

EDI Support Services

**EDISS Trading Partner Agreement Companion Document
For Iowa Professional Medicaid Providers
837 4010A1 Professional Claim**

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The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, 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. 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 Medicaid Management Information Systems (MMIS). **The information in this document is subject to change.** Changes will be communicated on the EDISS web site: www.edissweb.com and via the EDISS Email Listing. This companion document supplements, but does not contradict any requirements in the X12N 837 Professional 4010 Addenda implementation guide. Additional companion documents/trading partner agreements will be developed for use with other HIPAA standards, and will be posted as they become available.

Item No.	Loop ID - Loop Description	Element - Element Description	IG Page #	Medicaid 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. Medicaid will process only HL structures as described in the implementation guide front matter (Billing provider HL (parent) followed by the appropriate Subscriber HL (child).
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 - Compression	GENERAL	NA	EDISS will only process one transaction type (Ex. Claims, Eligibility, Claim Status) per interchange (ISA-IEA).
4	General - Provider Number 2010AA, 2010AB, 2310B, 2420A, 2420F	REF Segment With a EI or SY Qualifier	NA	The complete NPI must be submitted, and needs to be sent in the NM109 with NM108 = XX in all loops. Atypical providers need to send their atypical provider number (starting with X00...) in the REF segment with a G2 qualifier. After 5/22/08, any claim sent with a 1A, 1B, 1D, and 1G qualifiers will be rejected.

5	General - Provider Number 2310A	REF Segment With a EI Qualifier	NA	The complete Provider Employee Identification Number (EI) must used if submitting a REF segment in the 2310A Loop. The complete NPI must be submitted, and needs to be sent in the NM109 with NM108 = XX.
6	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 Medicaid processing system. Consequently, data later submitted for Coordination of Benefits (COB) will be submitted in upper case.
7	General - 9999 Segments per Loop	General	NA	EDISS may reject an interchange (transmission) submitted with more than 9,999 segments per loop.
8	General - Must pick up a 997	General	NA	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.
9	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.
10	General - Qualifiers to use for Medicaid	General	NA	Only valid qualifiers for Medicaid should be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicaid processing not defined for use in Medicaid billing may cause the claim or the transaction to be rejected.
11	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
12	General - 9999 Loops per Transaction	General	NA	EDISS may reject an interchange (transmission) submitted with more than 9,999 loops.
13	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 at the EDISS translator.
14	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).
15	Taxonomy Codes	PRV - Provider Specialty Information	71, 198	NPI billing requires the taxonomy code to be sent with the claim in the 2000A/PRV. When billing with an NPI that is associated with a Medipass number, Medicaid 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.

16	General - Zip Codes 2010AA 2310D 2420C	N403	NA	The zip code that is billed should match the zip code that was verified with IME. If a five digit or nine digit zip code is on file with IME, that is what should be submitted on the claim.
17	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.
18	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.
19	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.
20	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.
21	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.
22	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 Receiver's Code) based on the receiver definition. The value for Iowa Medicaid is 0026 .
23	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. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) may cause the transaction to be rejected.
24	ENVELOPE - 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.
25	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.
26	ENVELOPES - 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 intermediary code. Each individual receiver determines this code. This value is '33477'.
27	Envelopes - Transaction Type	GS - GE (Functional Group) ST - SE (Transaction Set)	B.3 - B.10	EDISS will only process one transaction per functional group.
28	Envelopes - Transaction Set Purpose Code	BHT02 - Transaction Set Purpose Code	B.3 - B.10	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).

29	ENVELOPES and 1000A	GS02 and NM109	B.8, 67	The values in the ISA06, GS02, and NM109 (1000A loop) are used by EDISS's front-end claim system to verify that each trading partner is authorized to send claims for each provider represented within the transaction. The values in the GS02 also aid in report delivery. When testing begins a unique number will be assigned by EDISS for each provider, clearinghouse, billing service, and billing group. If these numbers are not submitted in the correct elements it will cause the file to be rejected.
30	Envelopes - Claim or Encounter Indicator	BHT06 - Transaction Type Code	B.3 - B.10	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).
31	Beginning of Hierarchical Transaction	REF02	66	For 4010A1 version of the 837P claims transaction, this value must equal 004010X098A1.
32	1000B - Receiver Name	NM109 - Identification Code	75	The receiver primary identifier is '18049'.
33	2010AB - Pay-To Provider Name	REF - Reference Identification	106 - 107	Only the first occurrence of the segment will be used.
34	2010BA - Subscriber Name	NM108 - Identification Code Qualifier	119	Qualifier of 'MI' needs to be submitted.
35	2010BA - Subscriber Name	NM109 - Identification Code	119	The 8 digit Iowa Medicaid recipient ID needs to be submitted.
36	2010AB - Pay-To Provider Name	REF - Reference Identification	126 - 127	Only the first occurrence of the segment will be used.
37	2010BB - Payer Name	NM109 - Identification Code	131	The payor primary identifier is '18049'.
38	2300 - Claim Information, 2320 - Other Subscriber Information, 2400 - Service Line	CLM02 - Total Claim Charge, SV102 - Line Item Charge Amount, SV104 - Service Unit Count	NA	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: Total Claim Charge Amount (2300 Loop, CLM02), Payer Paid Amount (2320 Loop, AMT02), Allowed Amount (2320 Loop, AMT02), Line Item Charge Amount (2400 Loop, SV203), Service Unit Count (2400 Loop, SV207),
39	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.
40	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.
41	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).

42	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.
43	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). Medicaid does not accept decimal points in diagnosis codes.
44	2300 - Claim Information	CLM01 - Claim Submitter's Identifier	171	Only the first 13 bytes will be used.
45	2300 - Claim Information	CLM02 - Monetary Amount	172	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).
46	2300 - Claim Information	CLM05-3 - Claim Frequency Code	173	The only valid value for CLM05-3 is '1' (ORIGINAL). Claims with a value other than "1" may be rejected.
47	2300 - Claim Information	CLM20 - Delay Reason Code	179	Data submitted as a delay reason code in CLM20 may not be used for processing.
48	2300 - Claim Information	DTP - Onset of Current Symptoms or Illness (431) and Acute Manifestation of a Chronic Condition (453)	188 - 191	Only the first occurrence of the segment will be used.
49	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.
50	2300 - Claim Information	PWK02 - Report of Transmission Code	216	The attachment code of 'BM' or 'FX' need to be submitted if a paper attachment is submitted for the electronic claim in order to be matched with the claim. If sending by mail, mail to PO Box 150001, Des Moines, IA 50315. If sending by fax, the fax number is 515-256-4626.
51	2300 - Claim Information	PWK06 - Identification Code	216	Only the first 20 bytes will be used. This number should be indicated on the paper attachment.
52	2300 - Claim Information	REF01 - Reference Identification Qualifier	228	The qualifier that needs to be submitted is 'G1'.
53	2300 - Claim Information	REF01 - Reference Identification	228	Only the first 10 bytes will be used.
54	2300 - Claim Information	REF - Clinical Laboratory Improvement Amendment (CLIA) Number (X4)	231 - 232	Only the first occurrence of the segment will be used.
55	2300 - Claim Information	REF02 - Clinical Laboratory Improvement Amendment (CLIA) Number	232	Only the first 10 bytes will be used.
56	2300 - Claim Information	CR106 - Quantity (Transport Distance)	250	Only the first 5 bytes will be used.
57	2300 - Claim Information	(HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2) - Industry Code	265 - 270	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.
58	2300 - Claim Information	HI - Health Care Diagnosis Code	265	Only the first 4 diagnosis codes will be used.
59	2310A - Referring Provider Name		282 - 289	Only 1st iteration of this loop will be used.
60	2310A - Referring Provider Name	NM101 - Entity Identifier Code	283	The qualifier that needs to be submitted is 'DN'.
61	2310A - Referring Provider Name	REF01 - Referring Provider Secondary Identifier	288-289	2nd iteration of this segment is required in cases where a MediPASS referral is involved.
62	2310A - Referring Provider Name	NM101 - Entity Identifier Code	283	The qualifier that needs to be submitted is 'P3'.

63	2310A - Referring Provider Name	NM109 - Identification Code	288 - 289	The Medipass NPI should be submitted in this segment. (NM108 needs to be XX) Medipass NPI should be used for MediPass referrals.
64	2310A - Referring Provider Name	REF02 - Reference Identification Qualifier	289	The value that should be submitted in this segment is the referring Social Security Numer with an SY qualifer in the REF01, or the Employer's Identification Number with a EI qualifier.
65	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 Medicaid (2300 loop, AMT01=MA and 2010BD loop).
66	2310E - Supervising Provider Name	NM108 - Identification Code Qualifier	314	Qualifier of '34' needs to be submitted.
67	2310E - Supervising Provider Name	REF - Supervising Provider Secondary Identification	316 - 317	Only the first occurrence of the segment will be used.
68	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
69	2400 - Service Line 2410 - Drug identification	SV104 - Quantity CTP04 - Quantity	403	Service unit counts (units or minutes) (SV104) and National Drug Unit Count (CTP04) cannot exceed 9999999.999.
70	2400 - Service Line	SV101-1 - Product/Service ID Qualifier	401	Qualifier of 'HC' needs to be submitted.
71	2400 - Service Line	SV101-3 thru SV101-6 - Procedure Modifier	401 - 402	Only the first two modifiers will be used.
72	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.
73	2400 - Service Line	CR106 - Quantity (Transport Distance)	414	Only the first 5 bytes will be used.
74	2420A - Rendering Provider Name	REF - Rendering Provider Secondary Identification	507	Only the first occurrence of the segment will be used.