims transaction, this value must equal 004010X098A1.

48	2400 - Service Line	MEA03 - Qualifiers = R1, R2, and R4	465	For qualifiers of R1, R2, and R4 in MEA02 the value in MEA03 cannot exceed 99.9.
49	2400 - Service Line	PS1	489	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.
50	2000A - Billing/Pay - To Provider Hierarchical Level 2310A - Referring Provider Name	PRV - Provider Specialty Information	79, 285	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/taxonomy . Claims submitted with invalid taxonomy codes will be rejected.
51	2400 - Service Line	SV104 - Quantity (Minutes)	403	Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes may be rejected. The maximum value for anesthesia minutes (qualifier MJ) cannot exceed 4 bytes numeric. Claims for anesthesia services that exceed this value will be rejected. (SV104).
52	2400 - Service Line	SV104 - Quantity (Units)	403	Claims with Units of Service (qualifier UN) cannot exceed a maximum value of 999.9.

53	2000A - Billing/Pay - To Provider Hierarchical Level	CUR02 - Currency Code	82	Currency code (CUR02) must equal 'USA'. There are no other valid codes for Medicare claims.
54	GENERAL - File Structure	General	NA	EDISS recommends that trading partners make full use of the ANSI X12 structure in that all claims for a single billing entity be batched within a single ST-SE and/or GS-GE rather than batching each claim within it's own ST-SE and/or GS-GE. This will eliminate potential problems with duplicate checking, result in smaller reports and expedite front-end claims processing.
55	Envelopes - Interchange Control Number	ISA13 - Interchange Control Number	NA	Due to guidelines that we are required to implement in our translator, the ISA13 value in the file that is submitted to us by our trading partners will be changed when the file is forwarded on to the MCS system for claims processing. Please note that the value in ISA13 of the file that you submit to EDISS will not match the value reported on the BDCL from the MCS claims processing system.

56	GENERAL - 1000A, 1000B, 2010AA, 2010AB, 2010BA, 2010BB, 2010BC, 2010CA, 2310A, 2310B, 2310C, 2310D, 2310E, 2330A, 2330B, 2420A, 2420C, 2420D, 2420E, 2420F, 2420G	NM102 - Entity Type Qualifier NM103 - Last Name or Organization Name	N/A	For every NM103 where NM102 = 1, we allow only 'A' - 'Z', 'a' - 'z', dash (/), hyphen (-) or space character values. The first position must contain an 'A' - 'Z' or 'a' - 'z' character value. For every NM103 where NM102 = 2, we allow only 'A' - 'Z', 'a' - 'z', '0' - '9', dash (/), hyphen (-), slash (/), period (.), comma (,), ampersand (&), single quotation apostrophe ('), double quotation apostrophe (") or space character values. The first position must contain an 'A' - 'Z', 'a' - 'z' or '0' - '9' character value.
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57	Envelopes - ISA04 Value	ISA04	N/A	The value submitted in the ISA04 field must not contain an asterisk, this will cause the file to reject. If any value submitted in the ISA04 field is the same as any segment, element, or sub-element delimiter the file will reject.
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The following information details the cutoff times of when claims need to be received by EDISS' front-end claims processing system in order to be accepted into standard system for payment processing. If a claim file is not received before the following times the data will not be processed until the next cycle. **Note:** File size affects the total processing time. If larger files are being sent, ensure they are sent early enough to complete processing by the cutoff time.

- **Midwest (ND, SD, and WY) – In order for the claim to make it into the same days cycle the claim file must be received and processed by 4:30 P.M. (CST) that day.**
- **Montana and Utah – In order for the claim to make it into the same days cycle the claim file must be received and processed by 4:30 P.M. (CST).**
- **Southwest (AZ) – In order for the claim to make it into the same days cycle the claim file must be received and processed by 4:30 P.M. (CST) that day.**
- **Northwest (AK, OR, and WA) – In order for the claims to make it into the same days cycle the claim file must be received and processed by 4:30 P.M. (CST) that day.**

The Carrier Code Listing displays the ISA08 (Interchange Receiver ID), **GS03** (Application Receivers Code) and 1000B and 2010BC NM109 values that EDISS requires for claim routing purposes based on **line of business (LOB)**. Failure to submit a valid code from this list will cause the transaction to be rejected. If the code submitted is from the list but for the wrong region or LOB, the transaction may be accepted. This would cause the claims to be routed incorrectly, resulting in the need for the transaction to be manually worked ultimately impacting the payment time frame. The designated values can be located in the Carrier Code Listing at the following link:

http://www.edissweb.com/docs/cgp/carrier_codes.pdf

For more information regarding possible edits or errors you may be receiving on the EDISS Claims Confirmation Report please visit http://www.edissweb.com/docs/shared/claims_conf_a1.pdf