

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1116	Date: NOVEMBER 24, 2006
	Change Request 5334

Subject: Revised American National Standards Institute X12N 837 Institutional Health Care Claim Companion Document

I. SUMMARY OF CHANGES: A revised 837 Institutional Companion Document is attached. It has been modified to add National Provider Identifier (NPI) and taxonomy code reporting information. This companion document is a set of statements, which supplements the X12N 837 Institutional Implementation Guide and clarifies Medicare contractor expectations regarding data submission, processing, and adjudication. Information in a companion guide may not contradict any other items in the companion document or X12N 837 Institutional Implementation Guide.

New / Revised Material

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
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III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 1116	Date: November 24, 2006	Change Request 5334
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SUBJECT: Revised American National Standards Institute X12N 837 Institutional Health Care Claim Companion Document

I. GENERAL INFORMATION

A. Background: A revised 837 Institutional Companion Document is provided due to updates needed in the current version and the need for additions for the National Provider Identifier (NPI). This companion document is a set of statements, which supplements the X12N 837 Institutional Implementation Guide and clarifies Medicare contractor expectations regarding data submission, processing, and adjudication. Information in a companion guide may not contradict any other items in the companion document or X12N 837 Institutional Implementation Guide.

The descriptions provided indicate whether the statement usage is:

(R) Required – Intermediaries must include this language in your companion document.

(S) Situational – RHHIs must include this language in their companion document.

(O) Optional – Intermediaries can choose to include this language in your companion document, if applicable.

(R/O) Selection required - Intermediaries must choose one statement from the list of the statements provided. The choices will be labeled either (A) or (B) to identify the options for each statement. Intermediaries should select the language that is applicable to the business situation.

B. Policy: N/A

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other A/B MAC
						F I S S	M C S	V M S	C W F	
5334.1	Contractors shall update their current companion guide to include the corrections and additions in the attached document.	X	X							X

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	A/B MAC
5334.2	<p>Contractors shall include the following language in their X12N 837 companion document:</p> <p>“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 submission of claims for all services, supplies, equipment, and health care other than retail pharmacy prescription drug claims. The implementation guides for each X12 transaction adopted as a HIPAA standard are available electronically at http://www.wpc-edi.com.</p> <p>The following information is intended to serve only as a companion document to the HIPAA X12N 837 institutional claim implementation guide. The use of this document is solely for the purpose of clarification.</p> <p>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] provider news bulletin and on [Contractor name] Web site: [Contractor URL]. This companion document supplements, but does not contradict any requirements in the X12N 837 Institutional implementation guide.”</p>	X	X							X

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other A/B MAC
F I S S	M C S					V M S	C W F			
5334.3	For those statements in the attachment that include the choice between options A or B, contractors shall select the one option that meets their business needs and publish it in your finalized companion document.	X	X							X
5334.4	For those statements in the attachment that include the choice between [<i>will/may</i>], contractors shall select either “will” or “may”, depending on their business situation, in your finalized companion document.	X	X							X

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other A/B MAC
F I S S	M C S					V M S	C W F			
5334.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X							X

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2007 Implementation Date: January 2, 2007 Pre-Implementation Contact(s): Matt Klischer, 410-786-7488, matthew.klischer@cms.hhs.gov Post-Implementation Contact(s): Matt Klischer, 410-786-7488, matthew.klischer@cms.hhs.gov	No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.
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Attachment – 837 v. 4010A1 Inbound Institutional Claim Companion Document

**837 v. 4010A1 Inbound Institutional Claim
Companion Document**

ATTACHMENT

Description			Language	Page
General Statements				
			R	The maximum size for the fields containing number of days information (covered, lifetime reserve, etc.) in the Medicare system is four characters. Claims submitted with data that exceed will be returned to the provider (RTP'd) or will be errored back to the submitter by [contractor name] .
			R	The maximum size for dollar amount fields in the Medicare system is 10 characters. Claims submitted with dollar amounts in excess of 99,999,999.99 will be RTP'd or will be errored back to the submitter by [contractor name] .
			R	Claims submitted with attending, other, or operating physician UPIN data exceeding 6 positions will be RTP'd or will be errored back to the submitter by [contractor name] .
			R	Claims with external code set data that does not conform to the format requirements of the external code set maintainer will be RTP'd or will be errored back to the submitter by [contractor name] . Data elements referencing external code sets are limited to the size of the data as defined by the code set maintainer. For example, the element in the Implementation Guide designated for HCPCS information may contain up to 30 positions but the HCPCS external code list allows only 5 positions (claims with more than 5 positions of HCPCS data in this element would be RTP'd or will be errored back to the submitter by [contractor name]).
			R	The maximum size for the service unit count field in the Medicare system is 7 characters. Claims submitted with data that exceeds this limit will be RTP'd or will be errored back to the submitter by [contractor name] . Claims submitted with decimal data will be rounded to the closest whole number before being processed.
			R	The Medicare system does not process decimal points in diagnosis codes or ICD9-CM procedure codes. Medicare will strip out decimal points submitted in valid diagnosis before processing. Medicare will strip out decimal points submitted in valid procedure codes before processing.
			R	You may send as many diagnosis codes as allowed in the implementation guide. However, only the primary/principal and first 8 other diagnosis codes will be considered for adjudication and payment determination.
			R	Hospital other (14X) claims that lack diagnosis information when required for CMS adjudication (2300 HI Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information) will be RTP'd or will be errored back to the submitter by [contractor name] .
			R	Claims that lack a patient status code when required for CMS adjudication will be RTP'd or will be errored back to the submitter by [contractor name] .
			R	Claims that lack an admission source code when required for CMS adjudication will be RTP'd or will be errored back to the submitter by [contractor name] .
			R	Inpatient claims that lack HCPCS when required for CMS adjudication will be RTP'd or will be errored back to the submitter by [contractor name] .

**837 v. 4010A1 Inbound Institutional Claim
Companion Document**

ATTACHMENT

Description			Language	Page
		R	Medicare will process only HL structures as described in the implementation guide front matter (Billing Provider HL (parent) followed by the appropriate Subscriber HL (child)).	
		S	Since the date care starts is considered for billing purposes to be the date the beneficiary is admitted to Home Health Agency (HHA) care, HHAs must enter the Home Health Start of Care Date as Admission Date (2300 DTP Admission Date/Hour) for Medicare processing purposes. Any compliant time is acceptable in this field.	
		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	Only loops, segments, and data elements valid for the HIPAA Institutional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.	
		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.	
		R	You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Institutional 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 intermediary's translator.	
		R	<i>After May, 22, 2007</i> , the National Provider Identifier (NPI) must be submitted in <i>all NM109 data elements</i> (NM108 = XX) <i>where NM109 is required and in the Service Facility (2310E) NM109 if known.</i>	
		R	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 will result in rejection of the claim or the applicable interchange (transmission).	
		O	[Contractor name] [will/may] reject an interchange (transmission) submitted with more than 9,999 loops.	
		O	[Contractor name] will reject an interchange (transmission) submitted with more than 9,999 segments per loop.	
		O	[Contractor name] [will/may] reject an interchange (transmission) with more than [contractor supplies value] CLM segments (claims) submitted per transaction.	
		R/O	A. Compression of files is not supported for transmissions between the submitter and [Contractor name] -OR- B. Compression of files using [name of software] is supported for transmissions between the	

**837 v. 4010A1 Inbound Institutional Claim
Companion Document**

ATTACHMENT

Description			Language	Page	
			submitter and [Contractor name].		
		R/O	A. Only valid qualifiers for Medicare must be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing which are not defined for use in Medicare billing [will/may] cause the claim or the transaction to be rejected -OR- B. 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 [will/may] cause the claim to be rejected.		
		R	Do not use Credit/Debit card information to bill Medicare. Credit/Debit card information will be ignored.		
		O	[Contractor name] will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Institutional Implementation Guides. Claims submitted with invalid Medicare identifiers will be RTP'd or will be errored back to the submitter by [contractor name].		
Interchange Control Header					
	ISA05	Interchange ID Qualifier	O	[Contractor name] will reject an interchange (transmission) that does not contain [qualifier] in ISA05.	B.4
	ISA06	Interchange Sender ID	O	[Contractor name] will reject an interchange (transmission) that does not contain a valid ID in ISA06.	B.4
	ISA07	Interchange ID Qualifier	O	[Contractor name] will reject an interchange (transmission) that does not contain [qualifier] in ISA07.	B.4
	ISA08	Interchange Receiver ID	O	[Contractor name] will reject an interchange (transmission) that does not contain [intermediary code] in ISA08. Each individual Contractor determines this code.	B.5
Functional Group Header					
			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 only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).	
	GS03	Application Receiver's Code	O	[Contractor name] [will/may] reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the intermediary definition.	B.8
Loop	Transaction Set				
			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.	
	ST02	Transaction Control Set	O	[Contractor name] will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.	56
	BHT02	Transaction Set Purpose	O	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).	58

**837 v. 4010A1 Inbound Institutional Claim
Companion Document**

ATTACHMENT

Description				Language	Page
	BHT06	Claim/Encounter Identifier	O	[Contractor name] will accept and process transmissions with a Claim or Encounter Indicator (BHT06) of 'CH' (Chargeable). [Contractor name] will accept but will ignore a Claim or Encounter Indicator (BHT06) if 'RP' (Reporting) during adjudication.	59
	REF02	Transmission Type Identification	O	The 837 Institutional claim transaction will not be piloted. Claim files submitted with a Transmission Type Code value of 004010X098DA1 in REF02 [will/may] cause the file to be rejected.	60
1000A	NM109	Submitter ID	R	[Contractor name] will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.	63
1000B	NM103	Receiver Name	O	[Contractor name] [will/may] reject an interchange (transmission) that is not submitted with a valid intermediary name (NM1).	68
1000B	NM109	Receiver Primary Identifier	O	[Contractor name] [will/may] reject an interchange (transmission) that is not submitted with a valid intermediary code (NM1). Each individual Contractor determines this code.	68
2000A	PRV	<i>Billing/Pay-To Provider Specialty Information</i>	R	<i>Providers shall be in compliance with CR 5243: Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims</i>	<i>Addenda 12</i>
2000B	HL	Subscriber Hierarchical Level	O	The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.	99
2000B	SBR02, SBR09	Subscriber Information	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.	103
Loop	Claim Information				
2300	CLM02	Total Submitted Charges	R	Negative values submitted in CLM02 [will/may] not be processed and [will/may] result in the claim being rejected.	159
2300	CLM02	Total Submitted Charges	R	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV203).	159
2300	CLM20	Delay Reason Code	R	Data submitted in CLM20 will not be used for processing.	179
2300	HI	Health Care Diagnosis Code	R	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 will be rejected.	228
2410	LIN03	Drug Identification	R	The format for National Drug Codes (NDC) is 5-4-2 (11 positions). Claims that contain NDC codes in any other format will be rejected.	Addenda 37
997 - Functional Acknowledgement					
			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 -OR- 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.	B.15
			R/O	A. [Contractor name] will return the version of the 837 inbound transaction in GS08	

837 v. 4010A1 Inbound Institutional Claim
Companion Document

ATTACHMENT

Description				Language	Page
				(Version/Release/Industry Identifier Code) of the 997 -OR- B. [Contractor name] will return [X] as the version in GS08 (Version/Release/Industry Identifier Code) of the 997.	