1.1 837 Institutional (Part A) 5010 Expectations

The defined set of statements below supplements the X12N 837 Institutional Implementation Guide and clarifies our expectations regarding data submission, processing, and adjudication. 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 drug claims. The Implementation Guides for each X12N transaction are adopted as a HIPAA standard available electronically on the Washington Publishing Company (WPC) Web site.

The information is intended to serve only as a companion document to the HIPAA X12N 837 Institutional Claim Implementation Guide and the 5010 Companion Guides (JL) (JH). 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 Fiscal Intermediary Shared System (FISS) for Novitas Solutions, Inc. Part A workloads as follows:

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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 four characters will be returned to the provider (RTP'd) for correction or will error back to the submitter by Novitas Solutions, Inc.
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 error back to the submitter by Novitas Solutions, Inc.
The maximum number of Transaction Sets (ST/SE) within a file should be 10,000.
The maximum number of (CLM) segments within any Transaction Set (ST/SE) should be 5000.
Claims submitted with attending, other, or operating physician NPI data not 10 positions will be RTP'd or will error back to the submitter by Novitas Solutions, Inc.
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 error back to the submitter by Novitas Solutions, Inc.
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 TR3 designated for Healthcare Common Procedure Coding System (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 error back to the submitter by Novitas Solutions, Inc.
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 error back to the submitter by Novitas Solutions, Inc. Claims submitted with decimal data will be rounded to the closest whole number before being processed.
The maximum number of lines per claim is 449.
The Medicare system does not process decimal points in diagnosis codes or International Classification of Diseases, Ninth Revision/Tenth Revision, Clinical Modification (ICD-10-CM) procedure codes. Medicare will remove decimal points submitted in valid diagnosis before processing. Medicare will remove decimal points submitted in valid procedure codes before processing.
You may send up to 25 diagnosis codes per claim as allowed by the implementation guide. Please note the first diagnosis code that is reported will be used as the primary diagnosis code, all other codes will be considered for adjudication and payment determination.
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 error back to the submitter by Novitas Solutions, Inc.

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Claims that lack a patient status code when required for CMS adjudication will be RTP'd or will error back to the submitter by Novitas Solutions, Inc.
Claims that lack an admission source code when required for CMS adjudication will be RTP'd or will error back to the submitter by Novitas Solutions, Inc.
Inpatient claims that lack HCPCS when required for CMS adjudication will be RTP'd or will error back to the submitter by Novitas Solutions, Inc.
Medicare will process only hierarchical level (HL) structures as described in the implementation guide front matter (Billing Provider HL (parent) followed by the appropriate Subscriber HL (child)).
Novitas Solutions, Inc. 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 Institutional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide will cause files to be rejected.
You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 TR3. 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 MAC's translator.
Medicare does require taxonomy codes for providers who submit claims for the primary facility and its subparts (such as psychiatric units, rehabilitation units) in order to adjudicate claims. Taxonomy codes that are submitted must be valid against the taxonomy code set. Claims submitted with invalid taxonomy codes will be rejected.
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).
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.
Novitas Solutions, Inc. will reject an interchange (transmission) that uses the following character as a delimiter:' _ '.
Novitas Solutions, Inc. will reject an interchange (transmission) that uses the following character as a delimiter:' \ '.
Medicare 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.
Medicare will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.
Medicare will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.
A nine-digit Zip Code is required in 2010AA N4 (Billing Provider Address), and 2310E (Facility Address)
The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.
For Medicare, the subscriber is always the same as the patient. (SBR02=18, SBR09= MA)
Negative values submitted in CLM02 will not be processed and will result in the claim being rejected.
Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV203).
Data submitted in CLM20 (Delay Reason Code) will not be used for processing.
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.
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. If the NDC format is 4-4-2, such as 1234-5678-90, a zero is added to the first part making the 5-4-2 form 01234-

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5678-90. If the NDC format is 5-3-2, such as 12345-678-90, a zero is added to the second part making the 5-4-2 form 12345-0678-90. If the NDC format is 5-4-1, such as 10234-5678-9, a zero is added to the third part making the 5-4-2 form 10234-5678-09. Remove the dashes when reporting the NDC number.
The National Provider Identifier (NPI) must be submitted in the NM109 segment with the XX qualifier in the NM108 in the following loops: 2010AA Billing Provider; 2310A Attending Physician; 2310B Operating Physician; 2310C Other Operating Physician; 2310E Service Facility; 2330C Other Payer Attending Provider; 2330D-Other Payer Operating Provider; 2330E-Other Payer Other Operating Physician; 2330F Other Payer Service Facility; 2420A Operating Physician; 2420B Other Operating Physician.

- If individual consideration should be given to certain procedures due to unusual circumstances, these circumstances should be reported in the extra narrative segment.

- Ineligible services should not be reported.

Chart Key:

R Required – Any data element that is needed in order to process a claim (e.g., date of service).

S Situational – Any data element that must be completed if other conditions exist (e.g., if the insured differs from the patient, the insured's name must be entered on the claim).

† If Medicare secondary payer or Medigap is involved, please refer to the X12N 5010 Institutional TR3 for further instruction.

* Use if different than information given at the claim level. Segments submitted at the claim level apply to the entire claim unless overridden by information at the service line level.

Envelope Control / Reference Number Matching for Version 5010 Claim Transitions

With the implementation of Accredited Standards Committee (ASC) X12 Version 5010 transactions for acknowledgements (TA1, 999, and 277CA), Medicare Fee-for-Service is recommending the use of unique numbering for several enveloping control / reference numbers built into the Version 5010 claims transitions. Using unique numbering for the ISA13, ST02, and BHT03 data elements on the inbound 837 Institutional and Professional claims will allow Medicare trading partners to easily match submitted claims with the acknowledgement transactions.

Examples of those pairing include:

- 837 ISA13 is mapped to the TA1 response transaction and located in the TA101 data element
  - The implementation guide for the TA1 (ASC X12 TA1 TR3) states for TA101: "This is the value in ISA13 from the interchange to which this TA1 is responding."
- 837 ST02 is mapped to the 999 response in the 2000.AK202 data element

- The implementation guide for the 999 (ASC X12 999 TR3) states for AK202: "Use the value in ST02 from the transaction set to which this 999 transaction set is responding."

- 837 BHT03 is mapped to the 277CA response in the 2200B.TRN02 data element
  - The implementation guide for the 277CA (ASC X12 277CA TR3) states for TRN02: "This element contains the value submitted in the BHT03 data element from the 837."

Billing Requirements – Part A

Loop	Segment	Data Element Description	Status	Requirements
	GS01	Functional ID Code	R	Enter HC
	GS02	Applications Sender's Code	R	Enter the submitter ID provided to you by EDI Services during the EDI Enrollment process.
	GS03	Applications Receiver's Code	R	Enter contractor ID for your locale. Refer to the Novitas Contractor ID/Payer ID Codes.
	GS04	Date	R	Enter CCYYMMDD format per the TR3.
	GS05	Time	R	Novitas Solutions, Inc. will accept HHMM as a minimum.
	GS06	Group Control Number	R	Assigned by provider and must be unique for each file created.
2000B 2320	SBR02 SBR02	Individual Relationship Code	S S	Required when subscriber is the same as the patient. Must=Self (18) Required if any other payers are known to potentially be involved in paying this claim.
2010AA or 2010AB *	NM109 (XX)	Provider Medicare Number	R	Enter the 10 byte National Provider Identifier Number (NPI) for the performing provider of service/supplies.
2010AA or 2010AB *	NM103, 04, 05 (85, 87)	Provider Last, First, Middle Initial or Organizational Name	R	Enter the provider of service/supplier's billing name, address, zip code and telephone number. **The 2010AA cannot contain a P.O. Box address.**
2010AA or 2010AB	N301	Provider's Address 1 Provider's City, State, Zip Code	R S	

Loop	Segment	Data Element Description	Status	Requirements
2010AA	N4 PER04	Provider's Phone Number		Enter the provider of service/supplier's telephone number.
2010BA	N3 N4	Subscriber Address Line Subscriber City State, Zip Code	R R	Enter the patient's mailing address.
2010BA	NM109	Subscriber Primary Identifier	S	Required for Medicare Enter the patient's Medicare Beneficiary Identifier (MBI) whether Medicare is Primary or Secondary. For Medicare, the patient is always the subscriber. Identification Qualifier Code (NM108) = Member Identification Number (MI)
2010BB	NM109	Payer Identifier	R	NM109 will equal the contractor ID number. Refer to the Novitas Contractor ID/Payer ID Codes for the appropriate Part A contractor ID for your locale.
2300 or 2400	NTE02	Extra Narrative Data	S	Note Segment for additional comments. If used, claim will be manually reviewed.
2300	REF02 (P4)	Demonstration Project Identifier	S	
2300	HI01-02 (ABK) HI02-02 (ABF) HI03-02 (ABF) HI04-02 (ABF)	Principal Diagnosis Code Diagnosis Code Diagnosis Code Diagnosis Code	S S S S	Required on all claims except claims for which there are no diagnosis. Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed. Enter the patient's diagnosis/condition. All physician specialties must use an ICD-10-CM code number and code to the highest level of specificity. Enter up to twenty-five codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.
2300	HI01-02 (BE)	Value Code	S	Required when there is a value code that applies to this claim. For Medicare secondary claims, report the appropriate value code identifying why Medicare is secondary.

Loop	Segment	Data Element Description	Status	Requirements
2300	HI01-02 (BH)	Occurrence Code	S	Required when there is an occurrence code that applies to this claim.
2300	REF02 (G1)	Prior Authorization or Referral Number	S	Enter the Professional Review Organization (PRO) prior authorization number for those procedures requiring PRO prior approval. Only bill one unique PRO number per claim.
2300	REF02 (LX)	Investigational Device Exemption Number	S	Required when the claim involves a Food and Drug Administration (FDA) assigned investigational device exemption (IDE) number.
2300	CLM05-1	Facility Type Code	R	Enter the appropriate place of service code. Identify the location, using a place of service code, for each item used or service performed.
2300	CLM05-3	Claim Frequency Code	R	Initial claims will be reported with a value of "1." If the code is reported as a "7" replacement of prior claim or "8" corrected claim, the original claim number must be reported in the 2300 REF with an F8 qualifier
2300	CLM07	Medicare Assignment Code	R	A=Assigned B=Assignment accepted on Clinical Lab services only C=Not assigned P=Patient refuses to assign benefits
2300	CLM02	Total Claim Charge Amount	R	Enter total charges for the services.
2310A	NM103 (DN) NM104 NM105 NM109	Attending Provider Last Name Attending Provider First Name Attending Provider Middle Name Attending Provider Identification Code	S S S S	Required when the claim contains any service other than non-scheduled transportation claims. Enter the NPI of the attending physician.
2400	PS101	Purchased (Professional) Service Provider	S	State specific provider number of entity performing the purchased test.

Loop	Segment	Data Element Description	Status	Requirements
		Identifier		
2310E	NM103	Service Facility Location	S	Required when the location of health care service is different than that carried in the Billing Provider Name (2010AA).
	N3,N4	Service Facility Address	S	
	NM109	Service Facility Location NPI	S	Enter the NPI of the service facility location.
2320	SBR03	Insured Group or Policy Number	S	Required if other payers are known to potentially be involved in paying this claim. If there is insurance primary to Medicare, enter the policy or group number of the insured.
2330A	NM109	Other Insured Identifier	S	
2320	SBR04	Other Insured Group Name	S	Enter the complete insurance plan or program name.
2330A	NM103	Other Insured Last Name	S	List the name of the insured if there is insurance primary to Medicare. Leave blank if Medicare is primary.
2330A	NM104	Other Insured First Name	S	
	NM105	Other Insured Middle Name	S	
2330A	N3	Other Insured Address Line	S	Required if any other payers are known to potentially be involved in paying this claim and the information is available. Enter the mailing address of the insured.
	N4	Other Insured City, State and Zip Code	S	
2330A	NM103	Other Insured Last Name	S	Required if enrolled in a Medigap policy. Enter the name of the enrollee in the Medigap policy.
	NM104	Other Insured First Name	S	
	NM105	Other Insured Middle Name	S	
2330A	NM109	Other Insured Identifier	S	Enter the policy and/or group number of the Medigap insured. Required if other payers are known to potentially be involved in paying this

Loop	Segment	Data Element Description	Status	Requirements
2320	SBR03	Insured Group or Policy Number	S	claim.
2330A	NM109	Medicaid Identification Number	S	Enter the patient's Medicaid number if patient is entitled to Medicaid.
2330B	NM109	Other Payer Primary Identifier	S	Enter the Medigap insurer's unique identifier provided by the local Medicare carrier and the name of the Medigap enrollee's insurance.
2320	SBR04	Other Insured Group Name	S	Required if other payers are known to potentially be involved in paying this claim.
2400	SV202-3 SV202-4 SV202-5 SV202-6	Procedure Modifier 1-4	S	Modifiers are required when they clarify/improve the reporting accuracy of the associated procedure codes. The Medicare Part A processing system you send your claims to may only use the first two modifiers for adjudication and payment determination of claims.
	SV202-7	Description of Service		Required when SV202-2 is a non-specific Procedure Code. Non-specific codes may include in their descriptors terms such as: Not Otherwise Classified (NOC); Unlisted; Unspecified; Unclassified; Other; Miscellaneous; Prescription Drug, Generic; or Prescription Drug, Brand Name.
2400	SV203	Line Item Charge Amount	R	Enter the charge for each service.
2400	SV204 (UN,DA)	Units of Service	R	Enter the number of days or units. If a decimal is needed to report units, include it in this element, e.g. 15.6.

1.2 835 (Electronic Remittance Advice (ERA)) 5010 Expectations

The defined set of statements below supplements the ANSI ASC X12N 835 5010 Technical Report Type 3 (TR3) and clarifies additional information regarding remittance transactions. The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, 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 TR3s for each X12N transaction are adopted as a HIPAA standard available electronically on the Washington Publishing Company (WPC) Web site.

Reason and Remark Codes

Reason Codes are maintained by the Blue Cross Blue Shield Association in the Joint Claim Adjustment/Claim Status Reason Code Maintenance Committee and Remark Codes are maintained by Centers for Medicare & Medicaid Services (CMS). Reason and Remark Codes are only available on the Washington Publishing Company (WPC) Web site.

Part A JL and JH Customers: Roll-Up Contractor ID Number Returned in 835 ERA File

For Part A customers notated in the charts below who are enrolled for Electronic Remittance Advice (ERA), a roll-up contractor ID number will be returned in the ANSI ASC X12N 835 ERA file. Below is a crosswalk of the contractor ID numbers that will be returned in the 835 file as a roll-up contractor ID number.

JL Part A Locale	JL Contractor ID	JL Roll-Up Contractor ID
DC	12201	12001
Maryland	12301	12001
New Jersey	12401	12001
Pennsylvania	12501	12001

JH Part A Locale	JH Contractor ID	JH Roll-Up Contractor ID
Arkansas	07101	07001
Louisiana	07201	07001
Mississippi	07301	07001
Colorado	04111	04011
New Mexico	04211	04011
Texas	04411	04011
Indian Health Service/Tribal Organizations	04411	04011
Veteran Affairs	04411	04011

Missing Claim Forward Information

Directions provided in the 835 TR3 document state that if the 2100 CLP02 does not equal 19, 20, 21, or 23, the 2100 NM1 Crossover Carrier Name is suppressed. This does not mean that your claims did not cross over; it just does not provide who they were crossed over to.

1.3 276/277 5010 Expectations

Novitas Solutions, Inc. will process your request for claim status information via batch Central Processing Unit to Central Processing Unit (CPU to CPU).

The 276 transaction must utilize delimiters as defined in the standard. The delimiters selected must not occur in the transmitted data elements. The delimiters used in a 277 response or in an acknowledgment may not necessarily be the same as the delimiters submitted in the original 276 request transaction.

Multiple functional groups (GS to GE segments) can be sent in one interchange (ISA to IEA segments). Multiple 276s or 277s (ST through SE) can be included in a single functional group.

Upon receipt of your 276, we will generate the following:

- TA1 or local reject report for interchange control errors immediately after the transmission.
- 999 for syntax errors immediately after the transmission. A 999 will not be sent for an accepted 276, the 277 will be the response for an accepted 276.
- 277 will be available 24 hours after the acceptance of the 276.

Novitas Solutions, Inc. will process your 276 as identified in the TR3 and create a 277 as identified in the TR3. At least the minimum response data will be sent.

All alphabetic characters in the 277 transaction will be upper case. If lower case characters are included in the 276 request, they will be converted to upper case for data storage and return processing purposes.

The following indicates those segments or data elements in the X12N 276/277 Version TR3 version 5010 that allow Medicare to specify its business requirements.

276 Request Transaction - Part A

Data Segment Name	Segment or Data Element	Supported Value(s)	Requirement
Payer Name	NM108	PI	Submitter uses the code "PI" to identify that the contractor identifier will follow.
Payer Name	NM109		Submitter uses the contractor ID. Refer to the Novitas Contractor ID/Payer ID Codes for the appropriate Part A contractor ID for your locale.
Information Receiver Name	NM108	46	This is the individual or organization requesting to receive the status information.
Information Receiver Name	NM109		Submitter uses contractor ID. Refer to the Novitas Contractor ID/Payer ID Codes for the

Data Segment Name	Segment or Data Element	Supported Value(s)	Requirement
			appropriate Part A contractor ID for your locale.
Provider Name	NM108	XX	Submitter uses the “XX” qualifier for the National Provider Identifier (NPI) in NM109.
Provider Name	NM109		Submitter enters the National Provider Identifier (NPI).
Subscriber Name	NM108	MI	Submitter uses the “MI” qualifier for the patient's Medicare ID number entered in NM109.
Subscriber Name	NM109		Submitter enters the patient's Medicare ID number.

277 Response Transaction – Part A

Data Segment Name	Segment or Data Element	Supported Value(s)	Requirement
Payer Name	NM108	PI	Medicare enters the “PI” qualifier for NM109.
Payer Name	NM109		Medicare enters contractor identification number. Refer to the Novitas Contractor ID/Payer ID Codes for the appropriate Part A contractor ID for your locale.

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