

X12N July
Transaction
User Guide 2009

EDI SERVICES

(501) 378-2419

(866) 582-3247

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Introduction

Welcome to the world of Electronic Data Interchange!

Electronic Data Interchange will save you time and money, and will help you better manage your business. The X12N Transaction User Guide provides you with information regarding the following HIPAA standard electronic transactions in the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N:

- q Health Care Claim Professional: ANSI ASC X12N 837 Professional Format Version 004010X098A1
- q Health Care Claim Institutional (**Arkansas only**): ANSI ASC X12N 837 Institutional Format Version 004010X096A1
- q Health Care Functional Acknowledgement: ANSI ASC X12N 997 Version 004010X096A1 (**Arkansas only**)
- q Health Care Functional Acknowledgement: ANSI ASC X12N 997 Version 004010X098A1
- q Health Care Claim Payment Advice: ANSI ASC X12N 835 Version 004010X091A1
- q Health Care Eligibility Benefit Inquiry and Response: ANSI ASC X12N 270 (Inquiry) and 271 (Response) Version 004010X092A1*
- q Health Care Claim Status Request and Response: ANSI ASC X12N 276 (Request) and 277 (Response) Version 004010X093A1*

*This document will be updated to include information for each new HIPAA X12N Implementation Guide transaction once the transaction has been implemented.

Benefits of Electronic Data Interchange

- q Eliminates Submitting Paper Claims – Electronic Data Interchange, or submitting claims electronically, eliminates paperwork so your office staff can accomplish more in less time. Eliminating paper claims means you will also save money on postage and claim forms.
- q Accurate Payment – Electronic Data Interchange reduces errors, so your claims process more accurately and consistently.
- q Improved Cash Flow – Beyond saving time and money for your office, electronic claim submission insures payment to you faster. Paper claims require a week or more of handling and administrative work prior to processing. Medicare and Private Business claims submitted via Electronic Data Interchange may be accepted into our processing system in as little as 24 hours. Faster receipt of your claims means faster payment to you.
- q Flexibility – With Electronic Data Interchange, you control the frequency and volume of claims submission. You can also submit claims for several practitioners at one time.
- q Electronic Reports for Better Business Management – Several reports are available only to electronic billers. The X12N 997 Functional Acknowledgement confirms that we received your submission. The Batch Processing Report and the MCS Pre-pass Error Report (Medicare Part B only) summarizes the claim information you sent to us electronically. Also available is the X12N 835 daily Electronic Remittance Advice (ERA), which provides payment information including check numbers, check dates and patient control numbers.
- q Support Personnel – EDI Services is a department dedicated to supporting our electronic claim submitters. We provide information about electronic billing and offer support to all electronic billers in the testing and production process.

EDI Submission via X12N Format

Electronic Data Interchange is an efficient, direct, intelligent solution for billing your claims. Claims can be electronically submitted in the 837 transaction format using direct modem submission to the NetX Gateway. You can use a billing agent or clearinghouse, of your choice, to submit your electronic transactions for you. If you choose to use a billing agent or clearinghouse to submit your electronic transactions, you will not be assigned a login ID and password unless you have a business need for one.

Modem Submission

Your office must have five items to be capable of submitting claims electronically: a computer, a modem, a software program that has the option of electronic data interchange to Medicare and/or Private Business, a printer and telecommunications package. Additionally, a dedicated telephone line for your modem is strongly recommended.

A telecommunication package supported by EDI Services is Hyperterminal. Other telecommunication packages are not supported by EDI Services.

The NetX Gateway submission system can interface using Asynchronous dial up communications with protocols of X, Y, Z, Kermit and FTP.

We support speeds of 28,800 BPS, and 56K for asynchronous transmissions.

Communication line set up between computer and modem includes the following for asynchronous transmission:

28,800 BPS, and 56K

2 – Two start bits

1 – One stop bit

8 – Eight data bits

N – No parity

Full duplex should be implemented to allow data to be sent in both directions at the same time.

Emulation – VT100 or VT100J

System Operation Hours

The NetX Gateway is accessible 24 hours a day, 7 days a week. The system also allows for multiple transmissions within one day, simply by assigning a unique submission number to each transmission. Your vendor/programmer can explain how this is done.

EDI Enrollment Procedures

The first step in becoming an electronic biller is to complete the Electronic Data Interchange (EDI) Trading Partner Agreement packet and EDI Enrollment Form. If you need assistance, please contact EDI Services at 501-378-2419 or toll free at 866-582-3247 for additional information about the EDI Enrollment Procedures. Please refer to the HIPAA Checklist on pages 81 through 82 for additional information about EDI Enrollment and HIPAA testing.

Modem Submitter Enrollment Procedures (Direct Submissions to the NetX Gateway)

Upon receipt of the completed Electronic Data Interchange (EDI) Trading Partner Agreement packet and EDI Enrollment Form, if applicable, EDI Services will assign you a Submitter ID number, User ID, and initial password, which must be changed on your first login attempt and you, will be authorized to transmit via a modem. Subsequent passwords, unique and meaningful only to you, are selected by you. The password must be eight characters in length, and may contain letters and/or numbers. Special characters, such as commas, periods, or hyphens are not acceptable.

If a password change attempt is unsuccessful, please contact EDI Services at (501) 378-2419 or toll free at (866) 582-3247.

SUBMITTER ID NUMBERS AND PASSWORDS

PROVIDERS THAT ENROLL WITH EDI SERVICES WILL BE ASSIGNED A SUBMITTER ID NUMBER, USER ID AND INITIAL PASSWORD. INITIAL PASSWORDS MUST BE CHANGED UPON THE FIRST LOGIN ATTEMPT.

PROVIDERS ARE NOT PERMITTED TO SHARE THEIR PERSONAL EDI SUBMITTER ID NUMBER, USER ID, AND PASSWORD WITH:

- ANY BILLING AGENT
- CLEARINGHOUSE / NETWORK SERVICE VENDOR

- ANYONE ON THEIR OWN STAFF WHO DOES NOT NEED TO SEE THE DATA FOR COMPLETION OF A VALID ELECTRONIC CLAIM, TO PROCESS A REMITTANCE ADVICE FOR A CLAIM, TO VERIFY BENEFICIARY ELIGIBILITY OR TO DETERMINE THE STATUS OF A CLAIM
- NO OTHER NON-STAFF INDIVIDUALS
- OTHER ENTITIES

A PROVIDER'S EDI SUBMITTER ID NUMBER AND PASSWORD SERVE AS A PROVIDER'S ELECTRONIC SIGNATURE AND THE PROVIDER WOULD BE LIABLE IF ANY ENTITY WITH WHICH THE PROVIDER IMPROPERLY SHARED THE SUBMITTER ID NUMBER AND PASSWORD PERFORMED AN ILLEGAL ACTION WHILE USING THAT SUBMITTER ID NUMBER AND PASSWORD. A PROVIDER'S EDI SUBMITTER ID NUMBER AND PASSWORD ARE NOT PART OF THE CAPITAL PROPERTY OF THE PROVIDER'S OPERATION, AND MAY NOT BE GIVEN TO A NEW OWNER OF THE PROVIDER'S OPERATION. A NEW OWNER MUST OBTAIN THEIR OWN EDI SUBMITTER ID NUMBER AND PASSWORD.

PROVIDERS THAT CONTACT A CONTRACTOR TO SUBMIT AND/OR RECEIVE TRANSACTIONS ELECTRONICALLY USING A BILLING AGENT AND/OR CLEARINGHOUSE/NETWORK SERVICE VENDOR, ARE REQUIRED TO HAVE AN AGREEMENT SIGNED BY THAT THIRD PARTY IN WHICH THE THIRD PARTY HAS AGREED TO MEET THE SAME MEDICARE SECURITY AND PRIVACY REQUIREMENTS THAT APPLY TO THE PROVIDER IN REGARD TO VIEWING OR USE OF MEDICARE BENEFICIARY DATA.

CLEARINGHOUSE AND THIRD PARTY REPRESENTATIVES MUST OBTAIN AND USE THEIR OWN UNIQUE EDI SUBMITTER ID NUMBER, USER ID, AND PASSWORD FROM MEDICARE CONTRACTORS TO WHOM THEY WILL SEND OR FROM WHOM THEY WILL RECEIVE EDI TRANSACTIONS.

Transmission Menu Screen for X12N Users (Menu-Driven Access – Asynchronous)

For asynchronous communication, the following steps will provide the method of access to the modem network. Please use the login ID and password that was assigned to you.

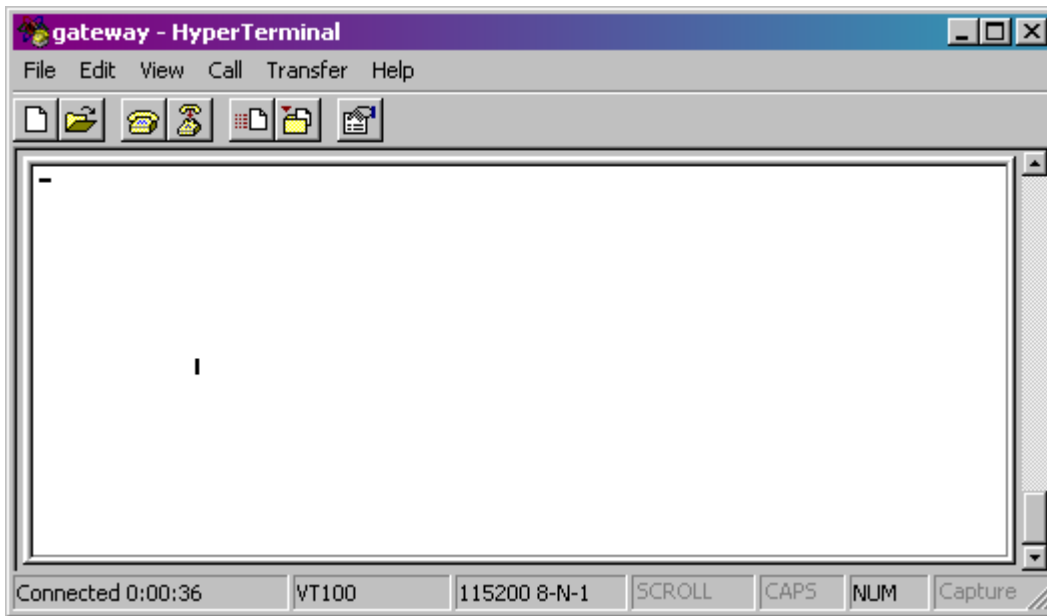
Passwords are case sensitive. The first time password will be a default password and must be entered in upper case. Additional password changes are also case sensitive. They can be upper case, lower case or a combination of both. They can contain numbers, letters or both, but not special characters. Once you have changed your password on the NetX Gateway, you must enter your password exactly for future logins. Your password will change every 30 days.

PLEASE WRITE YOUR PASSWORD DOWN UPON YOUR FIRST LOGIN.

It is your sole responsibility to keep a record of your password. EDI Services will not have access to your password once you have changed it and EDI Services will not be able to identify your password once you have changed it. If you have lost your password, please call EDI Services at (501) 378-2419 or toll free at (866) 582-3247.

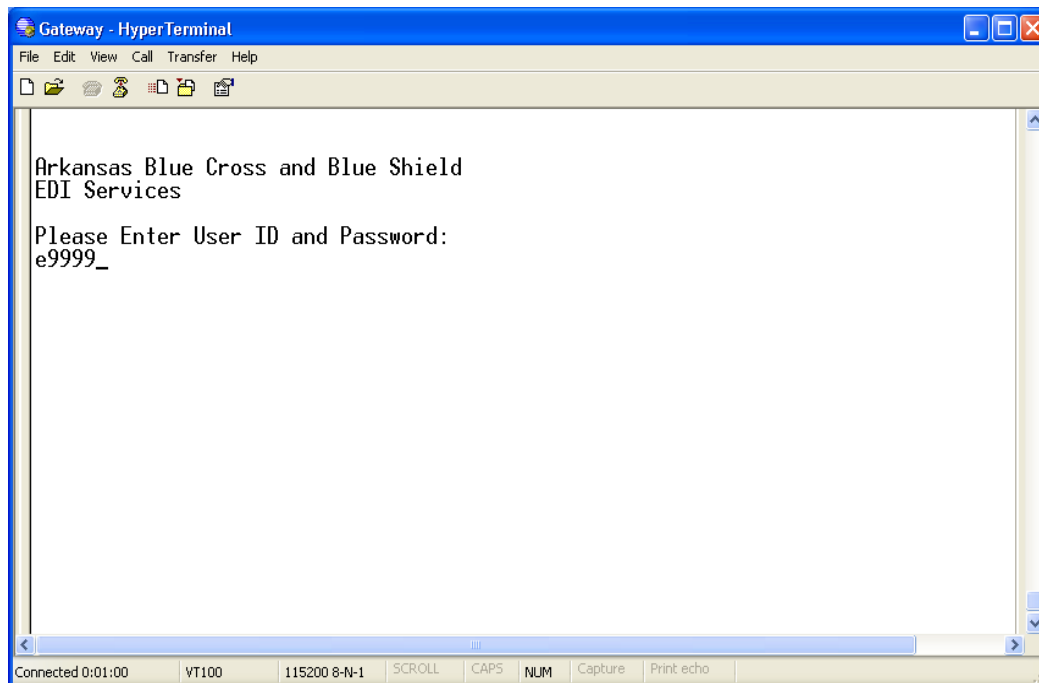
The following pages contain instructions and illustrations to accessing the NetX Gateway using telecommunications package, Hyperterminal.

Once connection has been established, you will get a blank screen. Hit the enter key to display the command prompts.



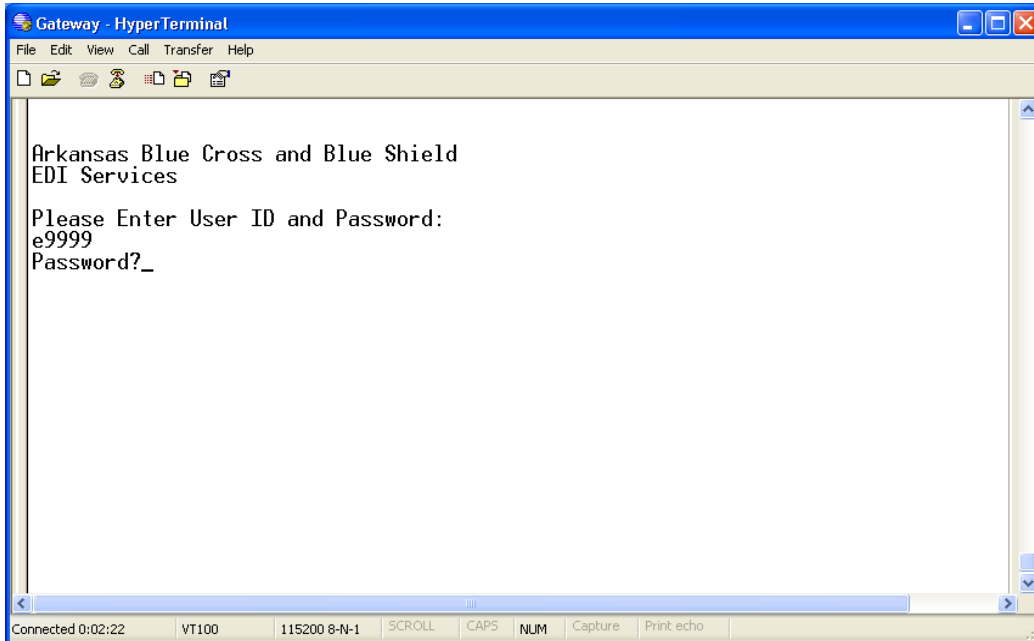
At the "Please Enter User ID and Password", enter the login ID assigned to you by EDI Services and hit the enter key.

NOTE: The login ID must be entered in lowercase.

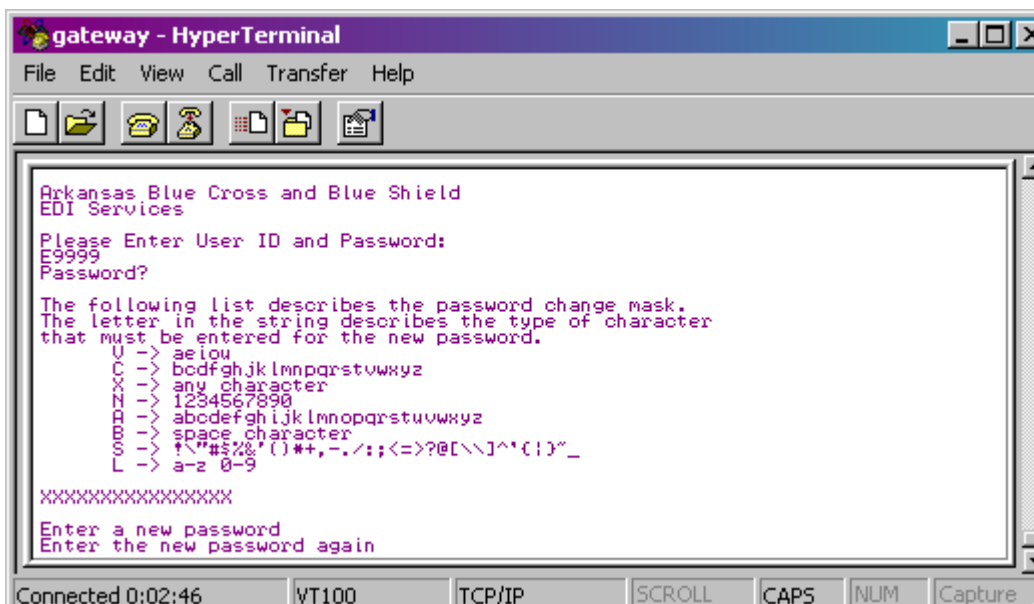


You are now prompted to enter the default password and then hit the enter key. Please remember the password is case sensitive and must be entered in uppercase.

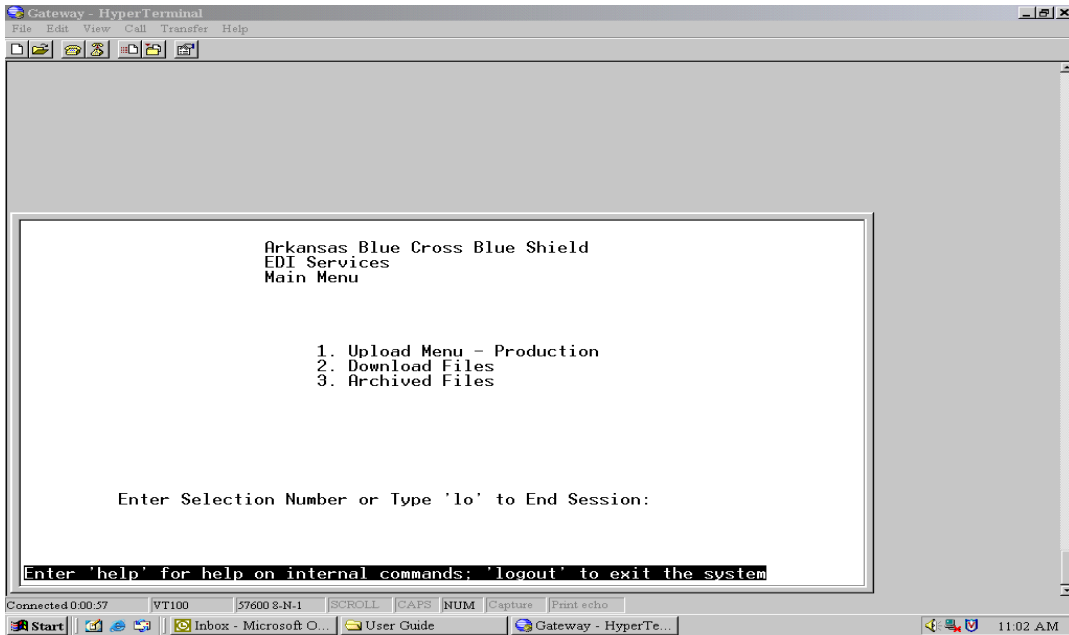
NOTE: Please call EDI Services at (866) 582-3247 or (501) 378-2419 to get the default password for accessing the NetX Gateway.



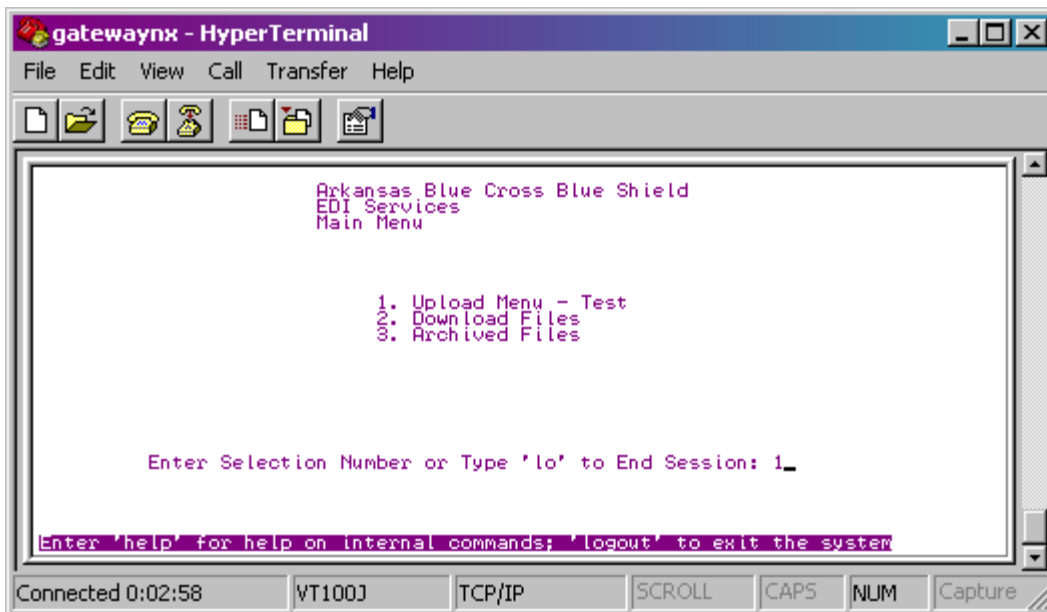
You will now be prompted to change your password. The password must be 8 characters long and passwords are case sensitive. It can be uppercase, lowercase or a combination of both, but no special characters may be used. Enter your new password and hit enter. Then re-enter your new password for verification and hit enter again.



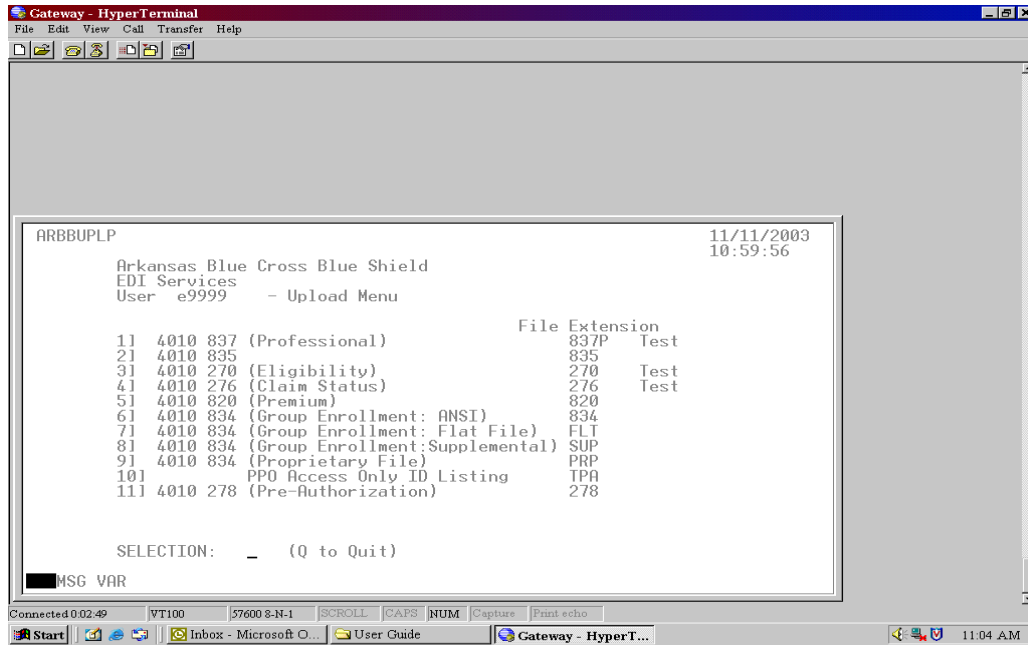
You are now at the Main Menu screen.



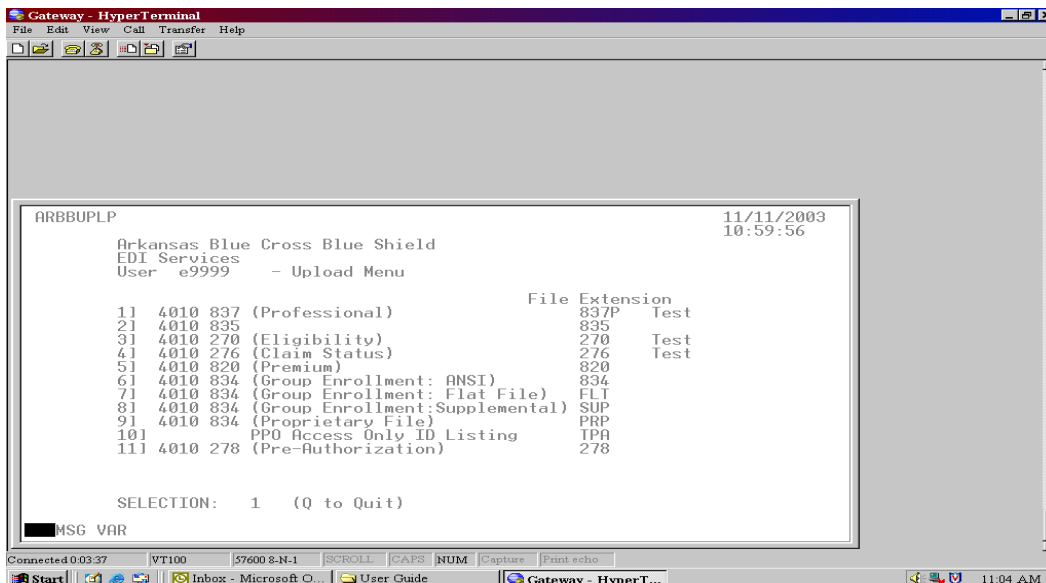
At the Main Menu screen, select either option 1 to upload a file, option 2 to download a file or option 3 to go to the archived files and hit the enter key.



This is an example of the Upload screen. Each user's screen will vary based on permissions.

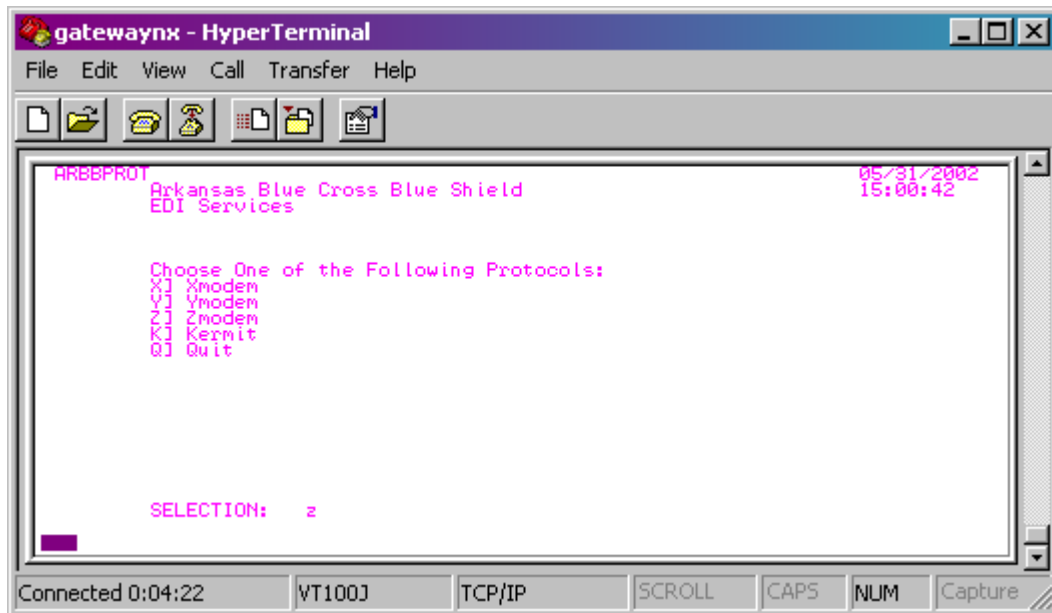


At the Upload Menu screen, select the appropriate option for the transaction you will be submitting and hit the enter key.

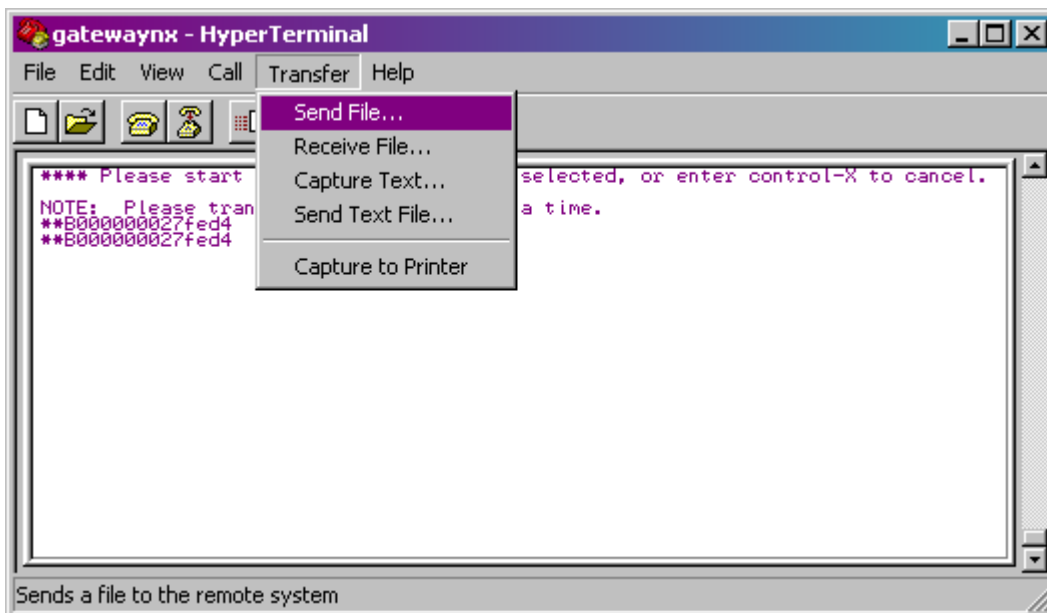


You will now choose a protocol from the list and enter at the selection prompt. Then hit the enter key.

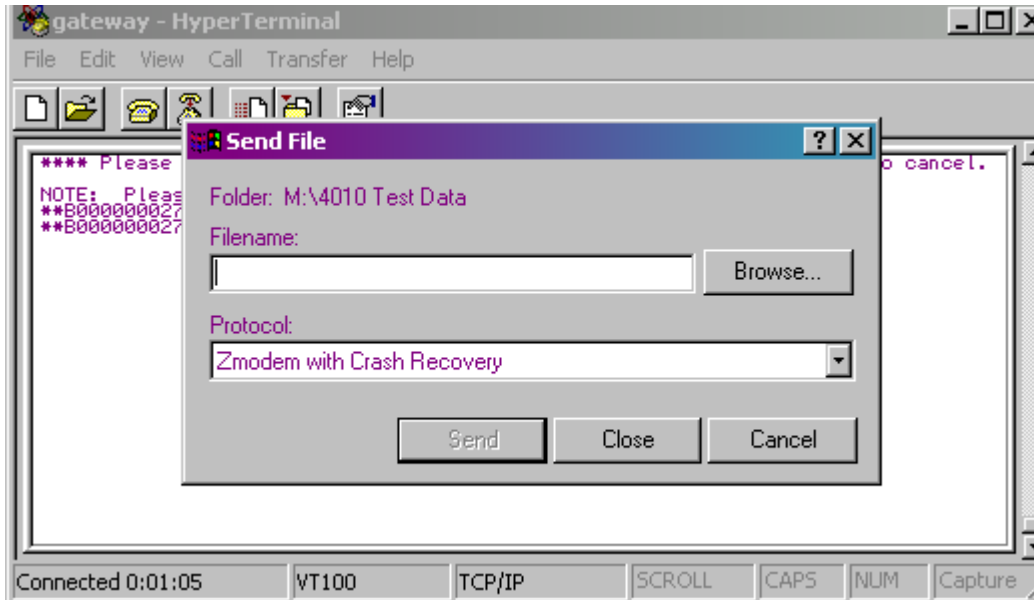
Note: We recommend using Zmodem.



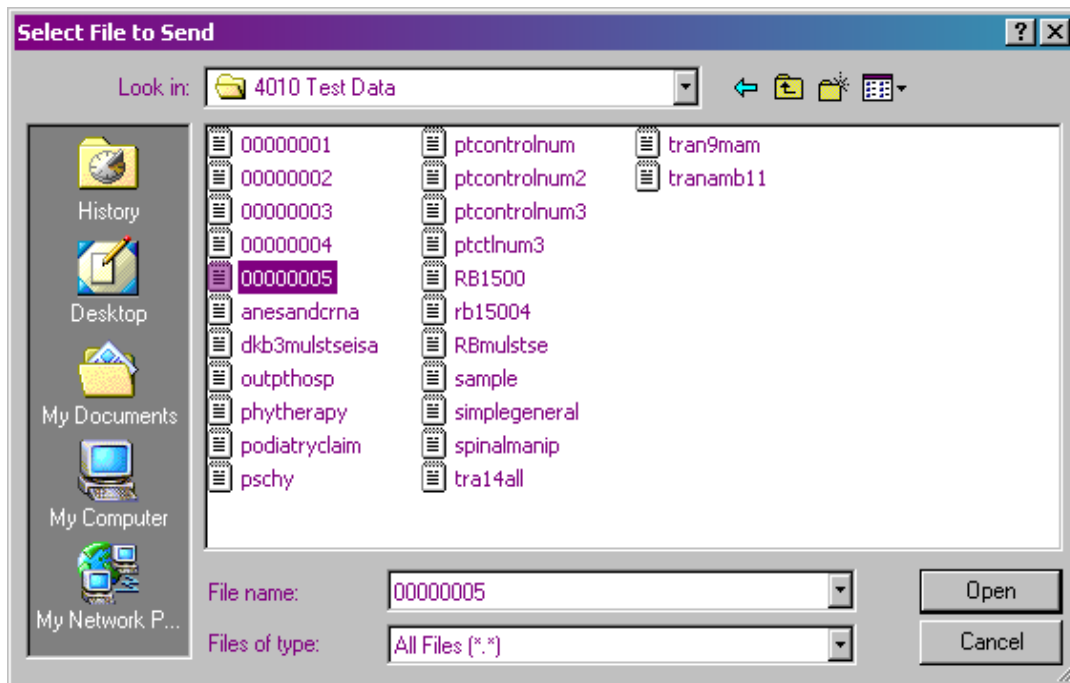
You will now go to Transfer on the tool bar and select Send File.



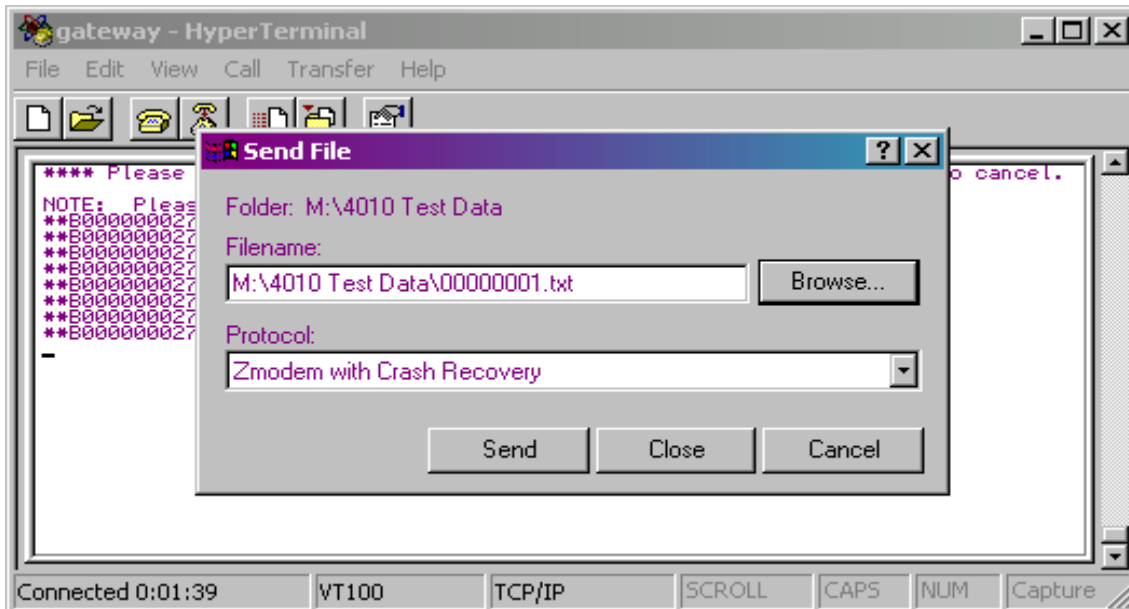
You will now enter the path of the file or select browse to search for the file on your system.



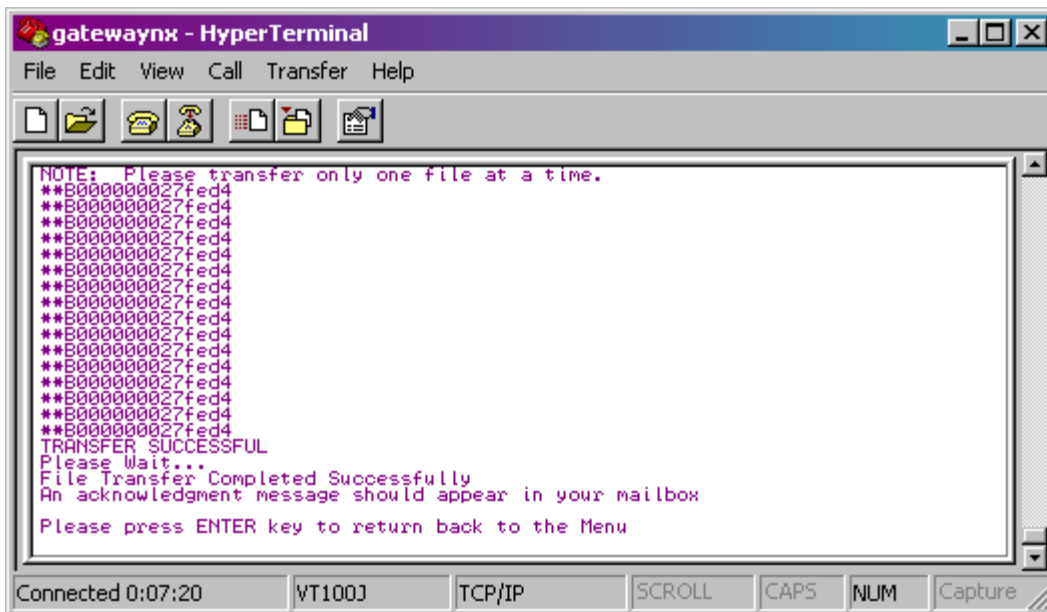
If you choose a filename or browse for your file, you will then select the file to transmit and then click Open.



The path of the file you have browsed for will now show in the Filename box. Click on the Send button. You must send only one file at a time. You will need to repeat the Transfer steps for each additional file.

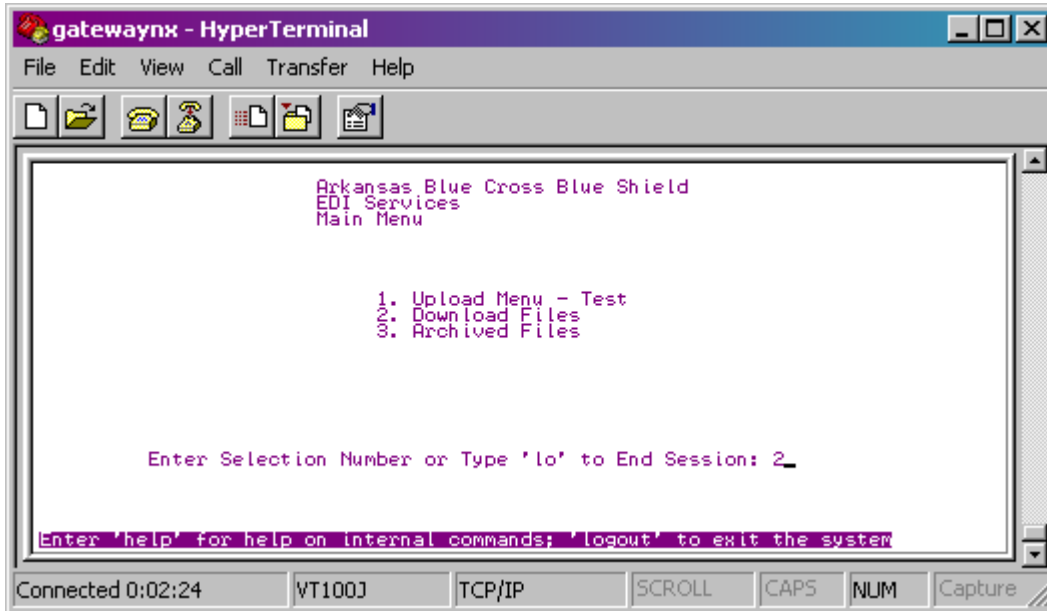


You will now get a File Transfer Completed Successfully message on your screen. Press the enter key to return to the Main Menu screen.



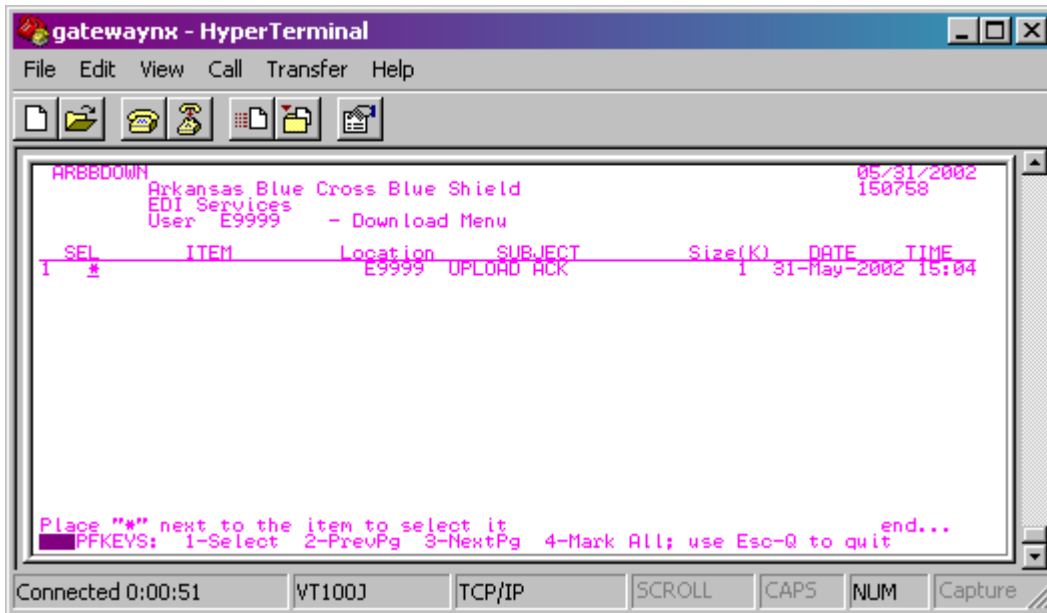
Once at the Main Menu screen, select option 2 to download reports and then hit the enter key.

Note: The cap lock should not be used when downloading your reports. Make sure the cap lock is turned off.



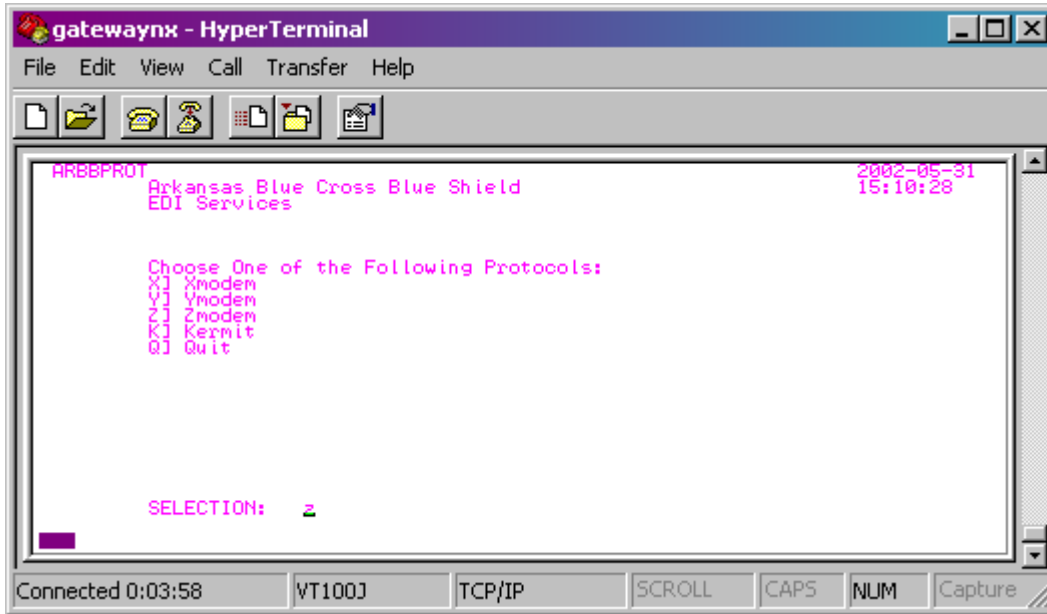
You will now be at the Download Menu screen. This screen is where your upload acknowledgment can be downloaded to verify if your transaction was received. Key an asterisk next to the report you want to download.

Note: If you have multiple upload acknowledgment reports on this screen and if you do not want all of the reports, press your space bar to skip over the reports you do not want.

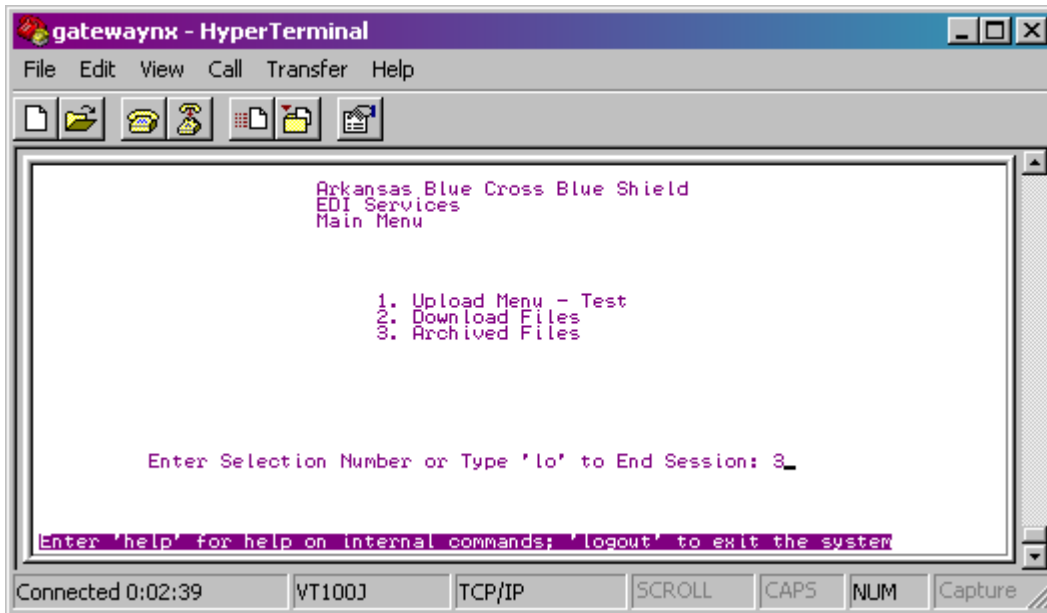


You will now choose the protocol and enter at the selection prompt. Then hit the enter key. After the report has downloaded, you must enter Esc-Q simultaneously to return to the Main Menu screen.

Note: Selecting Zmodem will automatically download multiple reports. If you have chosen a different protocol, you will have to go to Transfer on the tool bar, select Receive File and then rename the file on your system. Once you have downloaded your report, it will be moved to the Archived screen. The reports will remain in archive for 14 days.



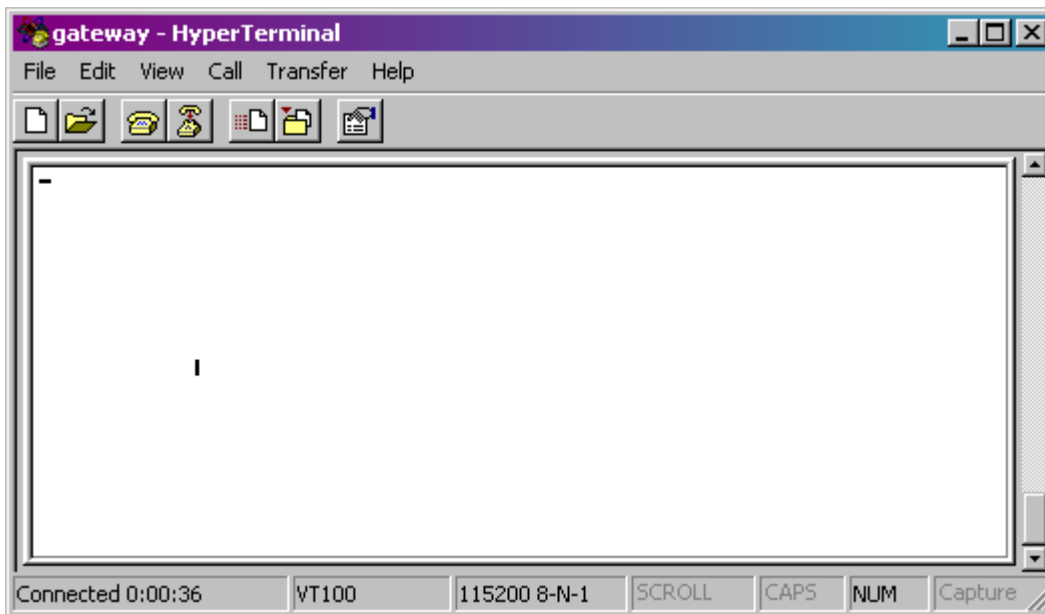
The next few screens demonstrate how to retrieve archived reports that you have already downloaded previously. At the Main Menu screen select option 3 and hit the enter key.



Changing Your Password

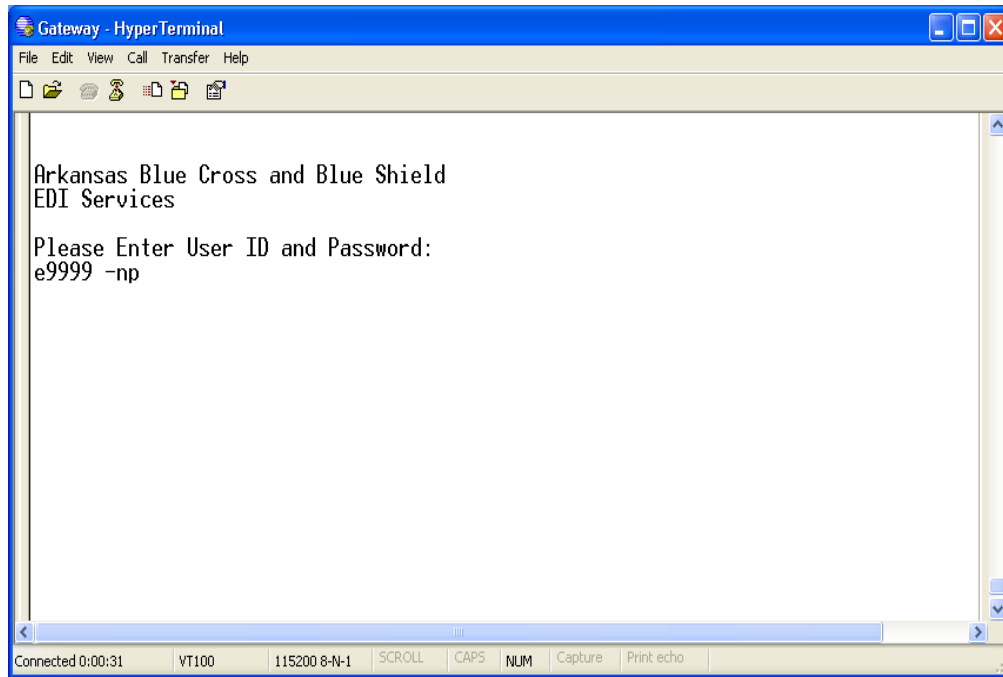
Users will be prompted to change their passwords every 30 days. However, users have the ability to change their passwords at anytime. The next few pages are step-by-step instructions for changing your password.

Once connection has been established, you will get a blank screen. Hit the enter key to display the command prompts.

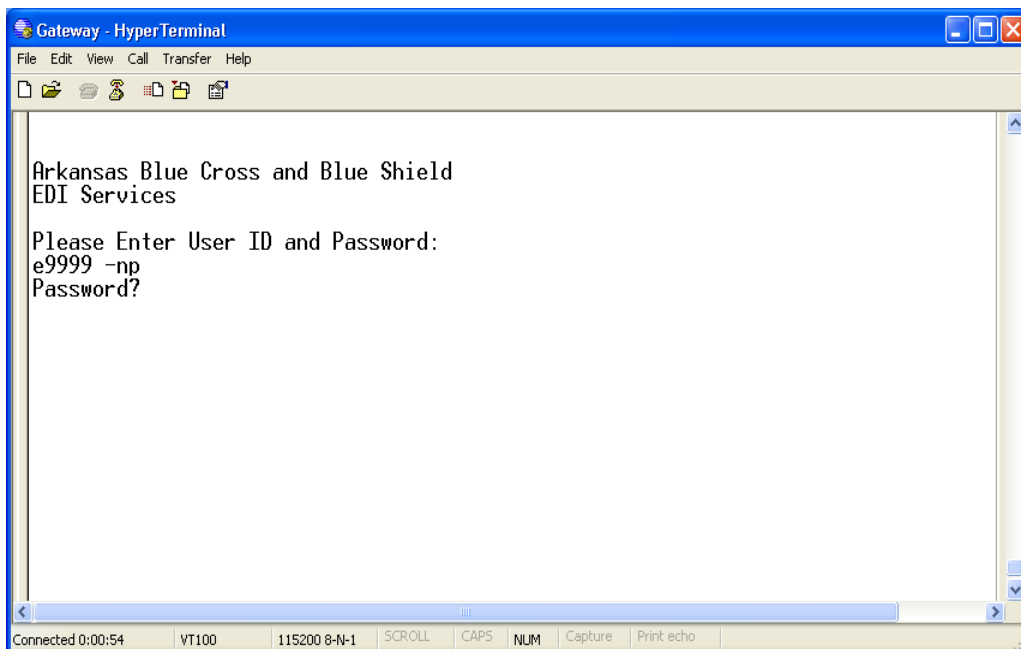


At the “Please Enter User ID and Password” prompt, enter your submitter ID number assigned by EDI Services followed by a space, a hyphen, the letters np and then press the enter key.

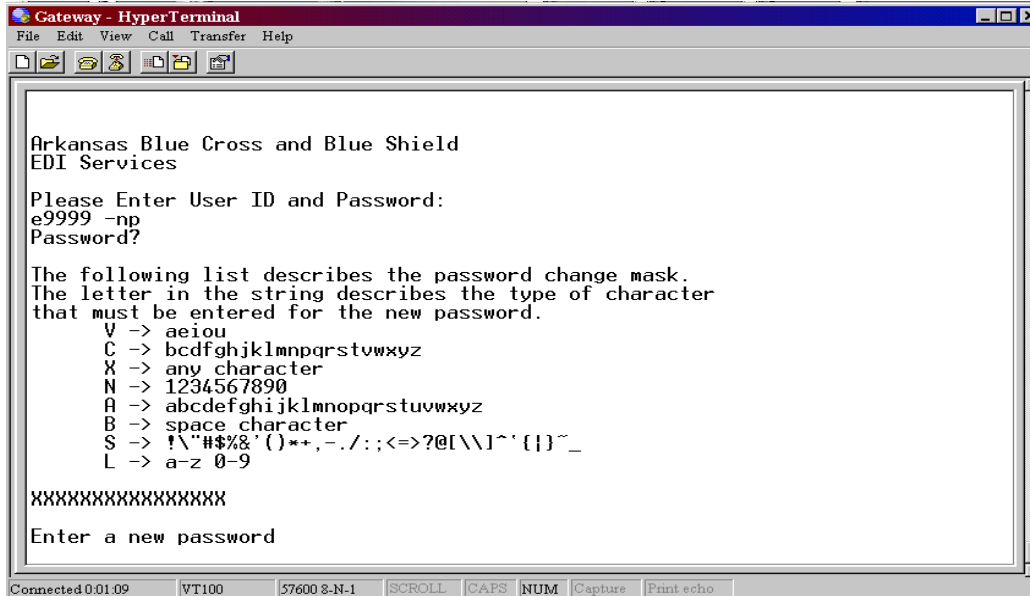
NOTE: The login ID must be entered in lowercase.



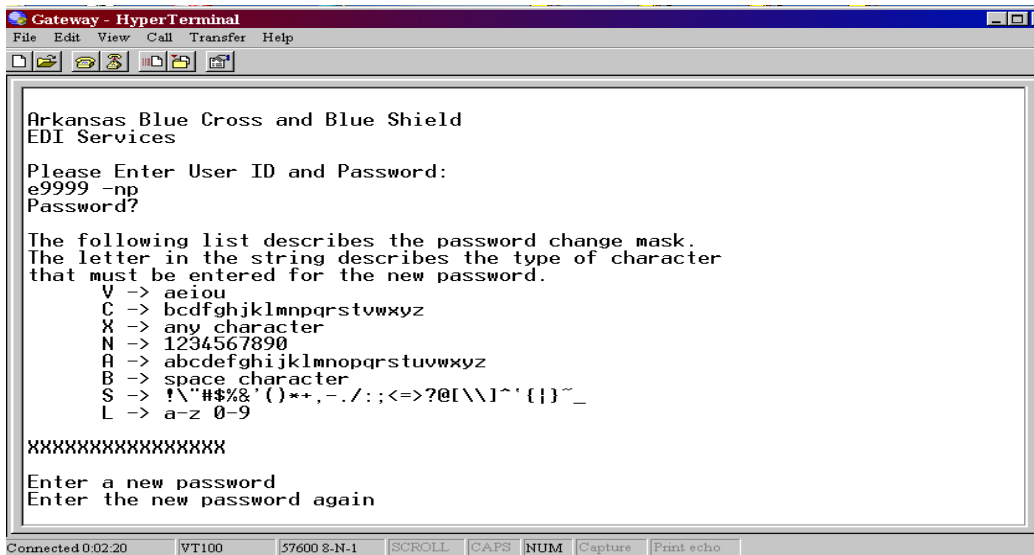
You are now prompted to enter a password. You must enter your current password and then press the enter key.



The user will now be prompted to enter a new password. The password must be eight characters long and passwords are case sensitive. It can be uppercase, lowercase or a combination of both, but no special characters may be used. Enter your new password and press the enter key.



Re-enter your new password and press the enter key. Once you have re-entered the new password, your password will be changed. The user will proceed to the main menu screen.

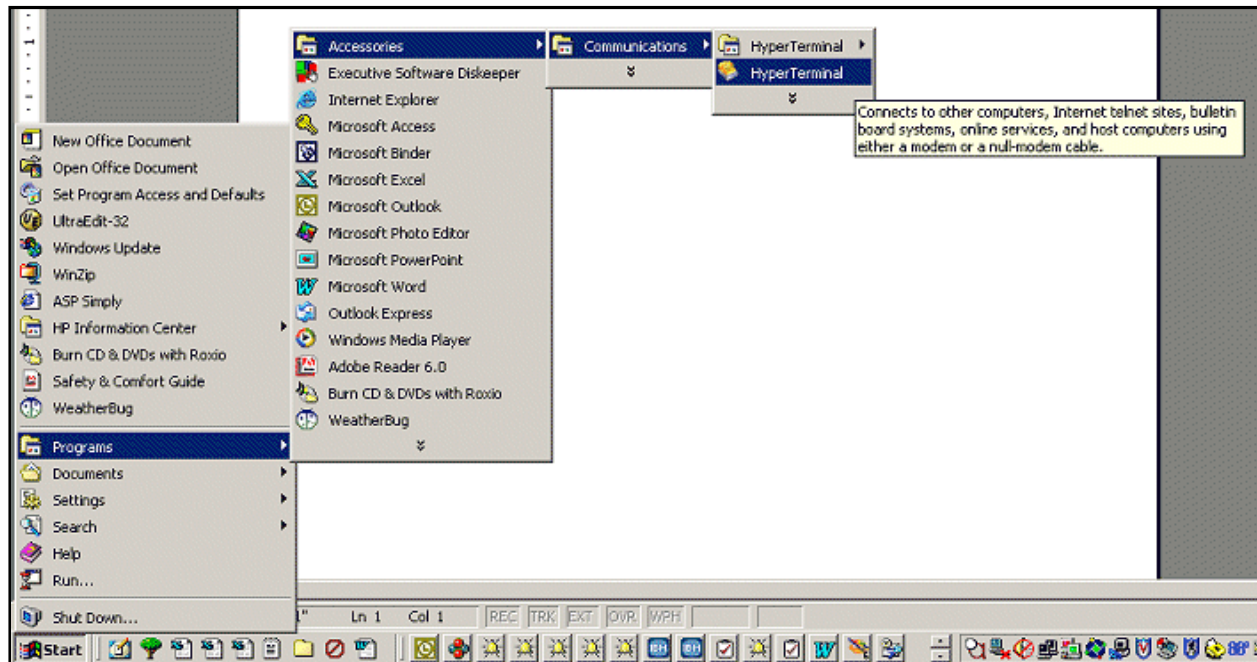


Changing Your Password

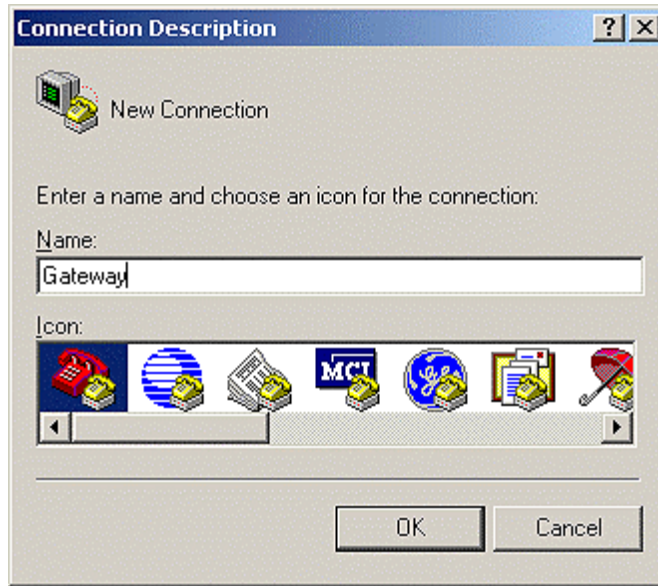
NOTE: THESE STEPS MUST BE TAKEN PRIOR TO CONNECTING VIA FTP. SOME OF THESE STEPS MAY VARY IF YOU ARE USING WINDOWS XP.

Before the initial FTP connection, the user must first access the NetX Gateway through an asynchronous dial-up connection (i.e. HyperTerminal) and change the default password.

From Windows, select Start > Programs > Accessories > Communications > HyperTerminal.



This should bring up the Connection Description window. From this window, enter a name (i.e. Gateway) in the Name field. Choose an icon and click OK.

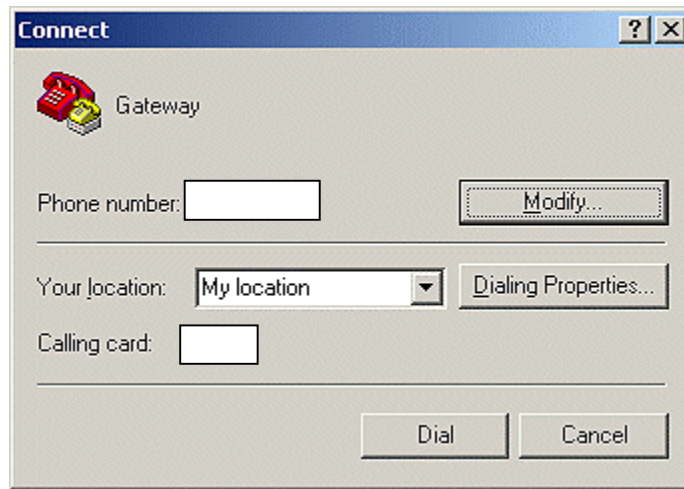


In the Connect To box, enter 501 in the Area code field. Then enter the phone number for the NetX Gateway in the Phone number field and then click OK.

NOTE: Please call EDI Services at (866) 582-3247 or (501) 378-2419 for the phone number to enter for the NetX Gateway in the Phone number field. If a modem is not listed in the Connect using field, contact your telecommunications support.



This will bring up the Connect box. Click on Dialing Properties.



This will bring up the Phone and Modem Options box.

Verify that **your** area code appears under the Area Code field on the Phone and Modem Options box.

If **your** area code **does** appear in the Area Code field, then **click OK only if you do not need to dial a 9 to get an outside line for local and/or long distance calling.**

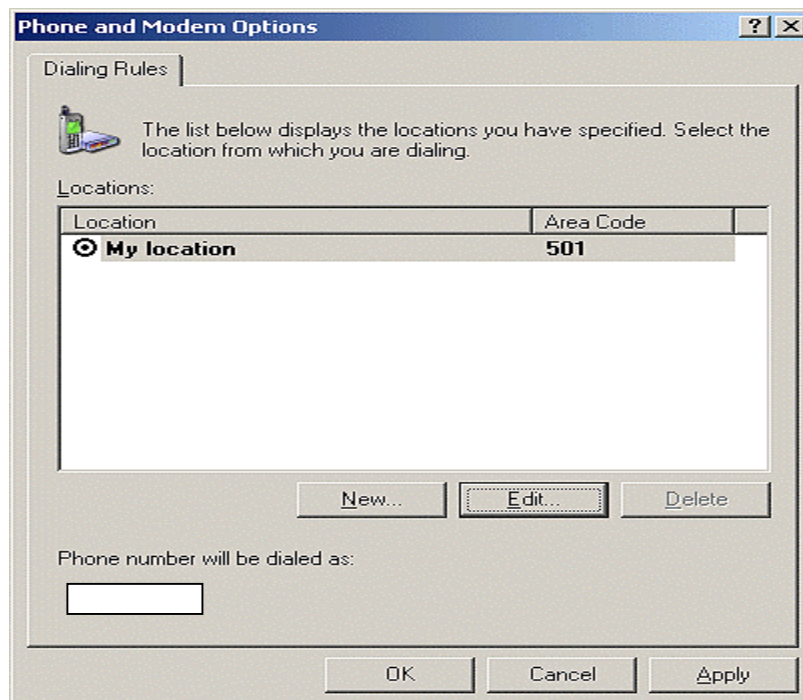
If you are required to dial a 9 to get an outside line for local and/or long distance calling, then click on Edit and following the instructions on the next page.

If **your** area code **does not** appear under the Area Code field in the Phone and Modem Options box, then click on New. Enter a location name in My location.

Enter the area code from which you will be dialing from (i.e. 401, 405, 417, 501, 504, 505).

Click OK.

Then click on Edit and follow the instruction on the next page.



If your phone system requires you to dial a 9 to reach an outside line for local and/or long-distance calling then;

- Click Edit on the Phone and Modem Options box. This will bring up the Edit Location box.
- Under the Dialing rules section on the Edit Location box, enter a 9 followed by a comma. Do not put any spaces between the 9 and the comma. Enter a 9 followed by a comma at the appropriate line(s) that apply to you.
- Then click on OK.

Edit Location [?] [X]

General | Area Code Rules | Calling Card

Location name: My location

Specify the location from which you will be dialing.

Country/region: United States Area code: 501

Dialing rules

When dialing from this location, use the following rules:

To access an outside line for local calls, dial: 9,

To access an outside line for long-distance calls, dial: 9,

Use this carrier code to make long-distance calls:

Use this carrier code to make international calls:

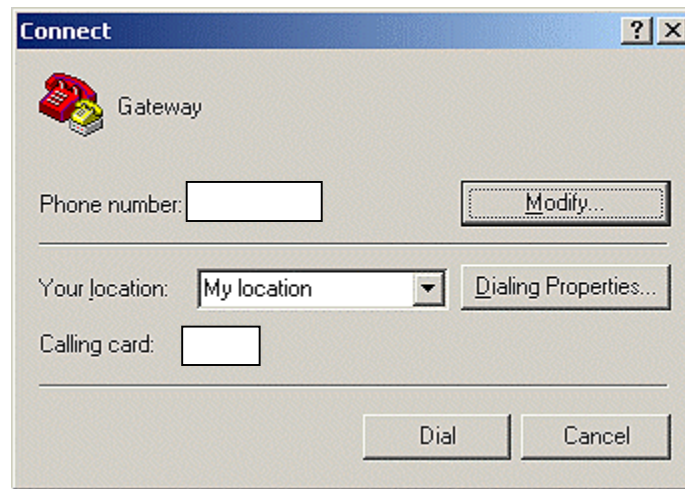
To disable call waiting, dial: *70,

Dial using: Tone Pulse

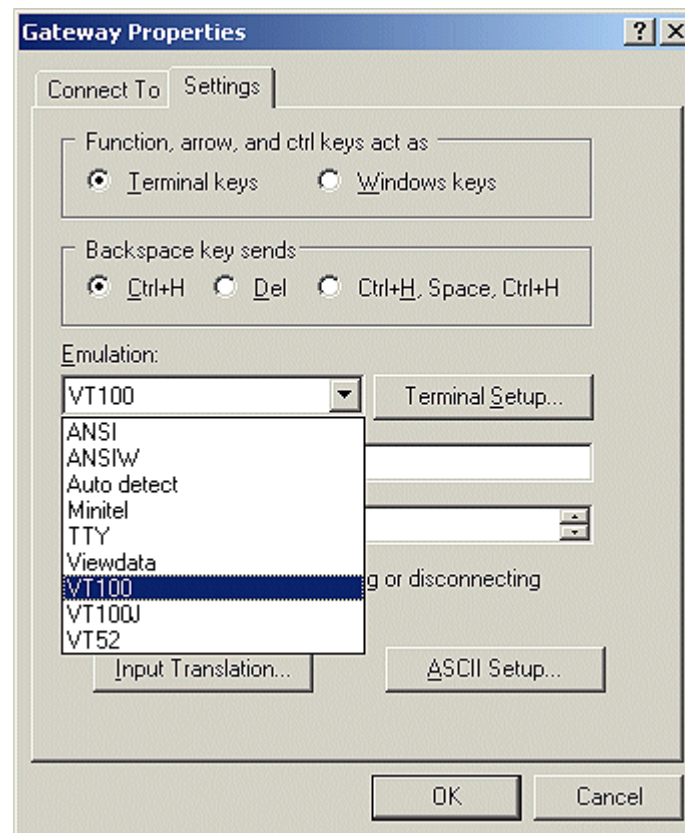
Phone number will be dialed as:

OK Cancel Apply

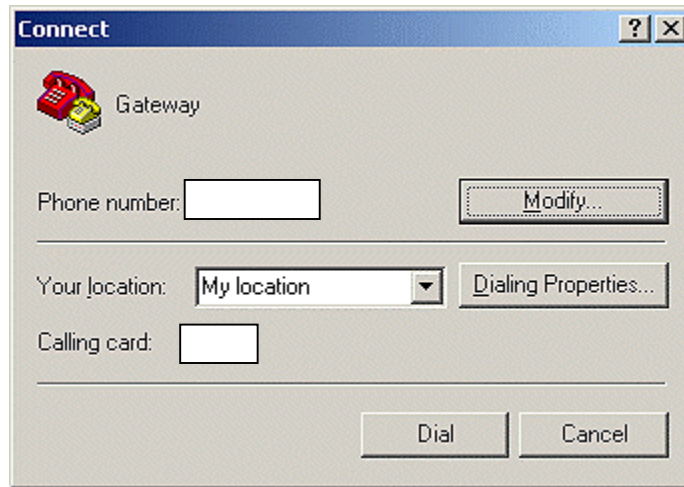
From the Connect box, click on Modify to go to the Properties box.



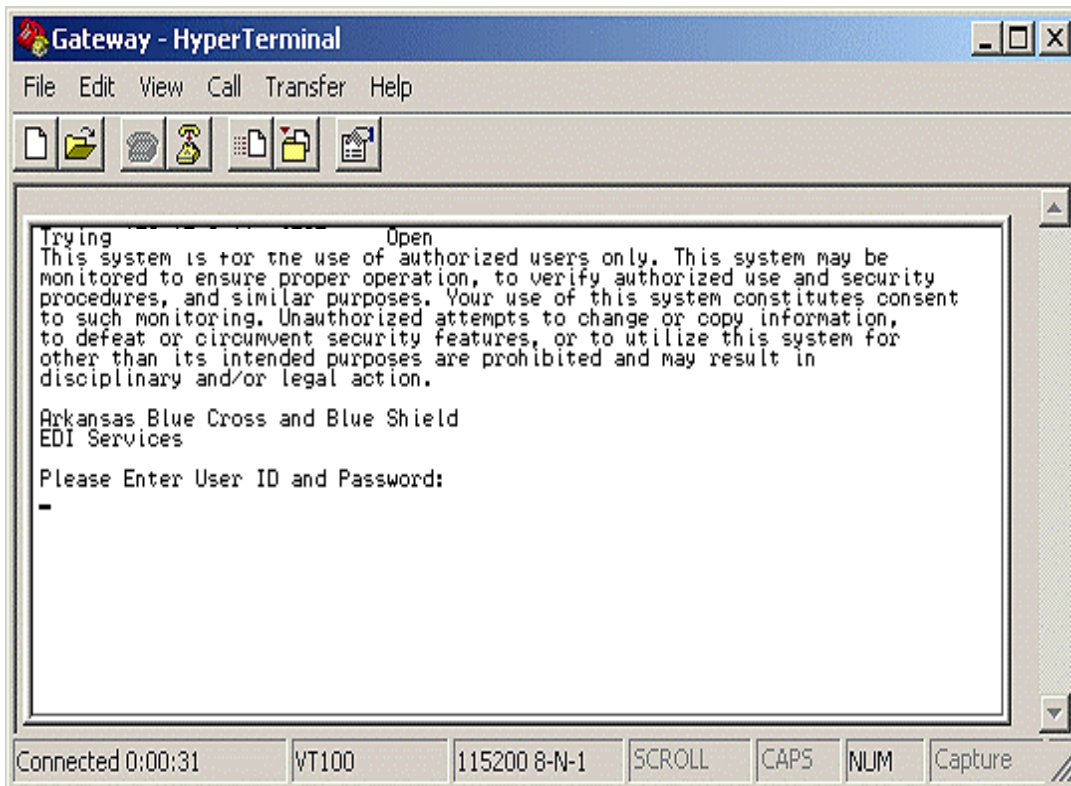
Select the Settings tab on the Properties box. Change the Emulation to VT100 and click OK.



You will now be back at the Connect box. Click on Dial.



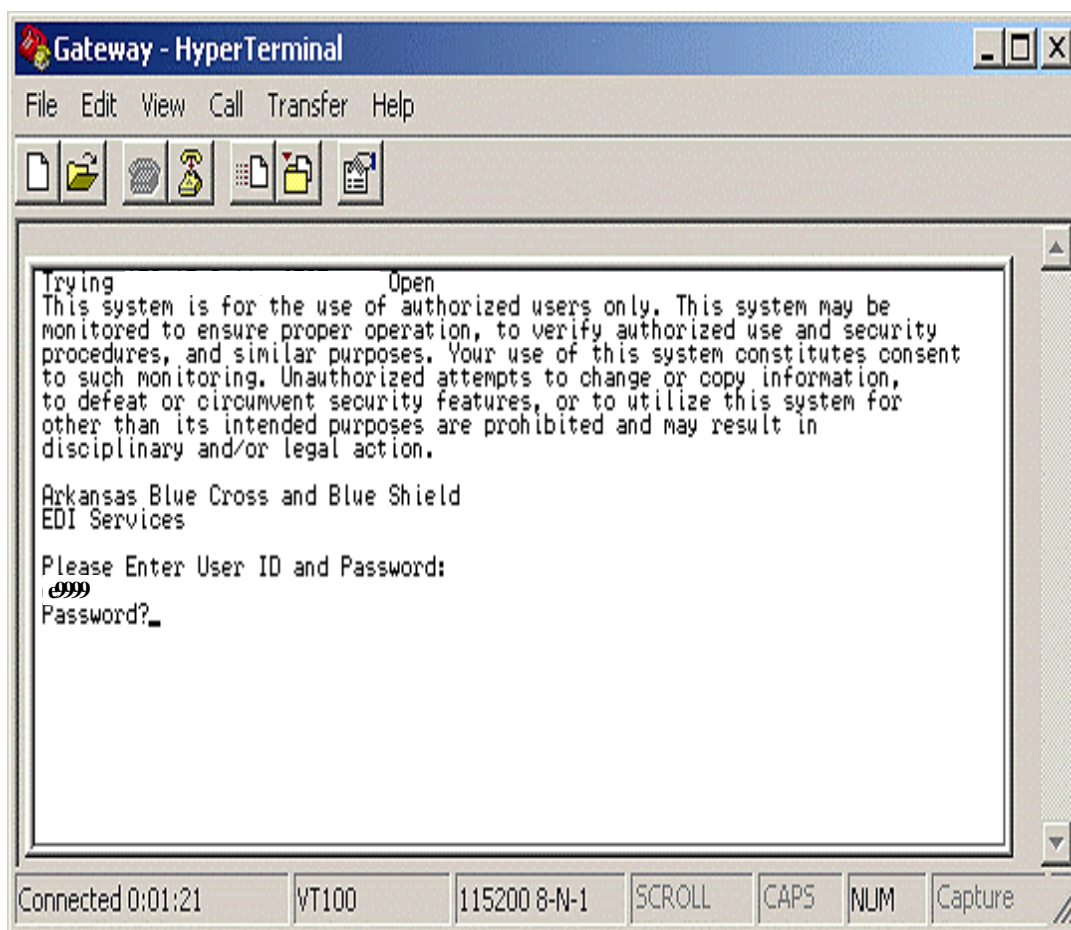
Once you are connected to the Gateway, press the Enter key. The User ID and Password prompt will be displayed. The User ID number is assigned by EDI Services. The User ID number must match the User ID number which is located in the ISA06 of the file. A **lower-case alpha-character MUST** be used when you enter the User ID number (i.e. e9999). Enter your User ID and press the Enter key.



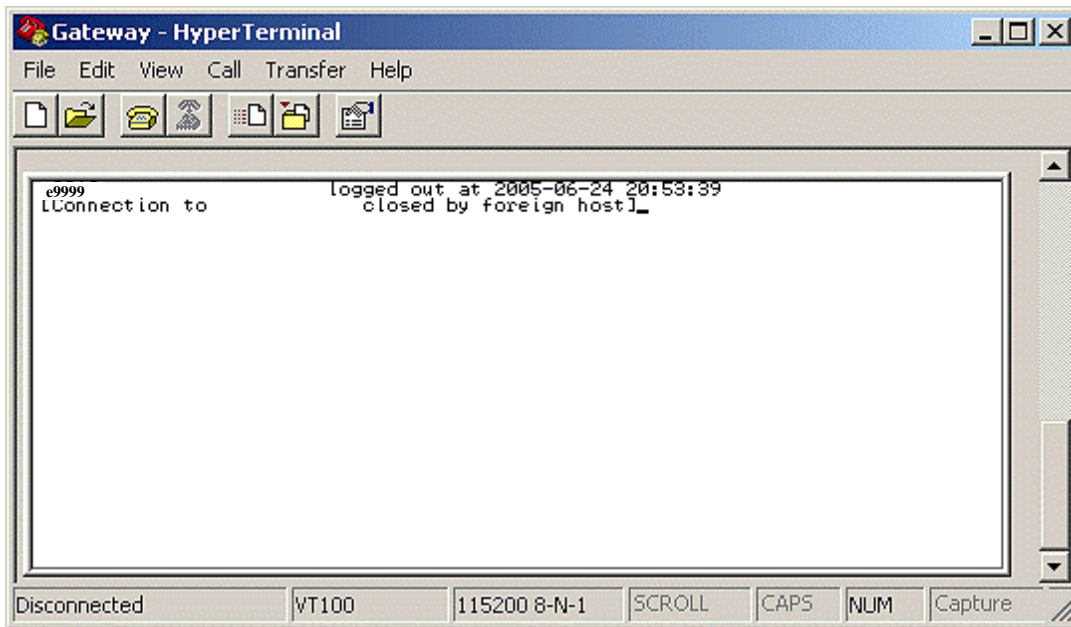
The user will be prompted for a password. Enter the default password that is provided by EDI Services and press the enter key. **Please call EDI Services at (866) 582-3247 or (501) 378-2419 to receive the default password that you must use.**

Once you have entered the default password, the user will be prompted to input a new password. Enter a new password and press the Enter key. Input the password again for confirmation and press the Enter key.

NOTE: Passwords must be a minimum of eight and a maximum of eight characters long with no repeating character side by side.

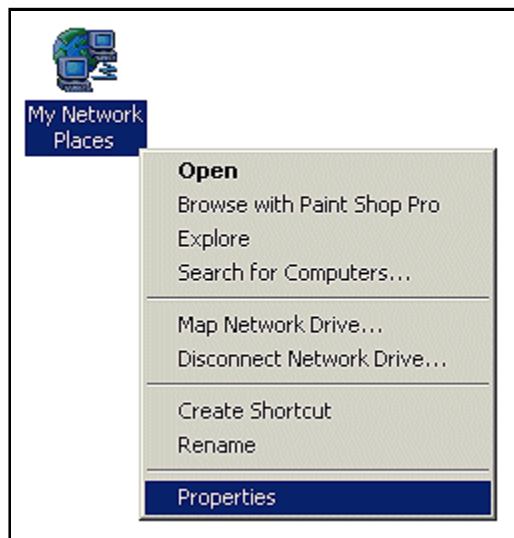


Once you have successfully changed your password, you will be disconnected from the Gateway because there are no asynchronous options to return.



Creating the FTP Connection

Right-mouse click on My Network Places and **left click** on Properties.



Right mouse click on the Make New Connection icon and then **left** mouse click on New Connection.

NOTE: This should begin the Network Connection Wizard.

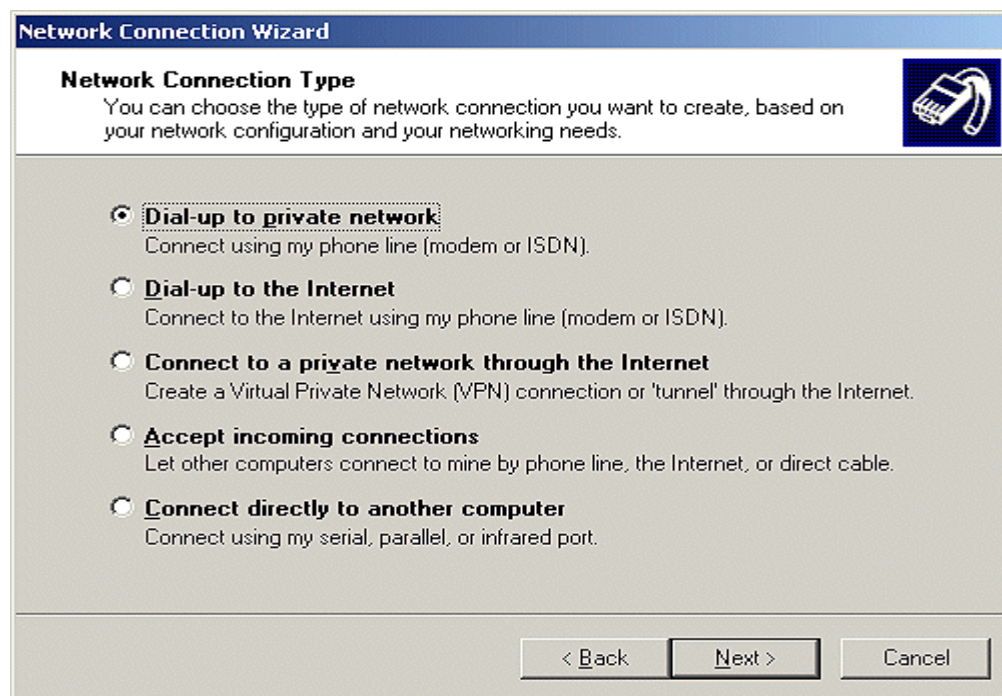


Click Next on the Network Connection Wizard.



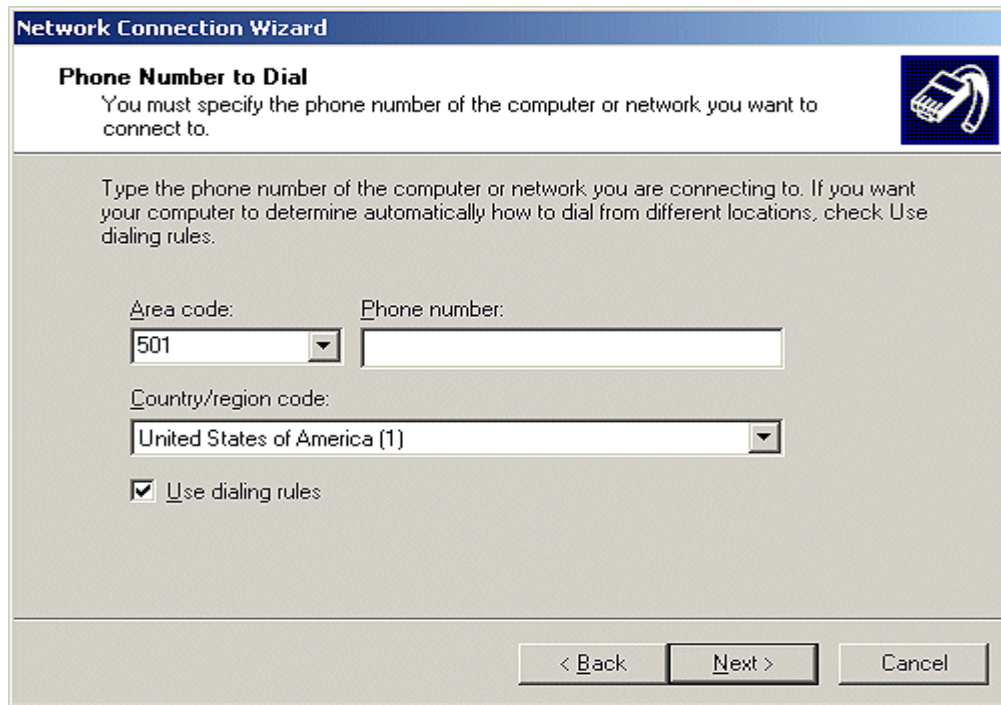
Then choose the Dial-up to Private Network option and click on Next.

NOTE: This screen may appear different depending on your operating system.



Enter the area code and phone number provided by EDI Services and click on Next. Please call EDI Services at (866) 582-3247 or (501) 378-2419 for the area code and phone number.

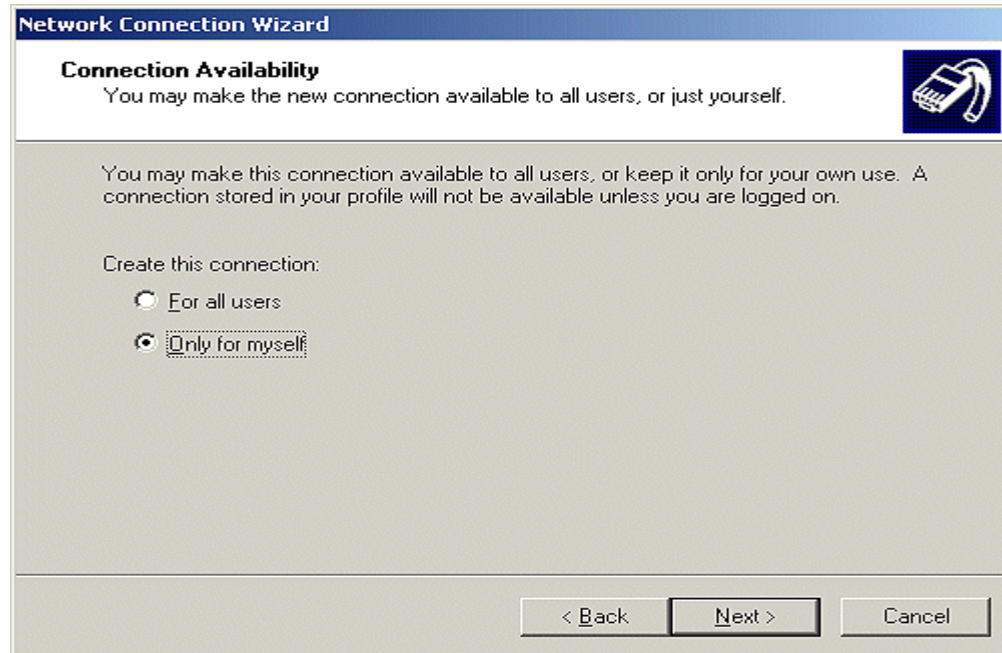
NOTE: If you are unable to enter the area code, populate the check box next to Use dialing rules.



The screenshot shows a dialog box titled "Network Connection Wizard" with a sub-header "Phone Number to Dial". The main text reads: "You must specify the phone number of the computer or network you want to connect to." There is a small icon of a telephone handset in the top right corner. Below the text, there is a prompt: "Type the phone number of the computer or network you are connecting to. If you want your computer to determine automatically how to dial from different locations, check Use dialing rules." The form contains three input fields: "Area code:" with a dropdown menu showing "501", "Phone number:" with an empty text box, and "Country/region code:" with a dropdown menu showing "United States of America (1)". There is a checked checkbox labeled "Use dialing rules". At the bottom, there are three buttons: "< Back", "Next >", and "Cancel".

Select the Only for myself option and click Next.

NOTE: This screen may not appear for all users. If not, proceed to the next step on the following page.

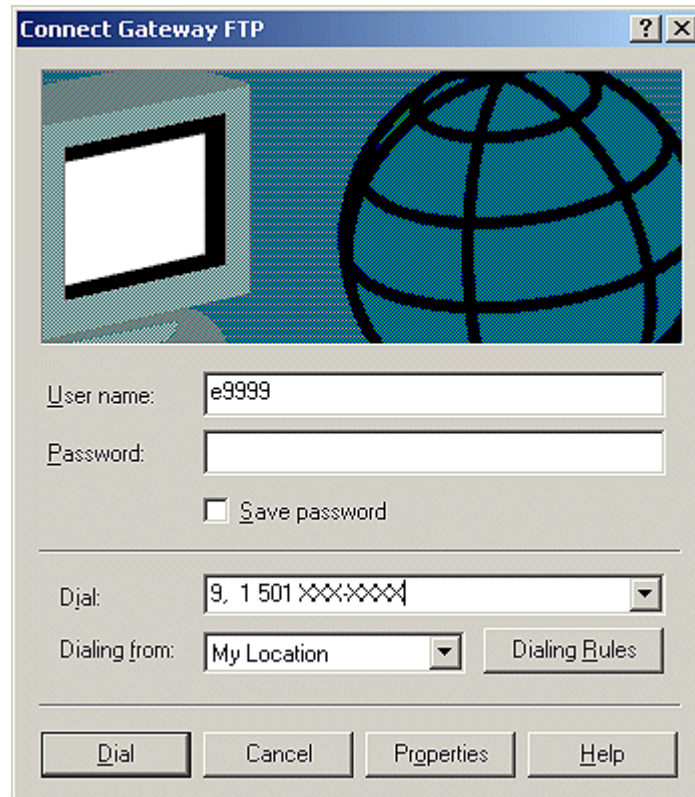


Choose a connection name (i.e. Gateway FTP) and ensure the Add a shortcut to my desktop checkbox is populated. Click on Finish.



You should now be at the Connect box.

NOTE: If your phone system requires a 9 to reach an outside line for local and/or long-distance calling, or if other dialing changes are necessary, click on Dialing Rules. This should bring up the Phone and Modem Options box.



If your phone system requires a 9 to reach an outside line for local and/or long-distance calling, or if other dialing changes are necessary then:

Verify that **your** area code appears under the Area Code field on the Phone and Modem Options box.

If **your** area code **does** appear under the Area Code field on the Phone and Modem Options box; then click on the Edit button and follow the instructions on the next page.

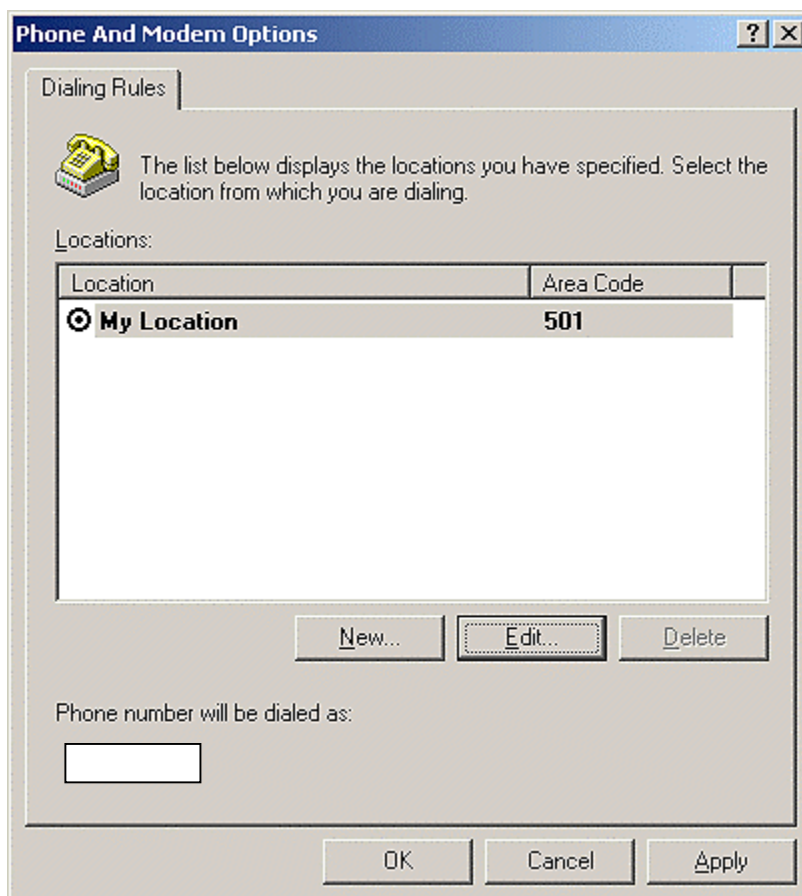
If **your** area code **does not** appear under the Area Code field in the Phone and Modem Options box, then click on New.

Enter a location name in My location.

Enter the area code from which **you** will be dialing from (i.e. 401, 405, 417, 501, 504, 505).

Click OK.

Then click on the Edit button and follow the instructions on the next page.



If your phone system requires a 9 to reach an outside line for local and/or long-distance calling or if other dialing changes are necessary then;


Enter a 9 followed by a comma on the appropriate line(s) to access an outside line for local calls and/or to access an outside line for long-distance calls. Do not put a space between the 9 and the comma.

Click OK on the Edit Location box.

You will then be back on the Phone and Modem Options box. Click OK to exit the Phone and Modem Options box. Select Cancel to close the session.

Edit Location [?] [X]

General | Area Code Rules | Calling Card

 Location name:

Specify the location from which you will be dialing.

Country/region: Area code:

Dialing rules:

When dialing from this location, use the following rules:

To access an outside line for local calls, dial:

To access an outside line for long-distance calls, dial:

To disable call waiting, dial:

Dial using: Tone Pulse

Phone number will be dialed as:

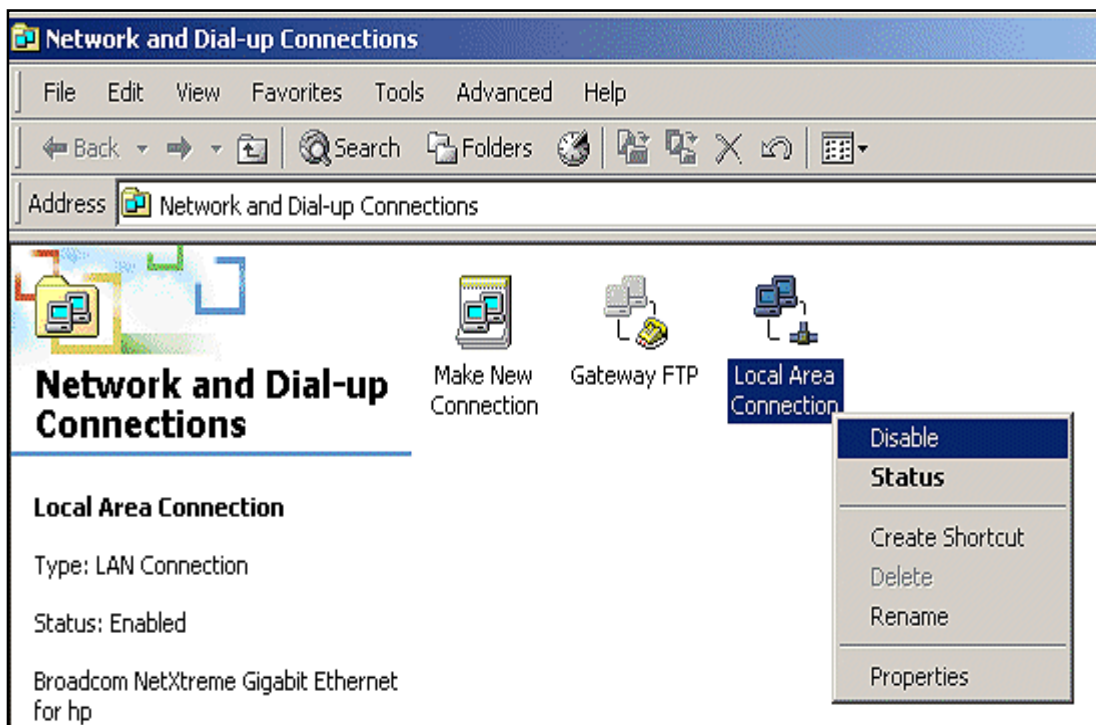
OK Cancel Apply

Using Your FTP Connection

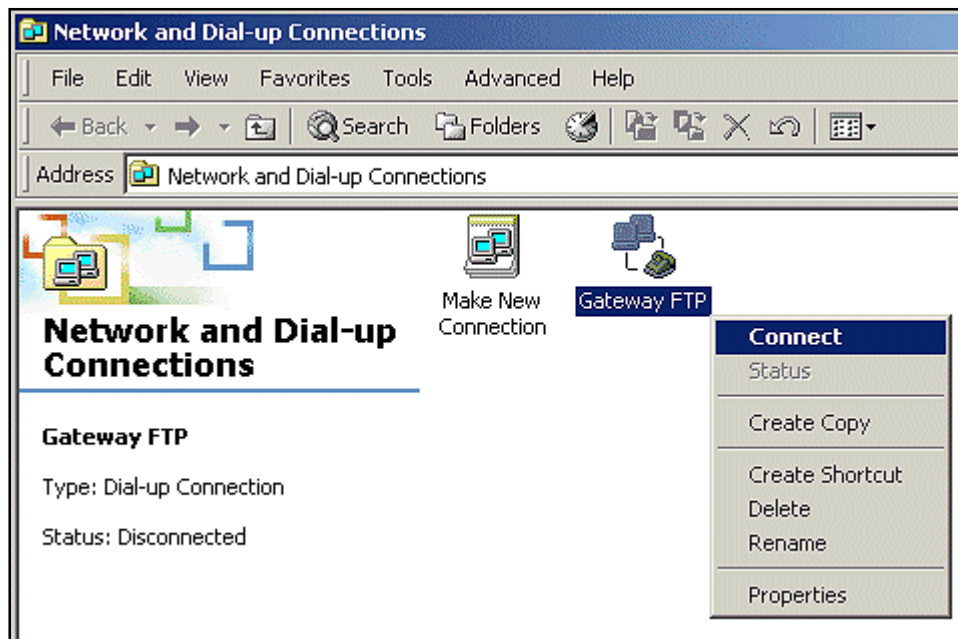
From your desktop, **right-mouse click** My Network Places and **left** click on Properties. This should open the Network and Dial-up Connections box.

If connected to a Local Area Network (LAN), that connection should be disabled before enabling the Gateway FTP connection.

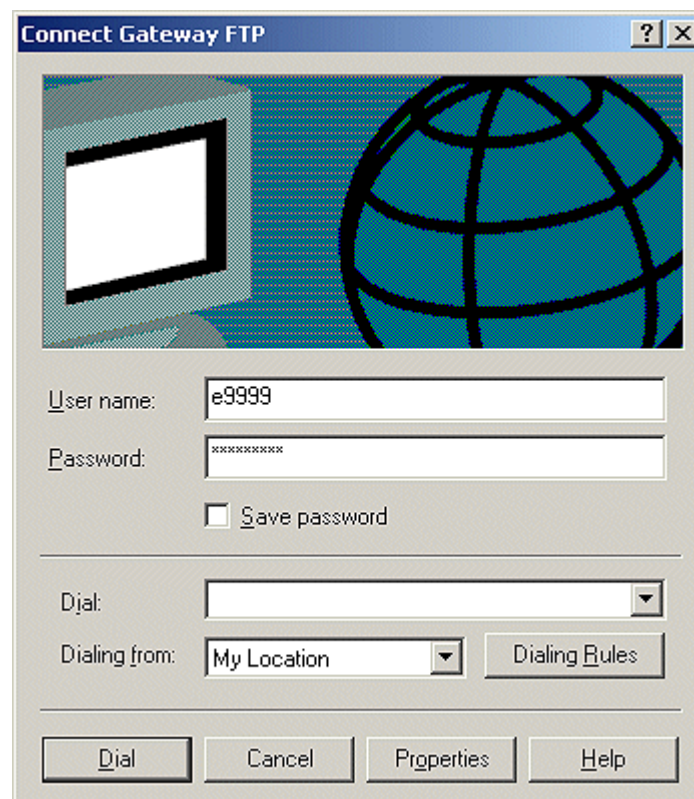
§ **Right-mouse click** Local Area Connection (if on a network) and **left** click on Disable.



Right-mouse click on the Gateway FTP connection created earlier and **left** click on Connect.



This should bring up your Gateway FTP connection window. Input your User name and Password, which will be the same as your Gateway login ID and password, and click on Dial.



Transmitting A File Via FTP

1. Once connected, you must open a DOS window.
2. From Windows, select Start, Run, and enter cmd, and click OK.
3. If necessary, change to the directory where files are located (i.e. cd desktop).
4. At the DOS prompt, type ftp and press enter.
5. From the ftp prompt, type open and the IP address (provided by EDI Services), and press Enter: (i.e. open XXX.XX.X.XX XXXXX).
6. You will be prompted to input the user ID and password.

§ The user ID should match that which is located in the ISA06 of your file. For logging in, the user ID MUST be entered using a lower-case alpha-character (i.e. e9999).

§ Enter the password as created in asynchronous connection. Passwords are case-sensitive.

7. Once logged in, type binary and press enter.

You should see this message: 200 Type set to I followed by the ftp> prompt. At this point, the file transfer upload may begin.

8. The upload command for ANSI 4010A1 837P transactions is as follows:

```
put filename.ext testup!837P (note: once in production, change testup to produp)
```

The following script should resemble the message received after a successful file transfer:

```
200 PORT command successful.  
150 Opening data connection for testup!TPA
```

```
226 Transfer complete  
134027 bytes sent in 0.02237 seconds  
local: filename.ext remote: testup!TPA
```

Receiving A File Via FTP

1. Connect to the Gateway following steps 1-3 above.
2. The download command for the 997, TA1, and BPR reports are as follows:

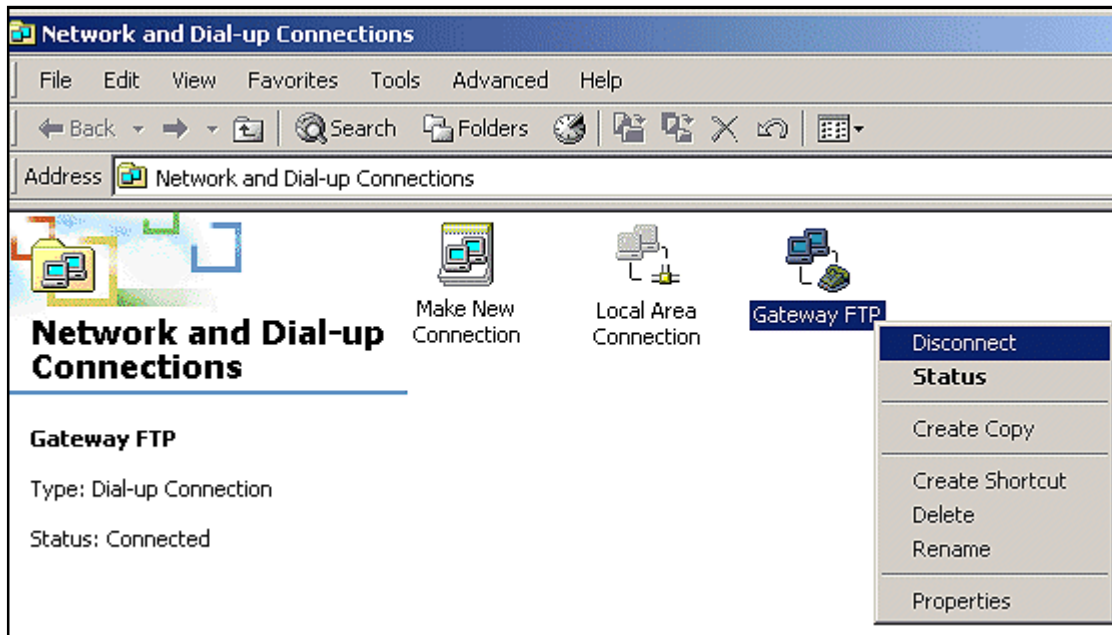
```
get e9999!rpt (replace e9999 with valid ISA06 submitter number)
```
3. Reports will be returned to the directory from which the ftp session began.
EXAMPLE: If at C:\> prompt when ftp is typed, then reports will be written to the C: drive.

A list of all possible extensions following the '!' are as follows:

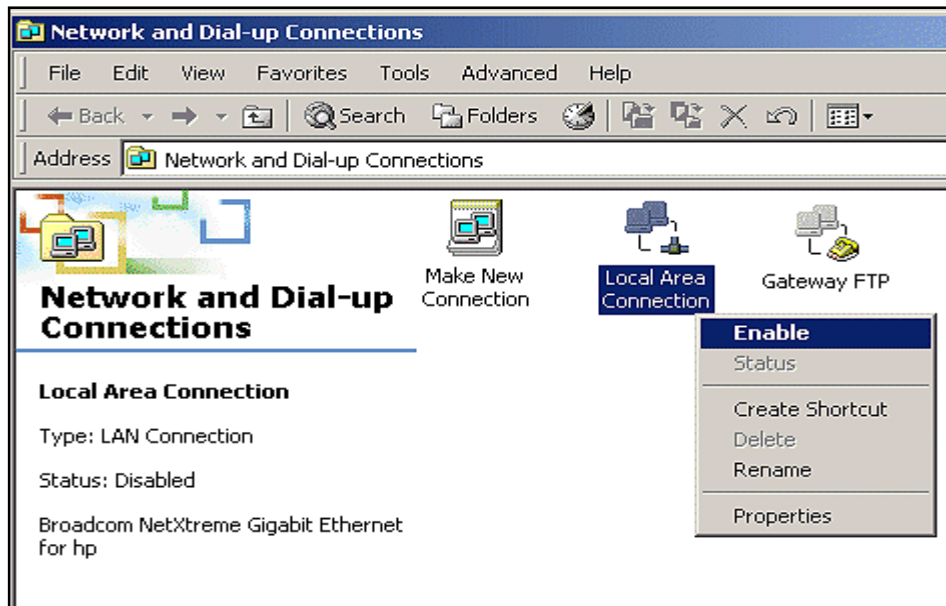
```
835 – 4010A1 835 Remittance  
rpt – 997's, TA1's, Batch Processing Reports  
txt – Text Report  
h99 – Med B File Status  
rej – Rejection Reports
```

Disconnecting Your FTP Connection

1. From your DOS prompt, type quit and press Enter.
2. Then type exit and press Enter.
3. From your desktop, **right-mouse click** on My Network Places and **left** click on Properties.
4. **Right-mouse click** on Gateway FTP and **left** click on Disconnect.



5. Wait a few seconds. **Right-mouse click** on Local Area Connection and **left** click on Enable (if on a network).



Testing Procedures

Testing for Electronic Data Interchange is required to ensure that the electronic information is accurate and “readable” in our processing system.

The number of tests required and the duration of the testing process is determined, in part, by the quality of the test claims we receive from you. During the testing process, we recommend that you continue to submit claims as you currently do today until you receive final approval for electronic billing. (Once you are approved for electronic billing, we strongly recommend submitting only electronic claims.) We also require retesting for electronic claims submission when upgrading to a more current version of your software or if you change software vendors.

Steps in the Testing Process

After you receive notification of your submitter ID/Login, your next step is to submit a test file. If you have opted to use a billing agent or clearinghouse, you will not be required to submit a test file directly to the NetX Gateway. Only direct submitter’s will send their test file to the NetX Gateway.

After submitting a test, you may verify whether the file was accepted by referencing the 997 Functional Acknowledgement and TA1 Functional Acknowledgment (if applicable). The 997 and/or TA1 will be returned to your electronic mailbox within 24 hours along with a Batch Processing Report. You must dial back into the Gateway to retrieve these documents. The Batch Processing Report will detail any errors encountered in your test file. Additionally, an EDI Analyst will contact you with the results of your test. If the test is not approved for production, a second test must be submitted for review.

Upon successful completion of the testing phase, the EDI Analyst will provide a date to begin submitting production electronic claims. Once approved for production, you must change the TEST indicator (indicating test claims) to PROD prior to submitting electronic claims in a production mode. Your software vendor will be able to assist you with changing your test indicator to prod.

Testing Requirements

Claims that are submitted for testing should be representative of the services that you intend to submit to Medicare and/or Private Business after you are approved for production. Additionally, a variety of procedures should be submitted for testing, as applicable to your specialty.

YOU MUST SUBMIT X12N TRANSACTIONS IN A CONTINUOUS STRING.

IF YOU DO NOT SUBMIT AN X12N TRANSACTION IN A CONTINUOUS STRING, YOUR FILE WILL NOT BE PROCESSED. AN EDI ANALYST WILL CONTACT YOU ABOUT YOUR REJECTED FILE.

Modem Testing

Test claims submitted by modem require:

- A minimum of 25 claims per practitioner
- Only one specialty should be submitted on each test transmission
- Secondary insurance information must be submitted on some of the test claims for Medicare Part A and Medicare Part B
- Private Business test files must have a mixture of different claim types (Blue Cross Blue Shield, Health Advantage, Blue Advantage, Medipak, FEP, First Pyramid Life and First Source)
- Submit real patient information in your test file. Failure to do so will cause the claims to reject.
- A submitter must demonstrate, at a minimum, a 95 percent accuracy rate in data testing before production is approved.
- The usual error rate for front-end edits for the submitter does not exceed five percent of the transactions. An error rate above five percent will require additional testing.
- Test files must pass 100 percent of format edits before production is approved.

Clearinghouse and Billing Agent Testing

1. Clearinghouses and/or billing agents may test for their clients to receive blanket approval for Medicare and/or Private Business subject to the following conditions.

- Clearinghouses and/or billing agents provide a listing of his/her clients for whom they are testing by completing the EDI provider spreadsheet. This must include all providers that have a business need to be assigned a separate submitter number, as defined in the Trading Partner Agreement.
- Clearinghouses and/or billing agents must test the specialty claim types that they have indicated on the Trading Partner Agreement (TPA), attachment D within the TPA, and they must be representative of the specialty claim types that will be submitted in production mode.
- Must submit a file containing no less than 25 claims and no more than 100 claims per specialty category.
- Must send test files for each state in which business is conducted.

Once the clearinghouse has been approved for production, no additional testing will be required for the 837 4010A1 transaction.

2. Claims must be submitted in accordance with the requirements of the Trading Partner Agreement.

3. The file must include claims of the following types that your client uses.

- 837 professional – Medicare (all states in which you do business)
- 837 professional – Private Business (Arkansas only)
- 837 institutional – Medicare and Private Business (Arkansas only for Medicare)

4. Submitted files will be processed through the test system on the day they are submitted. A 997 Functional Acknowledgement will be returned to the submitter's electronic mailbox within 24 hours. If the file is unreadable or if the ISA14 element of a readable file is populated with a 1, a TA1 Acknowledgement will be returned to the submitter's electronic mailbox within the same time period. A Batch Processing Report (which results from validation editing) will be returned to the

submitter's electronic mailbox within the same time period. Files that are unreadable and individual claims

that fail the validation edits will not be passed to the test system. EDI Services will be responsible for following

up on this process after reviewing the 997 and Batch Processing Reports. Files that are syntactically correct and contain clean claims will be passed to the test system for review by the various states' EDI departments. Each state will review the test claims and notify the submitter of errors. Once errors have been resolved, each state will communicate to submitter they have passed testing.

Vendor Testing

1. Any vendor that currently does not have a vendor code must contact EDI Services. The ISA01 must have a value of 03 and the assigned vendor code must be entered in the ISA02.
2. Vendors may test for their clients to receive blanket approval for Medicare and/or Private Business subject to the following conditions.
 - Vendors must provide a listing of his/her clients for whom they are testing by completing the EDI provider spreadsheet.
 - It is recommended that vendors test the specialty categories as indicated in the X12N User Guide.
 - The vendor must certify that each client is utilizing software identical to that which is being used to test with.
 - Vendors must send test files for each state in which business is conducted.
 - Vendors must submit a file containing no less than 25 and no more than 100 claims.
3. Upon successful completion of testing, the individual direct submitters identified in the EDI provider spreadsheet will be cleared for production. Each direct submitter approved in this manner must complete a Trading Partner Agreement before being assigned a production date. Once these tests have been approved for production, no additional testing will be required for the 837 4010A1 transaction. If, after moving 5 or more submitters from a single vendor into production, an error rate of over 25% occurs per submitter due to syntactical errors or because of excessive validation rejections, the vendor will be contacted and will lose blanket approval of the software package. Individual testing of all remaining direct submitters will be required before moving them to production.
4. Claims must be submitted in accordance with the requirements of the Trading Partner Agreement.
5. The file must include the type of claims submitted by the vendor's clients which may include:
 - 837 professional – Medicare (all states in which vendor does business)
 - 837 professional – Private Business
 - 837 institutional – Medicare and Private Business (Arkansas only for Medicare)
6. Submitted files will be processed through the test system on the day they are submitted. A 997 Functional Acknowledgement will be returned to the submitter's electronic mailbox within 24 hours. If the file is unreadable or if the ISA14 element of a readable file is populated with a 1, a TA1 Acknowledgement will be returned to the submitter's electronic mailbox within the same time period. A Batch Processing Report (which results from validation editing) will be returned to the submitter's electronic mailbox within the same time period. Files that are unreadable and individual claims that fail the validation edits will not be passed to the test system. EDI Services will be responsible for following up on this process after reviewing the 997 and Batch Processing Report(s). Files that are syntactically correct and contain clean claims will be passed to the test system for review by the various states' EDI departments. Each state will review the test claims and notify the submitter of errors. Once errors have been resolved, each state will communicate to the submitter they have passed testing.

Clearinghouses, Billing Agents and Vendors are required to test all specialty categories. The categories and **Medicare Part B** specialty codes are listed below.

CATEGORY	MEDICARE SPECIALTY CODE
Surgery	01, 02, 03, 04, 05, 12, 17, 85, 92 and 100
Medical	06, 07, 08, 09, 10, 11, 13, 14, 15, 16, 18, 21, 23, 24, 29, 30, 39, 40, 41, 42, 43, 44, 45, 48, 55, 57, 60, 61, 82, 89 and 91
Diagnostic/Therapeutic	22, 26, 27, 46, 52, 86 and 90
Chiropractic	35
Podiatry	31
Independent Laboratory	69
Physical Therapy	65
Ambulance Service	59
Anesthesiology	20, 79
Portable X-Ray Supplier	63
Psychiatry/Psychology	19, 62, 68 and 82
Ambulatory Surgery Center (ASC)	67
Physiological Lab	64

Clearinghouses, Billing Agents and Vendors are required to test all specialty categories. The categories and **Medicare Part A** bill types are listed below.

CATEGORY	BILL TYPE
Inpatient	11X
Ancillary	12X
Outpatient	13X, 14X
Rural Health Clinic	71X
FQHC	73X
ORF	74X
CORF	75X
SNF	18X, 21X, 22X, 23X
CMHC	76X
CAH	85X

Helpful Tips

The ISA Segment is the only "fixed-length" segment.
The Carrier Receiver ID Code in the **ISA08** for AR is 00520 and 00528 for LA.
The Carrier Receiver ID Code in the **GS03** for AR is 00520 and 00528 for LA.

X12N 997 Functional Acknowledgement

The X12N 997 Transaction, or the Functional Acknowledgment, confirms that we received the transmission and indicates whether the transmission was accepted or rejected. The Functional Acknowledgment is generated after the data file is transmitted.

The 997 Functional Acknowledgement will indicate "transmission accepted" or "transmission rejected."

If the transmission is rejected, the errors listed must be corrected and the entire claim file must be retransmitted. The claims will not go to the next level of edits. The Batch Processing Report will not be created, and your claims will not be processed.

If the transmission is accepted, the transmission has successfully passed the initial edits. Your file will be forwarded to the secondary edits and the Batch Processing Report will be created for you within 24 hours after transmission of your electronic claim file. After the transmission has passed the initial and secondary edits, the MCS Prepass Error Report will be available on the NetX Gateway for you to download the next business day.

The X12N 997 Functional Acknowledgement is available for approximately five to seven days. If you have a problem retrieving/printing the X12N 997 Functional Acknowledgement, call an EDI Analyst to reset the report.

Batch Processing Report

If the X12N 837 transmission is accepted at the X12N 997 Functional Acknowledgement level, the file is then subjected to a secondary editing process. The secondary editing process provides for validation edits to be performed. **It is imperative to retrieve this report.**

The Batch Processing Report allows you to verify whether the test or production claims you submitted were **Rejected or Accepted** into our processing system and will also identify any reporting errors made within that submission. The Batch Processing Report is available within 24 hours after an accepted transmission and lists any claim level rejections that were encountered when submitting your electronic transaction. Any claims and/or transmissions that reject on the Batch Processing Report are not forwarded to the Medicare and/or Private Business processing system for processing (payment or denial). Therefore, the Automated Response Unit (ARU) will not have a status of these claims.

If you need assistance or have questions about your Batch Processing Report, please call EDI Services at 866-582-3247 or 501-378-2419. You may be asked by the Customer Service Rep for the number indicated in the ISA13. The ISA13 is located on your Batch Processing Report.

THIS ACCEPTANCE DOES NOT GUARANTEE THAT PAYMENT WILL BE MADE ON ANY CLAIMS.

If you have a problem retrieving a report, contact a Medicare EDI Analyst to reset the report.

The following page is an example of an accepted Batch Processing Report.

Accepted Batch Processing Report

This is an example of an **accepted** Batch Processing Report. The bottom of the report, the row named Total File will show the following information:

1. The total claim count received
2. The total dollar amount of the received claims
3. The total claim count accepted
4. And the total dollar amount of the accepted claim count

BATCH PROCESSING REPORT - October 27 2003
Monday @ 12:51:04

SubmitterID: E9999
FileID : 0001FILE00138931 Name : E9999.E9999.837P.P.A.31
ISA13 : 000123456

PAYER	RECEIVED		ACCEPTED		REJECTED	
	#	\$\$	#	\$\$	#	\$\$
BC_CARE	10	550.00	10	550.00		
TOTAL FILE	10	550.00	10	550.00		

Rejected Batch Processing Report

This is an example of a Batch Processing Report that has a **rejected** claim. The Batch Processing Report will indicate information about the rejected claim. Information that will be provided is:

1. The patient name
2. The patient account number
3. Total claim charge
4. ID number or HIC number
5. Date of birth
6. Provider number
7. Statement from or date of service
8. And the error message.

The Batch Processing Report will indicate the file totals such as the total received claim count, total dollar amount of received claims, total accepted claim count, total dollar amount of the accepted claims, the total number of claims rejected and total dollar amount of all rejected claims.

BATCH PROCESSING REPORT - October 27 2003
Monday @ 08:40:05

SubmitterID: L9999
FileID : 0001FILE0013845F Name : L9999.L9999.837P.P.A.19
ISA13 : 000123456

REJECTED CLAIMS

```

=====
Patient   : Jane Doe           ID#       : 000000000A
PatAcct   : XXXXX999          DOB       : 1937-08-10
Payor     : LOUISIANA MEDICARE PART B Provider: 9999999999 NPI:9999999999
PyrAlias  : MB00528          PayerKey: LA_CARE
Bill Type: HCF              StmtFrom: 2007-09-27
ICN/PCN   :                  Encoder    :
BatchID   : 0001BTCH016B2D5C ClaimID   : 0001HCFA125B9BE1
Total Chg:          520.00    Script    : armc4010p.scr
=====

```

```

SUBS_CHILD_CODE      = 1
seq 1  MEDICARE CLAIMS SUBS AND PAT MUST BE SAME PERSON,CORRECT & RESUBMIT CLA
PTREL                = 01
seq 1  Patient 2000B SBR02 Relationship Field Must Equal 18

```

FILE AUDIT

PAYER	RECEIVED		ACCEPTED		REJECTED	
	#	\$\$	#	\$\$	#	\$\$
BC_CARE	63	12717.00	62	12410.00	1	307.00
TOTAL FILE	63	12717.00	62	12410.00	1	307.00

Overview of the MCS Prepass Error Report (Medicare Part B Only) (H99RAR04)

Once the X12N transmission has passed through the secondary editing process, the claim file is then subjected to the MCS Prepass editing. These edits determine whether a file, claim, or batch will be accepted into the batch cycle for processing. There are four types of edits that will be encountered:

- I-Informational
- C-Claim deletion
- B-Batch deletion
- F-File deletion

Informational edits will allow the claim or batch to continue into processing system to process normally. Informational edits will show on the error report as informational.

Claim, batch, or file delete errors will not be accepted into the processing system. These error types must be corrected and resubmitted.

The MCS Prepass Error Report can be downloaded from the NetX Gateway. The filename of the MCS Prepass Error Report on the NetX Gateway will be **MedB File Status**.

THIS ACCEPTANCE DOES NOT GUARANTEE THAT PAYMENT WILL BE MADE ON ANY CLAIM.

If you need assistance or have questions about your MCS Prepass Error report, please call EDI Services at 866-582-3247 or 501-378-2419. You may be asked by the Customer Service Rep for the number indicated in the ISA13 on your electronic claim file that we received from you. The number in the ISA13 on your electronic claim file can be located on your MCS Prepass Error report. The number is located on the MCS Prepass Error report in the field named TOTALS FOR THIS FILE.

Accepted MCS Prepass Error Report

The next page is an example of an **accepted** MCS Prepass Error Report. This report is also known as the H99 report or Batch Detail Control Listing. The bottom of the report indicates:

Total claims received
Total claims accepted
Total claims deleted
Total claims with errors
Total charges accepted

The total claims received on the MCS Prepass Error Report will match the total accepted claim count on the Batch Processing Report.

Example of an Accepted MCS Prepass Error Report

H99RAR04	MEDICARE SERVICES						PAGE	1
	PROFESSIONAL EMC PROGRAM							
PRODUCTION	MEDICARE-B EMC INPUT							
	BATCH DETAIL CONTROL LISTING							
	SUBMITTER ID: E9999			SUBMITTER NAME: MEDICAL CLINIC				
				ADDRESS: 123 MAIN STREET				
				CITY: LITTLE ROCK				
				STATE/ZIP: AR 72203				
	PROCESS DATE: 03/23/2008							
EMC PROVIDER : NPI: 9999999999		PIN:	BATCH NUMBER : 1					
PROV	PROV	REFERENCE	REC TYPE	DTL	FIELD IN	FIELD	MESSAGE	
NPI#	PIN#	NUMBER		NUM	ERROR	CONTENTS		

EMC PROVIDER : NPI: 9999999999		PIN:	BATCH STATUS : ACCEPTED					
TOTAL CLAIMS RECEIVED		:	10					
TOTAL CLAIMS ACCEPTED		:	10					
TOTAL CLAIMS DELETED		:	0					
TOTAL CLAIMS WITH ERRORS		:	0					
TOTAL CHARGES ACCEPTED		:	\$	550.00				

H99RAR04	MEDICARE SERVICES						PAGE	2
	PROFESSIONAL EMC PROGRAM							
PRODUCTION	MEDICARE-B EMC INPUT							
	BATCH DETAIL CONTROL LISTING							
	SUBMITTER ID: E9999			SUBMITTER NAME: MEDICAL CLINIC				
				ADDRESS: 123 MAIN STREET				
				CITY: LITTLE ROCK				
				STATE/ZIP: AR 72203				
	PROCESS DATE: 03/23/2008							
	TOTALS FOR THIS FILE			000000361				
TOTAL CLAIMS RECEIVED		:	10					
TOTAL CLAIMS ACCEPTED		:	10					
TOTAL CLAIMS DELETED		:	0					
TOTAL CLAIMS WITH ERRORS		:	0					
TOTAL BATCHES RECEIVED		:	10					
TOTAL BATCHES ACCEPTED		:	10					
TOTAL BATCHES DELETED		:	0					
FILE TOTAL CHARGED		:	\$	550.00				

Rejected MCS Prepass Error Report

The next page has an example of a MCS Prepass Error Report with a **rejected** claim. The report will indicate the following information:

1. Loop and segment in error
2. The Error Number and Error Message
3. Error Severity (file delete, batch delete, claim delete or informational)
4. The HIC number for the claim that is in error
5. Total claims received (Note: The total claims received will match the total accepted claim count on the Batch Processing Report)
6. Total claims accepted
7. Total claims deleted
8. Total claims with errors
9. And the total charges accepted

A complete listing of all of the error numbers with a description of the error number can be found on the Medicare websites. Go to one of the websites listed below and click on the HIPAA Information link on the left side of the screen. Then click on the Adobe document named ANSI X12 837 V4010 Prepass Edits.

www.arkmedicare.com
www.lamedicare.com

If you need assistance or have questions about your MCS Prepass Error report, please call EDI Services at 866-582-3247 or 501-378-2419. You may be asked by the Customer Service Rep for the number indicated in the ISA13 on your electronic claim file that we received from you. The number in the ISA13 on your electronic claim file can be located on your MCS Prepass Error report. The number is located on the MCS Prepass Error report in the field named TOTALS FOR THIS FILE. The next page is an example of a rejected MCS Prepass Error Report.

Example of a Rejected MCS Prepass Error Report

H99RAR04	MEDICARE SERVICES	PAGE	1			
PRODUCTION	PROFESSIONAL EMC PROGRAM					
	MEDICARE-B EMC INPUT					
	BATCH DETAIL CONTROL LISTING					
	SUBMITTER ID: E9999	SUBMITTER NAME: MEDICAL CLINIC				
		ADDRESS: 123 MAIN STREET				
		CITY: LITTLE ROCK				
		STATE/ZIP: AR 72203				
	PROCESS DATE: 03/23/2008					
	EMC PROVIDER : NPI: 9999999999	PIN: BATCH NUMBER : 1				
PROV NPI#	PROV PIN#	REFERENCE NUMBER	REC TYPE DTL NUM	FIELD IN ERROR	FIELD CONTENTS	MESSAGE

	EMC PROVIDER : NPI: 9999999999	PIN:	BATCH STATUS : ACCEPTED			
000000000	2300 HI	DX CD		M136	INVALID DIAG FORMAT	CLAIM DELETE
HIC FOR ABOVE CLAIM IN ERROR: 000000000A ICN:0000000000000						
TOTAL CLAIMS RECEIVED	:	62				
TOTAL CLAIMS ACCEPTED	:	61				
TOTAL CLAIMS DELETED	:	1				
TOTAL CLAIMS WITH ERRORS	:	1				
TOTAL CHARGES ACCEPTED	:	\$ 12,275.00				

H99RAR04	MEDICARE SERVICES	PAGE	2			
PRODUCTION	PROFESSIONAL EMC PROGRAM					
	MEDICARE-B EMC INPUT					
	BATCH DETAIL CONTROL LISTING					
	SUBMITTER ID: E9999	SUBMITTER NAME: MEDICAL CLINIC				
		ADDRESS: 123 MAIN STREET				
		CITY: LITTLE ROCK				
		STATE/ZIP: AR 72203				
	PROCESS DATE: 03/23/2008					
	TOTALS FOR THIS FILE	000000375				
TOTAL CLAIMS RECEIVED	:	62				
TOTAL CLAIMS ACCEPTED	:	61				
TOTAL CLAIMS DELETED	:	1				
TOTAL CLAIMS WITH ERRORS	:	1				
TOTAL BATCHES RECEIVED	:	1				
TOTAL BATCHES ACCEPTED	:	1				
TOTAL BATCHES DELETED	:	0				
FILE TOTAL CHARGED	:	\$ 12,275.00				

Medicare Part B Detail ICN Cross Reference Report (H99RAR06)

Beginning October 2007, an additional report has been made available to electronic submitters. The report is called the Detail ICN Cross Reference Report (H99RAR06) and can be downloaded from the NetX Gateway. Under the Subject column on the NetX Gateway, the name of the H99RAR06 report is ICN File. The filename of the H99RAR06 report will have a .icn extension.

Claims that do not reject out on the TA1, 997, Batch Processing Report and the MCS Prepass Error Report are forwarded to Medicare Part B for adjudication. Medicare Part B claims that do not reject out are assigned an internal control number (ICN). Providers who may need additional assistance or have questions about their electronic claims can provide the ICN of the claim from the H99RAR06 report to the Medicare Part B Customer Service representative to expedite the inquiry process for the claim. The Detail ICN Cross Reference Report (H99RAR06) not only provides electronic submitters the internal control number (ICN) that was assigned to each accepted claim, but also other information that was submitted in the electronic claim file. Other information on the H99RAR06 includes:

- The electronic submitter number that was transmitted in the 1000A / NM109
- The name and address of the electronic submitter
- The process date that the electronic claim file was processed on
- The ICN (internal control number) assigned to each claim accepted into the Medicare Part B processing system for further adjudication
- The patient account number from the 2300 / CLM01
- The NPI of the provider located in the 2010AA / NM109 or 2010AB / NM109
- The provider's Medicare Part B legacy number from the 2010AA / REF02 or the 2010AB / REF02 if submitted in the electronic claim file
- The health insurance claim (HIC) number of the patient submitted in the 2010BA / NM109

Below is an example of the Medicare Part B Detail ICN Cross Reference Report (H99RAR06).

H99RAR06		MEDICARE SERVICES			PAGE 1
PRODUCTION		PROFESSIONAL EMC PROGRAM			
		MEDICARE-B EMC INPUT			
		DETAIL ICN CROSS REFERENCE			
		SUBMITTER ID: E9999	SUBMITTER NAME: ABC Clinic		
			ADDRESS: 282 Main Street		
			CITY: Little Rock		
			STATE/ZIP: AR 00000 - 0000		
			PROCESS DATE: 11/28/2007		
ASSIGNED ICN	PATIENT NUMBER	PROV NPI	PROV PIN	HIC	SPLIT CLAIM
0207332123456	1234567890	1111111111	55555	555555555A	
0207332987654	9876543210	1111111111	55555	444444444A	
0207332555555	5432198765	1111111111	55555	333333333A	

THIS MEDICARE PART B DETAIL ICN CROSS REFERENCE REPORT (H99RAR06) DOES NOT GUARANTEE THAT PAYMENT WILL BE MADE ON ANY CLAIM.

X12N 837 - Medicare Part B Companion Document

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>.

The following information is intended to serve only as a companion document to the HIPAA X12N 837 professional claim 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 MCS system of

Arkansas Medicare Part B ----- (Contractor number 00520)

Louisiana Medicare Part B ----- (Contractor number 00528)

The information in this document is subject to change. Changes will be communicated in the standard monthly news bulletin and on the Web sites:

<u>Medicare Provider News</u>	<u>Website</u>
Arkansas Medicare Part B	www.arkmedicare.com
Louisiana Medicare Part B	www.lamedicare.com

<u>Providers' News</u>	<u>Website</u>
Health Advantage	www.HealthAdvantage-hmo.com
Blue Advantage	www.Blue AdvantageAdminArkansas.com
Blue Cross Blue Shield	www.ArkansasBlueCross.com
Federal Employee Program	www.fepproviderservice@arkbluecross.com
Arkansas First Source	www.ArkansasBlueCross.com
Blue Card Program	www.ArkansasBlueCross.com
First Pyramid Life	www.Blue AdvantageAdminArkansas.com

This companion document supplements, but does not contradict any requirements in the X12N 837 Professional implementation guide.

837 v. 4010A1 Inbound Professional Claim
Companion Document

ATTACHMENT

Description			Language	Page
General Statements				
			R	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.
			R	Claims that contain percentage amounts with values in excess of 99.99 may be rejected.
			R	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.
			R	Pinnacle Business 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.
			R	Only loops, segments, and data elements valid for the HIPAA Professional 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 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 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 carrier translator.
			R	When applicable, the National Provider Identifier (NPI) must be submitted in the NM109 segment (NM108=XX).
			R	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.
			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	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) submitted with more than 9,999 loops.
			O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) submitted with more than 9,999 segments per loop.

Pinnacle Business Solutions, Inc.
X12N Transaction User Guide
Chapter 7 – Companion Documents

General Statements			Language	Page	
		O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.		
		R/O	Compression of files is not supported for transmissions between the submitter and Pinnacle Business Solutions, Inc.		
		R/O	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.		
		R/O	You may send up to four modifiers; however, the last modifier may not be considered. The Medicare processing system may only use the first three modifiers for adjudication and payment determination of claims.		
		O	Pinnacle Business Solutions, Inc. will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Professional Implementation Guides.		
		O	Incoming 837 transactions that exceed 700 ISA-IEA's appended together per day will be rejected.		
		O	The recommended file size for incoming 837 transactions should not be more than 13 megs. Incoming 837 transactions that exceed 13 megs may be rejected.		
		O	Pinnacle Business Solutions, Inc. will process 999 ISA-IEA's per day per submitter. Electronic submitters who transmit more than 999 ISA-IEA's per day will have transactions rejected.		
		O	Failure to submit an NPI in the primary provider fields, 2010AA/NM109, 2010AB/NM109, 2310B/NM109 and/or 2420A/NM109 (NM108=XX), will result in your claim being rejected beginning January 1, 2008.		
Interchange Control Header			Language	Page	
	ISA05	Interchange ID Qualifier	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that does not contain ZZ in ISA05.	B.4
	ISA06	Interchange Sender ID	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that does not contain a valid ID in ISA06.	B.4
	ISA07	Interchange ID Qualifier	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that does not contain qualifier ZZ in ISA07.	B.4
	ISA08	Interchange Receiver ID	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that does not contain 00520 for AR or 00528 for LA in ISA08. Each individual Contractor determines this code.	B.5
	ISA13	Interchange Control Number	O	It is recommended that the Interchange Control Number (ISA13) be a unique number in each interchange (transmission).	B.5

Pinnacle Business Solutions, Inc.
X12N Transaction User Guide
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Functional Group Header				Language	Page
			O	Pinnacle Business Solutions, Inc. 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	Pinnacle Business Solutions, Inc. 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	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the carrier definition.	B.8
Loop	Transaction Set			Language	Page
			O	Pinnacle Business Solutions, Inc. 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.	
	ST02	Transaction Control Set	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.	62
	BHT02	Transaction Set Purpose Code	O	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).	64
	BHT06	Claim/Encounter Identifier	O	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).	65
	REF02	Transmission Type Identification	O	The 837 Professional claim transaction will not be piloted. Claim files submitted with a Transmission Type Code value of 004010X098DA1 in REF02 may cause the file to be rejected.	66
Loop	Description			Language	Page
1000A	NM109	Submitter ID	R	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.	69
1000B	NM103	Receiver Name	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that is not submitted with a valid carrier name (NM1).	75
1000B	NM109	Receiver Primary Identifier	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that is not submitted with a valid carrier code (NM1). Each individual Contractor determines this code.	75
2010AA	REF02	Billing Provider Additional Identifier	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that has been submitted with any special characters in the EIN or SSN.	92
2010AB	REF02	Pay-to Provider Additional Identifier	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that has been submitted with any special characters in the EIN or SSN.	107
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.	108
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.	111
2010BD		Credit/Debit Card Information	R	Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).	150

Pinnacle Business Solutions, Inc.
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Loop	Claim Information			Language	Page
2300	CLM02	Total Submitted Charges	R	Negative values submitted in CLM02 may not be processed and may result in the claim being rejected.	172
2300	CLM02	Total Submitted Charges	R	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).	172
2300	CLM05-3	Claim Frequency Type Code	R	The only valid value for CLM05-3 is '1' (ORIGINAL). Claims with a value other than "1" may be rejected.	173
2300	CLM20	Delay Reason Code	R	Data submitted in CLM20 will not be used for processing.	179
2300	PWK	Claim Supplemental Information	O	Any data submitted in the PWK (Paperwork) segment may not be considered for processing.	214
2300	AMT01	Credit/Debit Card Maximum Amount	R	Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).	219
2300	AMT02	Patient Amount Paid	R	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: AMT02.	220
2300	AMT02	Total Purchased Service Amount	R	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: AMT02.	221
2300	REF02	Prior Authorization and Referral Number	O	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.	227
2300	CR102, CR106	Ambulance Transport Information	R	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: CR102, CR106.	249, 250
2300	HI	Health Care Diagnosis Code	R	Diagnosis codes have a maximum size of five (5). Medicare does not accept decimal points in diagnosis codes.	265
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 pointed to or not, will be rejected.	265
2300	HI	Health Care Diagnosis Code	R/O	You may send up to eight diagnosis codes per claim; however, the last four diagnosis codes may not be considered in processing.	265
2320	AMT02	Coordination of Benefits Amounts	R	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: AMT02.	332 333
2400	SV102	Line Item Charge Amount	R	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: SV102.	402
2400	SV104	Professional Service	R	Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes may be rejected. (SV104)	403
2400	SV104	Professional Service	O	The max value for anesthesia minutes (qualifier MJ) cannot exceed 4 bytes numeric. Claims for anesthesia services that exceed this value will be rejected. (SV104)	403

Loop	Claim Information			Language	Page
2400	SV104	Professional Service	O	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)	403
2400	SV104	Professional Service	R	SV104 (Service unit counts) (units or minutes) cannot exceed 999.9.	403
2400	SV104	Professional Service	R	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: SV104.	403
2400	CR102, CR106	Ambulance Transport Information	R	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: CR102, CR106.	413, 414
2400	PS1	Purchased Service	O	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.	489
2400	PS102	Purchased Service	R	Negative values submitted in the following fields may not be processed and may result in the claim being rejected: PS102	490
2410	CTP04	Professional Service	O	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.	403
997 – Functional Acknowledgement				Language	Page
			R/O	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	Pinnacle Business Solutions, Inc. will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997.	

X12N 837 - Medicare Part A Companion Document

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>.

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.

The information describes specific requirements to be used for processing data in the FISS system of Medicare Services contractor number 00020 for Arkansas. The information in this document is subject to change. Changes will be communicated in the standard Medicare provider news bulletin and on the Medicare Services website, www.arkmedicare.com. This companion document supplements, but does not contradict any requirements in the X12N 837 Institutional implementation guide.

**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 Pinnacle Business Solutions, Inc.
			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 Pinnacle Business Solutions, Inc.
			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 Pinnacle Business Solutions, Inc.
			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 Pinnacle Business 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 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 Pinnacle Business Solutions, Inc.
			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 Pinnacle Business Solutions, Inc.
			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 Pinnacle Business Solutions, Inc.
			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 Pinnacle Business Solutions, Inc.
			R	Inpatient claims that lack HCPCS when required for CMS adjudication will be RTP'd or will be errored back to the submitter by Pinnacle Business Solutions, Inc.

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	Pinnacle Business 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.	
		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 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 may cause the interchange (transmission) to be rejected at the intermediary's translator.	
		R	After May, 22, 2007, the National Provider Identifier (NPI) must be submitted in all NM109 data elements (NM108=XX) where NM109 is required and in the Service Facility (2310E) NM109 if known.	
		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	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) submitted with more than 9,999 loops.	
		O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) submitted with more than 9,999 segments per loop.	
		O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.	
		R/O	Compression of files is not supported for transmissions between the submitter and Pinnacle Business Solutions, Inc.	

Description				Language	Page
			R/O	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.	
			R	Do not use Credit/Debit card information to bill Medicare. Credit/Debit card information will be ignored.	
			O	Pinnacle Business Solutions, Inc. 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 Pinnacle Business Solutions, Inc.	
			O	Incoming 837 transactions that exceed 700 ISA-IEA's appended together per day will be rejected.	
			O	The recommended file size for incoming 837 transactions should not be more than 13 megs. Incoming 837 transactions that exceed 13 megs may be rejected.	
			O	Pinnacle Business Solutions, Inc. will process 999 ISA-IEA's per day per submitter. Electronic submitters who transmit more than 999 ISA-IEA's per day will have transactions rejected.	
			O	Failure to submit an NPI in the primary provider fields, 2010AA/NM109 and/or 2010AB/NM109 (NM108=XX), will result in your claim being rejected beginning January 1, 2008.	
Interchange Control Header				Language	Page
	ISA05	Interchange ID Qualifier	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that does not contain ZZ in the ISA05.	B.4
	ISA06	Interchange Sender ID	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that does not contain a valid ID in ISA06.	B.4
	ISA07	Interchange ID Qualifier	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that does not contain ZZ in the ISA07.	B.4
	ISA08	Interchange Receiver ID	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that does not contain 00020 for Arkansas in ISA08. Each individual contractor determines this code.	B.5
Functional Group Header				Language	Page
			O	Pinnacle Business Solutions, Inc. 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	Pinnacle Business Solutions, Inc. 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	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that is submitted with an invalid value in GS03 (00020 for Arkansas) based on the intermediary definition.	B.8

Pinnacle Business Solutions, Inc.
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Loop	Transaction Set			Language	Page
			O	Pinnacle Business Solutions, Inc. 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.	
	ST02	Transaction Control Set	O	Pinnacle Business Solutions, Inc. 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 Code	O	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL)	58
	BHT06	Claim/Encounter Identifier	O	Pinnacle Business Solutions, Inc. will accept and process transmissions with a Claim or Encounter Indicator (BHT06) or 'CH' (Chargeable).	59
Loop	Description			Language	Page
	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 may cause the file to be rejected.	60
1000A	NM109	Submitter ID	R	Pinnacle Business Solutions, Inc. 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	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that is not submitted with a valid intermediary name (NM1).	68
1000B	NM109	Receiver Primary Identifier	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that is not submitted with a valid intermediary code (NM1). Each individual Contractor determines this code.	68
2000A	PRV	Billing/Pay-To Provider Specialty Information	R	Providers shall be in compliance with CR 5243: Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims.	Addenda 12
2010AA	REF02	Billing Provider Additional Identifier	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that has been submitted with any special characters in the EIN or SSN.	84
2010AB	REF02	Pay-to Provider Primary Identification Number	O	Pinnacle Business Solutions, Inc. will reject an interchange (transmission) that has been submitted with any special characters in the EIN or SSN.	93
2000B	HL	Subscriber Hierarchical Level	O	The subscriber hierarchical level (HL segment) must be in order from one, by (+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			Language	Page
2300	CLM02	Total Submitted Charges	R	Negative values submitted in CLM02 may not be process and 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

Pinnacle Business Solutions, Inc.
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Chapter 7 – Companion Documents

Loop	Claim Information			Language	Page
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
2400	SV205	Quantity	R	The maximum size for the service unit count field (SV205) 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 Pinnacle Business Solutions, Inc. Claims submitted with decimal data will be rounded to the closet whole number before being processed.	449
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
2410	CTP04	Quantity (National Drug Unit Count)	R	The format for the Quantity is 9(7)V999 and will only allow up to three positions to the right of the assumed decimal. Claims that contain CTP04 in any other format will be RTP'd or will be errored back to the submitter by Pinnacle Business Solutions, Inc.	Addenda 39
997 – Functional Acknowledgement				Language	Page
			R/O	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	Pinnacle Business Solutions, Inc. will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997.	

[X12N 276/277 – Health Care Claim Status Request and Response Companion Document](#)

The table provided on the next page indicates those segments or data elements in the X12N 276/277 Implementation Guide version 4010A1 that allow for Medicare to specify its business requirements. The information describes specific requirements used by Medicare Services 00520 for Arkansas and 00528 for Louisiana. The information in this document is subject to change. Changes will be communicated in the Medicare Provider News bulletin and/or on the Medicare websites:

www.arkmedicare.com

www.lamedicare.com

General Requirements:

The ISA15 must contain a value of P for production mode when submitting a 276 transaction.

Data elements that are defined by a previous qualifier will contain valid and appropriate information for the noted qualifier.

Examples:

- If ISA07 has a value of “28” indicating a fiscal intermediary ID Number, then ISA08 will contain a valid Fiscal Intermediary ID Number.
- If NM108 has a value of “24” indicating an EIN, then NM109 will contain a valid EIN for the identified provider.

Medicare Services will process your request for claim status information in batch.

Upon receipt of your 276, we will generate the following: TA1 or local reject report for interchange control errors the next business day unless a holiday. 997 for syntax errors on the next business day unless a holiday. 277 the next business day unless a holiday.

The Upload Acknowledgment Report will be the only report returned to your mailbox if a value of T has been submitted in the ISA15. The Upload Acknowledgment Report will verify if your file has been successfully received. No other reports will be generated and returned to your electronic mailbox.

Medicare Services will process your 276 as identified in the implementation guide and create a 277 as identified in the implementation guide. At least the minimum response data will be sent.

Medicare Service keeps its online paid claims file for 24 months. After that time, paid claims are stored in an off-line paid claims history file. A 276 inquiry for a claim that has reached history, will result in a 277 response with a health care claim status code “35” (claim not found).

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.

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.

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.

For Medicare the subscriber and patient are the same person. The Dependent Level hierarchical level is never used.

Incoming 276 transactions that exceed 700 ISA-IEA's appended together in a single transmission will be rejected.

The recommended file size for incoming 276 transactions should not be more than 13 megs. Incoming 276 transactions that exceed 13 megs may be rejected.

It is highly recommended that incoming 276 transactions be sent in a continuous string. Incoming 276 transactions that are not sent in a continuous string may be rejected.

Page		Data Segment Name	Segment or Data Element	Supported Value(s)	Requirement
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276 Request Transaction

B.4		Interchange Control Header	ISA05	ZZ	Interchange Identity Qualifier for ISA06 Submitter uses the "ZZ" value.
B.4		Interchange Control Header	ISA06		Interchange sender ID. Submitter chooses and enters a value later used by the contractor for sending back the 277.
B.4		Interchange Control Header	ISA07	27, 28	Carrier submitter uses a "27"; intermediary submitter uses a "28" as the Interchange I.D. Qualifier for ISA08.
B.5		Interchange Control Header	ISA08		Interchange Receiver ID. Submitter uses the CMS assigned Medicare carrier or intermediary number.
28 addenda		Functional Group Header	GS01		Submitter uses code "HR" to designate the 276.
28 addenda		Functional Group Header	GS02		Submitter uses codes agreed to by trading partners.
28 addenda		Functional Group Header	GS03		Submitter uses code agreed to by trading partners.
29 addenda		Functional Group Header	GS05		Submitter uses the recommended HHMM format.
55		Payer Name	NM108	PI	Submitter uses the code "PI" to identify that the carrier or intermediary identifier will follow.
56		Payer Name	NM109		Submitter uses the identifier provided by the carrier or intermediary.
57		Payer Contact Information			This segment is not needed for Medicare.
63		Information Receiver Name	NM108	46	(This is the individual or organization requesting to receive the status information.
63		Information Receiver Name	NM109		Submitter uses identification code as assigned by the carrier or intermediary.
68		Provider Name	NM108	XX	Submitter uses the "XX" qualifier for the National Provider Identifier (NPI) NPI in the NM109.
69		Provider Name	NM109		Submitter enters the National Provider Identifier (NPI).
75		Subscriber Name	NM108	MI	Submitter uses the "MI" qualifier for the patient's Medicare health insurance claim (HIC) number entered in NM109.
76		Subscriber Name	NM109		Submitter enters the patient's Medicare health insurance claim (HIC) number.
14 addenda		Group Number	REF		This segment is not used for inquiries to Medicare.

277 Response Transaction

B.4		Interchange Control Header	ISA05	27, 28	Contractor enters the valid code as a qualifier for ISA106 for Carrier or Intermediary Identification Number as assigned by CMS. Carriers enter "27" and intermediaries enter "28."
B.4		Interchange Control Header	ISA06		Contractor enters the Carrier or Intermediary Identification Number as assigned by CMS.
B.4		Interchange Control Header	ISA07	ZZ	Contractor enters the "ZZ" Qualifier for ISA108.
B.5		Interchange Control Header	ISA08		Contractor enters the ID number assigned by the 276 submitter in the 276, ISA06.
28 addenda		Functional Group Header	GS01		Contractor uses code "HN" to designate the 277.
28 addenda		Functional Group Header	GS02		Contractor uses the code agreed to by trading partners.
28 addenda		Functional Group Header	GS03		Contractor uses the code agreed to by trading partners.
29 addenda		Functional Group Header	GS05		Contractor enters the recommended HHMM format.
131		Payer Name	NM108	PI	Contractor enters the "PI" qualifier for NM109.
132		Payer Name	NM109		Contractor enters identification code.

X12N 276/277 – Health Care Claim Status Request and Response

Medicare can accept transmission of the ASC X12N 276/277. The ASC X12N 276, Claim Status Transaction Inquiry, is used to transmit request(s) to Medicare about the status of specific health care claim(s). The ASC X12N 277, Claim Status Response Transaction, is Medicare's answer back to you about a specific health care claim(s).

Medicare carriers and intermediaries periodically update their claims system with the most current health care claim status codes for use with the ASC X12N 276 and the ASC X12N 277. The X12N 276/277 version 4010A1 implementation guide as well as the claim status codes and category codes may be downloaded from www.wpc-edi.com/hipaa.

The 276/277 Health Care Claim Status Request and Response are submitted and received in batch mode. A 997 Functional Acknowledgment report will be returned to you within 24 hours when your 276 Health Care Claim Status Request has been received. If the 276 transaction has been accepted then a 277 Claim Status Response will be returned back to you.

Providers who want to start taking advantage of the 276/277 must complete a Trading Partner Agreement (TPA) and the ANSI 4010A1 276/277 Claim Status Inquiry Enrollee Information Form. The TPA and the ANSI 4010A1 276/277 Claim Status Inquiry Enrollee Information Form can be downloaded from any of our websites. Testing is not required for the 276/277 transactions.

www.arkmedicare.com www.lamedicare.com

If you have any questions about the Health Care Claim Status and Response (276/277) please call EDI Services at 866-582-3247 or 501-378-2419.

X12N 270/271 - Beneficiary Eligibility Inquiry and Response

The CMS Implementation Guide for the X12N 270 and 271 standard transactions sets allow you to write your own program to submit a file containing a beneficiary eligibility request and to receive a response from Medicare in real time. If you are interested in obtaining the X12N 270/271 transaction set guides, visit one of our internet sites listed below for the current version or www.cms.hhs.gov/ElectronicBillingEDITrans/09_Eligibility.asp.

www.arkmedicare.com

www.lamedicare.com

CR 4366; transmittal 892)(Effective Date: (10/01/05)
(Implementation Date: 11/07/05)
(Medlearn Matters Number MM4093)

Change request (CR) 4366, transmittal 892 states that in June of 2005 only certain clearinghouses, certain providers and trading partners will be permitted to submit 270 transactions via the CMS AT&T communication Extranet (the Medicare Data Communication Network or MDCN). This Extranet is a secure closed private network currently used to transmit data between Medicare Fee-for-Service (FFS) contractors and CMS. All 270 files will be processed at the CMS data center.

A provider that prefers to obtain eligibility data in an electronic data interchange (EDI) format, but does not want to use the 270/271 version 4010A1, may contract with a clearinghouse to translate the information on its behalf; however, the provider would be liable for those clearinghouse costs.

Starting October 1, 2005

In order to obtain access to the CMS 270/271 Medicare Eligibility transaction via the Medicare Data Communication Network (MDCN), a submitter will access the appropriate forms at www.cms.hhs.gov/AccessToDataApplication.

1. [Click on the link located to the left called Medicare Beneficiary Eligibility Inquiries \(270/271\).](#)
2. [In the section named Related Links Inside CMS, click on the link named 270/271 Access Form.](#)

The first form to be completed is the **TRADING PARTNER AGREEMENT SUBMISSION**. Submitters must electronically provide the information requested on the form and click on the appropriate assurances. If the appropriate boxes of the agreement are checked and you supply the information requested, a copy of the completed form will be electronically submitted to the CMS 270/271 Medicare Eligibility Integration Contractor (MEIC) for security authentication. The access process will then continue and you will be directed to complete an MDCN connectivity form and submit it electronically in order to be connected to the 270/271 eligibility database.

The CMS staff will ensure that all of the necessary information is provided on the form, as well as ensure the complete connectivity to the 270/271 application. The MEIC will be responsible for contacting the clearinghouses, providers and trading partners to authenticate the accessing entity's identity.

Once the authentication has been completed, the MEIC will provide the clearinghouses, providers and trading partners with a submitter ID that is required to be used on all 270/271 transactions. Testing will be coordinated by the MEIC. After successful testing, 270 production inquiries may be sent real-time.

Note: In order to access the MDCN, an entity must on its own obtain the necessary telecommunications software from the AT&T reseller.

The current AT&T resellers are:

IVANS: www.ivans.com

1-800-548-2675

McKesson: www.mckesson.com

1-800-782-7426, option 5, then key option 8

The MEIC will provide help desk support during the hours of 7:00am – 9:00pm eastern time Monday through Friday. The phone number is: 1-866-324-7315. The e-mail address for the help desk is:

MCARE@cms.hhs.gov.

You may also access the Medlearn Matters Articles on the CMS website. The Medlearn Matters Articles was developed by CMS for Medicare providers. You can view the Medlearn Matters Articles by going to:

<http://www.cms.hhs.gov/medlearn/matters>

From the web page, look for CR 4093 in the CR NUM column on the right, and click on the file for that CR. If you have any questions please call EDI Services at 866-582-3247 or 501-378-2419.

Electronic Funds Transfer

How would you like direct deposit of your paycheck without relying on the US Mail? Claim payment is your "paycheck" from Medicare, and we want to help get those funds to you as easily and quickly as possible. That's what Electronic Funds Transfer, or EFT, is all about. All you need to do is contact us and complete the EFT Authorization Form. In order to obtain an EFT form, contact us at one of the phone numbers listed below. The Electronic Funds Transfer form, EFT, can also be obtained from the following websites.

EDI Services (Arkansas and Louisiana)

(866) 562-3247
(501) 378-2419

www.arkmedicare.com

www.lamedicare.com

X12N 835 - Electronic Remittance Advice

Electronic Remittance Advice (ERA) replaces the bulky paper vouchers with an electronic version. Of course, the same information on claim payment and deductible, as well as co-insurance is all there. Some banks and billing services even offer to automatically reconcile claim payments to accounts receivables. If you want to simplify your life, call EDI Services at (501) 378-2419 or toll free at (866) 582-3247.

You must test before receiving the electronic remittance advices in production mode. Listed below are the criteria for testing ERA's.

1. You must currently receive ERA's in a non-HIPAA format.
2. Complete the ANSI 4010A1 ERA form. The ANSI 4010A1 ERA form is available for download on any of the Medicare websites.
3. Contact EDI Services and request to receive a test ERA in the ANSI 4010A1 format.
4. When your ERA is available for testing, an EDI Analyst will contact you.
5. Once you have successfully downloaded the ANSI 4010A1 electronic remittance advice from the NetX Gateway, and our office has processed the ANSI 4010A1 ERA form, you can be released for production mode.

NOTE: PLEASE PROVIDE EDI SERVICES WITH A PRODUCTION DATE TO START RECEIVING YOUR ERA'S.

Medicare Remit Easy Print Software (MREP)

As part of the RA initiative, CMS developed MREP software to enable physicians and suppliers to read and print the HIPAA-compliant ERA (also known as Transaction 835 or "the 835").

MREP software uses the ERA file that is sent to you in the HIPAA-compliant 835 format. Other electronic formats cannot be used.

With the new MREP software, you will be able to:

- Navigate and view the ERA using your personal computer;
- Search and find ERA/claims information easily;
- Print the ERA in the SPR format;
- Print and export reports about ERAs including denied, adjusted and deductible applied claims; and
- Archive, restore, and delete imported ERAs.

To utilize the MREP software, you will need to receive a HIPAA-compliant ERA (HIPAA 835). Contact EDI Services to find out more about MREP and/or for information on how to receive HIPAA compliant ERAs.

MREP software will be revised three times per year to accommodate Claim Adjustment Reason and Remittance Advice Remark Code set changes. You can sign up to be notified automatically when a new version of MREP is available at you on any of our Medicare websites.

Availability and Cost

MREP software can save you time resolving Medicare claim issues, and it provides features unavailable with the standard paper remittance advice (SPR). MREP is available to you **free-of-charge**. For further information on the software, including how to obtain a free copy, contact EDI Services at (866) 582-3247 or (501) 378-2419.

Benefits of Using MREP Software

1. Save Time and Money

You can print remittance information directly from your computer the day the HIPAA 835 is available. No more time is spent waiting for the mail!

2. Create and Print Special Reports

With MREP, you can run several useful reports including:

- **Deductible Service Lines Report:** Shows claim service lines that have a deductible amount.
- **Adjusted Service Lines Report:** Shows claims within a single remittance that have a claim status 22 (reversed claim).
- **Denied Service Lines Report:** Shows only claim service lines that have an allowed amount of zero *and* are associated with a claim that does not have a claim status 22 (reversed claim).

3. Print and Forward Claims for Other Payers

MREP provides the ability to print remittance information for individual or multiple selected claims, and it allows you to forward only those claims that are needed by other payers for secondary payment. You may view and/or print as many or as few claims as needed. This eliminates the need for you to darken individually identifiable data on the SPR, as you may do today, that does not pertain to the claim for which you are requesting payment.

4. Navigate and View Remittance Information

MREP organizes and presents information in a manner that makes it easy for you to view. It also provides separate tabs to access the following:

- A list of claims;
- Details for individually selected claims;
- Summary information;
- Glossary information containing Claim Adjustment Reason Codes, Remittance Advice Remark Codes, and their definitions;
- A data view that allows you to look at the various loops and segments containing data in the HIPAA 835; and
- A search-function to find claims containing specific information.

5. Search for Claim(s) Information Quickly and Easily

MREP's search function can help you find a claim (or multiple claims) based on your customized search criteria. Using it, you can search by names, numbers, and even portions of information such as:

- Health Insurance Claim Number (HICN);
- Beneficiary Last Name;
- Internal Control Number (ICN);
- Beneficiary Account Number,
- Procedure Code,
- Service Date, and
- Rendering Provider Number.

Note: MREP's search capability provides a powerful way to save time and money when examining remittance information.

6. Eliminate Need for Physical Filing and Storage Space

MREP software imports a HIPAA 835 (once you have received it from your carrier / DMERC) and save the information as a separate import file to help ensure that the original HIPAA 835 file remains intact. It also provides an easy-to-use method to archive, restore, and delete these import files as you maintain your remittance records (further reducing the need for physical filing of printed copies and additional storage space).

Medicare Part A Remote Entry

Medicare Part A offers online access to the Medicare Part A system for Arkansas providers who submit Medicare Part A claims for payment. This is referred to as remote entry. The benefits of remote entry are:

Direct data entry (DDE) of Medicare Part A claims

Claim correction

Claim status

Eligibility access for Part A beneficiaries

Any **new** Arkansas Medicare Part A provider that wants to utilize the benefits of remote entry must complete the ***Part A Agreement for Medicare Remote Entry*** and the ***Trading Partner Agreement***. Both of these forms are available for download at www.arkmedicare.com. If you are currently transmitting Medicare Part A claims electronically and want to start using the Medicare Part A remote system, then you will only need to complete the ***Part A Agreement for Medicare Remote Entry***. Contact EDI Services at 501-378-2419 or toll free at 866-582-3247 if you need assistance or have any questions. AR EDI Customer Service hours are 7:00-4:30 CST, Monday – Friday.

Any questions concerning connection issues and/or coordinating installation, contact the Arkansas Help Desk at 501-378-2317, option #2.

Any questions concerning communication problems or if you need your password reset contact AR EDI Services at 501-378-2419 or toll free at 866-582-3247. **Arkansas providers, please have your RACFID and PIN available.** Arkansas EDI Customer Service Hours are 7:00 – 4:30 CST, or 8:00 – 5:30 EST, Monday – Friday.

Submitting Medical Documentation For Electronic Claims

Follow these steps when forwarding medical documentation for electronic claims:

1. At least seven days prior to your electronic claim submission, mail all pertinent medical documentation to the appropriate state:

Arkansas Medicare Services
P. O. Box 2181
Little Rock, AR 72203-2181

Louisiana Medicare Services
P. O. Box 98501
Baton Rouge, LA 70884-9501

2. All documentation must have an attachment that clearly indicates patient name, Health Insurance Claim (HIC) Number, Date of Service, and your Provider Identification Number (PIN).

Note: Only send medical documentation when necessary for the adjudication of procedures/services that are unusual or require such documentation.

Procedure Code Manual

CMS (previously the Health Care Financing Administration, or HCFA) Common Procedure Coding System (HCPCS) provides complete information on numeric procedure codes and modifiers. It is available in the Procedure Terminology Manual. These manuals can be obtained by contacting:

Procedure Terminology Manual HCPCS Alpha-numeric codes (A0000-V9999)

Order Department U.S. Government Printing Office
American Medical Association Superintendent of Documents
P. O. Box 7046 P. O. Box 371954
Dover, DE 19903 Pittsburgh, PA 15250
Telephone: 1-800-621-8335 Telephone: 202-512-1800
Fax: 312-464-5600 Fax: 202-512-2250

Diagnosis Code Manual

The ICD-9-CM can be obtained from:

ICD-9-CM, Fourth Edition
P. O. Box 371954
Pittsburgh, PA 15250-6121
Telephone: 202-512-1800
Fax: 202-512-2250

Railroad Beneficiaries

United Healthcare processes claims for services rendered to railroad annuitants. A Railroad beneficiary's Medicare Health Insurance Claim (HIC) Number will begin with an alpha prefix (i.e., A123456789). Send railroad annuitants claims to:

United Healthcare
RRB Medicare Claim Office
P.O. Box 10066
Augusta, GA 30999-0001
Telephone: 706-855-1386

Submitting Supplemental Insurance Information (Medicare Only)

Medicare forwards claims to many supplemental insurance companies. Most of these companies provide Medicare with an eligibility file of their insured patients. We will forward claims based on the eligibility file. If you are going to send supplemental insurance information on the claim, you must complete loops 2320, 2330A and 2330B.

Several providers have questioned what information should be sent in the 2330B/NM109, Identification Code or Other Payer Primary Identifier. You can submit any information in this data element. The information must comply with the X12 Implementation Guide. The information must be a minimum of two characters but no more than eighty characters. The data submitted must also be a character from the basic or extended character set in the X12 Implementation Guide.

If the beneficiary has a supplemental insurance known as a Medigap policy, you must provide complete information on the claim or we will not forward the claim to the Medigap insurer. You must complete the 2320/SBR03 with the patient's group or policy number. The 2320/SBR05 must contain the qualifier MI to indicate Medigap. The 2330B/NM109 must contain a valid 5-digit INKEY code. The claim will be rejected if the Medigap INKEY field is blank. The Medigap inkey list is available on the websites.

www.arkmedicare.com
www.lamedicare.com

Billing Requirements Medicare Part B only

Please refer to the ANSI ASC X12N 837 Professional Format Version 4010/4010A1 Billing Requirements on the following pages for additional information.

ANSI 837 version 4010A1	Loop	Data Element Description	Status	Requirements
2-005-SBR09	2000B	Claim editing indicator Code	R	Must=MB for Medicare Part B claims
2-015-NM109	2010BA	Subscriber primary identifier	S	Required for Medicare Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is Primary or Secondary. For Medicare the patient is always the subscriber. Entity Identifier Code (NM101) = Insured or Subscriber (IL), Identification Qualifier Code (NM108) = Member Identification Number (MI)
2-015-NM103 2-015-NM104 2-015-NM105	2010BA	Subscriber last name Subscriber first name Subscriber middle name	R R S	Enter the patient's name as shown on their Medicare card (for Medicare the patient is always the subscriber)
2-032-DMG02	2010BA	Subscriber birth date	R	Enter the patient's birth date. Must be formatted as CCYYMMDD. Date Qualifier (DMG01)=D8
2-032-DMG03		Subscriber gender code	R	Enter the patient's sex. F=Female M=Male U=Unknown
2-325-NM103 2-325-NM104 2-325-NM105	2330A	Other insured last name Other insured first name Other insured middle name	S S S	List the name of the insured if there is insurance primary to Medicare. Leave blank if Medicare is primary. See box 9 if there is Medigap coverage
2-025-N301 2-025-N302 2-030-N401 2-030-N402 2-030-N403 Not mapped	2010BA	Subscriber address line 1 Subscriber address line 2 Subscriber city name Subscriber state code Subscriber postal zone or zip code	R S R R R	Enter the patient's mailing address.
2-005-SBR02 2-290-SBR02	2000B 2320	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.
2-332-N301 2-332-N302 2-340-N401 2-340-N402 2-340-N403 Not mapped	2330A	Other insured address line 1 Other insured address line 2 Other insured city name Other insured state code Other insured postal zone or zip code	S S S S 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.
Not mapped Not mapped Not mapped				
2-325-NM103 3-325-NM104 3-325-NM105	2330A	Other insured last name Other insured first name Other insured middle name	S S S	Required if enrolled in a Medigap policy. Enter the name of the enrollee in the Medigap policy.
2-325-NM109	2330A	Other insured identifier	S	Enter the policy and/or group number of the Medigap insured. Required if other payers are

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ANSI 837 version 4010A1	Loop	Data Element Description	Status	Requirements
2-290-SBR03	2320	Insured group or policy number	S	known to potentially be involved in paying this claim.
2-305-DMG03 2-305-DMG02	2320	Other insured gender code Other insured birth date	S S	Enter the Medigap insured's sex. F=Female M=Male U=Unknown Enter the Medigap insured's birth date. Must be formatted as CCYYMMDD. Date Qualifier (DMG01)=D8
Not Mapped				
2-325-NM109 2-290-SBR04	2330B 2320	Other Payer Primary Identifier Other insured Group name	S S	Enter the Medigap insurer's unique identifier provided by the local Medicare carrier and the name of the Medigap enrollee's insurance. Insurance Type Code (SBR05)= Medigap Part B (MI) Required if other payers are known to potentially be involved in paying this claim.
2-130-CLM11-1 2-130-CLM11-2 2-130-CLM11-3	2300	Employment related indicator	S	Required if Date of Accident (DTP01=439) is used and the service is employment related.
2-130-CLM11-1 2-130-CLM11-2 2-130-CLM11-3	2300	Auto accident indicator	S	Required if Date of Accident (DTP01=439) is used and the service is related to an auto accident.
2-130-CLM11-1 2-130-CLM11-2 2-130-CLM11-3	2300	Other accident indicator	S	Required if Date of Accident (DTP01=439) is used and the service is accident related.
2-325-NM109	2330A	Medicaid identification number	S	Enter the patient's Medicaid number if patient is entitled to Medicaid.
2-130-CLM11-4	2300	Auto Accident State or Province Code	S	Required if Related Cause (CLM11-1, -2 or -3)=Auto Accident (AA) to identify the state in which the automobile accident occurred.
2-290-SBR03 2-325-NM109 Not mapped 2-290-SBR09 2-290-SBR05	2320 2330A 2320	Insured group or policy number Other Insured Identifier Claim filing indicator code Insurance Type Code	S 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.
2-305-DMG03 2-305-DMG02	2320	Other insured gender code Other insured birth date	S S	Enter the insured's sex. F=Female M=Male U=Unknown Enter the insured's birth date. Must be formatted as CCYYMMDD. Date Qualifier (DMG01)=D8
Not mapped			N	
2-290-SBR04	2320	Other insured group name	S	Enter the complete insurance plan or program name.
2-130-CLM10 2-130-CLM09 Not mapped	2300	Patient signature source code Release of information code	S R	Patient Signature Source Code (CLM10) is required except in cases where Release of Information (CLM09) =No (N)
2-130-CLM10	2300	Patient signature source code	S	Required except in cases where Release of

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ANSI 837 version 4010A1	Loop	Data Element Description	Status	Requirements
2-310-OI03	2320	Benefits assignment certification indicator	S	Information (CLM09)=No (N)
2-135-DTP03 (439)	2300	Accident date	S	Required if Related Cause Code (CLM11-1, -2 or -3)= Auto Accident (AA), Abuse (AB), Another Party (AP) or Other (OA). Required when available.
2-135-DTP03 (431)	2300 2400	Onset of current illness or injury date	S	
2-455-DTP03 (431)*	2300	Initial treatment date	S	
2-135-DTP03 (454)	2400			
2-455-DTP03 (454)*				
2-135-DTP03 (438)	2300	Onset of similar symptoms or illness	S	Required when claim involves services to a patient experiencing symptoms similar or identical to previously reported symptoms.
2-455-DTP03 (438)*	2400			
2-135-DTP03 (360)	2300	Disability from date (CCYYMMDD)	S	Enter the date when patient is employed and unable to work in current occupation. An entry here may indicate employment related insurance coverage.
2-135-DTP03 (361)		Disability to date (CCYYMMDD)	S	
2-250-NM103 (DN)	2310A or 2420F*	Referring provider last name	S	Required if claim involved a referral. When reporting the provider who ordered services such as diagnostic and lab utilize the Referring Provider Name (2310A) loop at the claim level. Required if a service or supply was ordered by a provider and that provider is a different entity than the rendering provider for this service line. When a claim involves multiple referring and/or ordering physicians, a separate claim must be billed for each ordering/referring physician.
2-250-NM104		Referring provider first name	S	
2-250-NM105	Referring provider middle name	S		
2-500-NM103	2420E	Ordering provider last name	S	
2-500-NM104		Ordering provider first name	S	
2-500-NM105		Ordering provider middle name	S	
2-271-REF02 (1G)	2310A 2420F 2420E	Referring Provider Secondary Identifier	S	Enter the HCFA assigned UPIN of the referring/ordering physician listed in Item 17.
2-525-REF02 (1G)*		Ordering Provider Secondary Identifier	S	
2-525-REF02 (1G)				
2-135-DTP03 (435)	2300	Related Hospitalization Admission Date	S	Enter the date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
2-135-DTP03 (096)		Related Hospitalization Discharge Date	S	
2-135-DTP03 (304)	2300 2400 2310E 2420D	Date Last Seen	S	Enter the date patient was last seen and the UPIN of his/her attending physician when an independent physical or occupational therapist, or physician providing routine foot care submits claims. Only bill one supervising/attending provider per claim.
2-455-DTP03 (304)*		Supervising/Attending provider UPIN	S	
2-271-REF02 (1G)				
2-525-REF02 (1G)*				
2-220-CRC03 (IH)	2300	Homebound indicator	S	Required when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient.

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ANSI 837 version 4010A1	Loop	Data Element Description	Status	Requirements
2-190-NTE02 2-485-NTE02*	2300 2400	Extra narrative data	S	To be used at the provider's discretion.
2-135-DTP03 (090) 2-135-DTP03 (091)	2300 2300	Date-assumed care dates Date-relinquished care dates	S S	
2-180-REF02 (P4)	2300	Demonstration Project Identifier	S	
2-450-CRC02 (70)	2400	Hospice Employed Provider Indicator	S	Required on all claims involving physician services to hospice patients.
2-135-DTP03 (455) 2-455-DTP03 (455)*	2300 2400	Last X-Ray date	S	Required when claim involves spinal manipulation if an x-ray was taken.
2-488-PS102*	2400	Purchased service charge amount	S	Required if there are purchased service components to this claim.
2-231-HI01-02 (BK) 2-231-HI02-02 (BF) 2-231-HI03-02 (BF) 2-231-HI04-02 (BF) 2-231-HI05-02 (BF) 2-231-HI06-02 (BF) 2-231-HI07-02 (BF) 2-231-HI08-02 (BF)	2300	Principal Diagnosis code Diagnosis code Diagnosis code 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-9-CM code number and code to the highest level of specificity. Enter up to four codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.
2-180-REF02 (G1)	2300	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.

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ANSI 837 version 4010A1	Loop	Data Element Description	Status	Requirements
2-180-REF02 (LX)	2300	Investigational device exemption number	S	Required when claim involves an FDA assigned investigational device exemption (IDE) number.
2-250-NM101(FA) 2-271-REF02 (LU)	2310D	HHA/Hospice provider number for CPO services	S	For physicians performing care plan oversight services, enter the Medicare provider number of the home health agency (HHA) or hospice. Providers submitting CPO claims must submit the Facility (FA) qualifier in the Entity Identifier Code (NM101) leaving the Identification Code Qualifier (NM108) and the Identification Code (NM109) blank. The CPO PIN should be submitted in a Reference Identification (REF) segment of the same loop & use the Location Number (LU) qualifier. This is to distinguish the CPO PIN from the Facility PIN. Only bill one unique HHA/Hospice provider number per claim.
2-180-REF02 (X4) 2-470-REF02 (X4)*	2300 2400	CLIA certification number	S	Required on claims for any laboratory performing tests covered by the CLIA act. Enter the 10-digit CLIA (Clinical Laboratory Improvement Amendment) certification number for laboratory services billed by an entity performing CLIA covered procedures. Only bill one unique CLIA number per claim.
2-250-NM101(77) 2-250-NM102(2) 2-265-N301 2-265-N302 2-270-N401 2-270-N402 2-270-N403	2310D	Point of Pick up	S	Required on ambulance claims. Enter the point of pick up.
2-455-DTP03 (472)	2400	Service date	R	Enter the service date for each procedure, service or supply. If a single date the Date/Time Qualifier (DTP02)=CCYYMMDD (D8) If a range of dates the Date /Time Qualifier (DTP02) = CCYYMMDD-CCYYMMDD (RD8)
2-130-CLM05-1 2-370-SV105*	2300 2400	Facility Type Code Place of Service Code	R S	Enter the appropriate Place of Service code. Identify the location, using a place of service code, for each item used or service performed.
2-370-SV101-2 2-370-SV101-3 2-370-SV101-4 2-370-SV101-5 2-370-SV101-6	2400	Procedure code Procedure modifier 1 Procedure modifier 2 Procedure modifier 3 Procedure modifier 4	R S S S S	In Product/Service ID Qualifier (SV101-1) enter (HC) for HCPCS Codes. Enter the procedures, services or supplies using the HCFA Common Procedure Coding System (HCPCS). Modifiers are required when they clarify/improve the reporting accuracy of the associated procedure codes. The Medicare Part B processing system you send your claims to may only use the first two modifiers for adjudication and payment determination of claims.
2-370-SV107-1 2-370-SV107-2 2-370-SV107-3	2400	Diagnosis code pointer Diagnosis code pointer Diagnosis code pointer	S S S	A submitter must point to the primary diagnosis for each service line. Use remaining diagnosis pointers in declining level of importance to service line.

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ANSI 837 version 4010A1	Loop	Data Element Description	Status	Requirements
2-370-SV107-4		Diagnosis code pointer	S	
2-370-SV102	2400	Line item charge amount	R	Enter the charge for each service.
2-370-SV104 (UN) 2-370-SV104 (MJ)	2400	Units of service Anesthesia/oxygen minutes	R 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. For anesthesia, show the elapsed time. Convert hours into minutes and enter the total minutes required for the procedure.
2-271-REF02 (1C) 2-525-REF02 (1C)* 2-488-PS101	2310B 2420A 2400	Rendering provider secondary identifier Purchased (Professional) Service Provider Identifier	S S	Enter the carrier assigned Provider Identification Number (PIN) when the performing provider/supplier is a member of a group practice. State specific provider number of entity performing the purchased test.
2-015-NM109 (85, 87) 2-015-NM108 (34) 2-015-NM108 (24)	2010AA or 2010AB*	Provider tax ID Social Security number indicator Employer's ID number indicator	R	Enter your provider of service or supplier Federal Tax ID (Employer Identification Number) or Social Security Number.
2-130-CLM01	2300	Patient account number	R	Enter the patient's account number assigned by the provider of service's accounting system. As a service, any account number will be returned to you up to 20 characters.
2-130-CLM07	2300	Medicare assignment code	R	A=Assigned B=Assignment accepted on Clinical Lab services only C=Not Assigned P=Patient refuses to assign benefits
2-130-CLM02	2300	Total claim charge amount	R	Enter total charges for the services.
2-175-AMT02 (F5)	2300	Patient amount paid	S	Required if the patient has paid any amount towards the claim for covered services only.
2-130-CLM06 Not mapped	2300	Provider or supplier signature indicator	R	A 'Y' value indicates the provider signature is on file; an 'N' value indicates the provider signature is not on file.
2-250-NM103 (FA, TL, 77, LI) 2-265-N301 2-270-N401, 02, 03 2-500-NM103 (FA, TL, 77, LI) 2-514-N301 2-520-N401, 02, 03 2-271-REF02 (1C) 2-525-REF02 (1C)	2310D 2420C* 2310D 2420C* 2400 2420B	Service facility location Service facility address Service facility location Service facility address Service facility location PIN Purchased (Technical) service provider identifier	S S S	Required when the location of health care service is different than that carried in the Billing Provider Name (2010AA) or Pay to Provider (2010AB) loops. Required if the service was rendered in a Health Professional Shortage Area (QB or QU modifier billed) and the place of service is different than the HPSA billing address. If an independent laboratory is billing, enter the place where the test was performed and the carrier assigned PIN. The reference lab identification number should also be reported here. Only bill one unique facility number per claim. Providers of service must identify the supplier's name, address and PIN when billing for purchased diagnostic tests. If the supplier is a certified mammography screening center, enter the FDA approved certification number.

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ANSI 837 version 4010A1	Loop	Data Element Description	Status	Requirements
2-488-PS101 2-525-REF02 (1C)* 2-180-REF02 (EW) 2-470-REF02 (EW)*	2300 2400	Mammography certification #	S S	
2-035-REF02 (1C) 2-015-NM103, 04, 05 (85, 87) 2-025-N301 2-030-N401 2-030-N402 2-030-N403 2-040-PER04	2010AA or 2010AB* 2010AA or 2010AB* 2010AA or 2010AB* 2010AA	Provider Medicare number Provider last or organizational name Provider first name Provider middle initial Provider's address 1 Provider's city Provider's state Provider's zip code Provider's phone number	R R R S	Enter the Group Number for the performing provider of service/supplies who is a member of a group practice or PIN of performing provider who is not a member of a group practice. Enter the provider of service/supplier's billing name, address, zip code and telephone number.

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 4010A1 Professional Implementation Guide 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.

Who to Call for Help

For assistance, please use the following information to reach the appropriate contact.

Call your **Software or Hardware Vendor** if:

- Modem does not dial or connect with the NetX Gateway
- Error messages are received in your software billing program
- Question on reports generated by software program (Pre or post billing reports)

Call EDI Services at (501) 378-2419 or toll free at (866) 582-3247 Monday through Friday 7:00 am – 4:30 pm CST if:

- Enrolling as an electronic biller
- Electronic claim specifications, X12N
- Questions on reports generated by electronic billing:
- 997 Functional Acknowledgement
- Questions on Batch Processing Report
- Questions on Medicare Prepass Edit Report
- Electronic Remittance Advice (ERA)
- Acceptance of electronic claim submissions
- How to enroll in Electronic Funds Transfer and Electronic Remittance Advice
- Software Support for PCACE
- Transmission protocol and NetX Gateway
- Reset electronic Functional Acknowledgement, Batch Processing Report, Medicare Prepass Edit Report, or the Electronic Remittance Advance (ERA)

Call **Customer Service** for:

- Claim and check status
- Procedure pricing
- Proper reporting of modifiers
- EOMB requests
- Explanation of processing determinations
- Medical policy or procedure questions
- Cashier/overpayment concerns
- Automatic crossover, Medigap, Medicaid

Customer Service Phone Numbers:

Arkansas Medicare Part A:	(866) 548-0527
Arkansas Regular Business:	(800) 827-4814
Arkansas Medicare Part B:	(877) 908-8434 (Claim Status Only)
Arkansas Medicare Part B:	(866) 345-0274
Louisiana Medicare Part B:	(877) 567-7204 (Claim Status Only)
Louisiana Medicare Part B:	(866) 567-8419

Notifying EDI Services/Provider Enrollment of Changes

Changes within an office are both necessary and inevitable. As an electronic biller, you will need to notify EDI Services and/or Provider Enrollment of some changes that may take place at your office.

Address Changes

Address changes for electronic billers must be reported to Provider Enrollment Services to update your provider number and address. EDI Services must be contacted to update your address information for your electronic files. EDI Services will update your information for Medicare Part A for Arkansas, Medicare Part B for Arkansas and Louisiana. The addresses for EDI Services and Provider Enrollment are listed below.

EDI SERVICES (FOR ALL STATES)

EDI SERVICES
P. O. Box 2181
Little Rock, AR 72203-2181

PROVIDER ENROLLMENT

Arkansas Medicare Services
P. O. Box 34260
Little Rock, AR 72203
Attn: Provider Enrollment Services

Louisiana Medicare Services
P. O. Box 83860
Baton Rouge, LA 70884-3860
Attn: Provider Enrollment

Changes in Physician Staff

Contact EDI Services at (501) 378-2419 or toll free at (866) 582-3247 when additions have been made in physician staffing. Additionally, please notify EDI Services when a doctor leaves your office/practice so that he/she can be deleted from your electronic billing information retained in our office.

System Changes

Any changes in the software or hardware of your office computer system should be reported to EDI Services. These changes may or may not affect your ability to bill electronically.

EDI Services HIPAA Testing Checklist

Note: Many of the documents referred to below are in Adobe Acrobat Portable Document Format.

- I send claims directly to Medicare. (See 1 & 2 below)
- I send claims to Medicare through a clearinghouse. (See 3 below)
- I send claims using Medicare software (See 4 below)

Vendor Testing – If you are sending claims direct to Arkansas Medicare and using a software vendor, you should contact that vendor and ask if they are testing their software with us. If your vendor has no plans to test with us you will need to follow the directions in 2 below. We will allow vendors to receive “Blanket Approval” for their software products. This means the vendor can test on behalf of their customers. Once testing is completed, the vendor can then complete a vendor Blanket Approval form, letting us know which clients this test will cover. In addition, the following steps must be completed.

1. You must complete a Trading Partner Agreement (TPA). The completed document must be returned to EDI Services via mail to the address noted on page 66. The Trading Partner Agreement can be downloaded from one of the websites listed below.
2. Once EDI Services has processed your TPA and testing is successfully concluded, we will contact you to establish a date for migrating your submissions to the new format.

Individual Testing – If your vendor will not be testing the new format for you, it will be necessary for you to submit test transactions for yourself. Several documents can be obtained and will be helpful in the testing process, including the X12N Transaction User Guide and the Medicare Companion Documents. These documents can be found on the following websites.

www.HealthAdvantage-hmo.com
www.USABLEAdminArkansas.com
www.ArkansasBlueCross.com
[www.fepproviderservice@arkbluecross.com](mailto:fepproviderservice@arkbluecross.com)

www.arkmedicare.com
www.lamedicare.com

- a. You must complete a Specialty Testing Form. A printable copy can be obtained from one of the websites listed above. The completed document must be returned to EDI Services via mail to the address noted below or you may fax it to (501-378-2265).
- b. Within three business days, your submitter ID will be added to the Gateway.
- c. You must transmit a 4010A1 test file containing all the specialties for which you routinely bill.
- d. Reports (ANSI 997, Batch Processing Report and/or ANSI TA1) will normally be returned to your Gateway Electronic Mailbox within 30 minutes. EDI Services will contact you via telephone a few days after transmission to discuss your test file.
- e. You must complete a Trading Partner Agreement (TPA). The Trading Partner Agreement can be downloaded from one of the websites listed on page 60. This document contains important information about submitting claims in the ANSI format. Consequently, we suggest you complete this document early in the process. The completed document must be returned to EDI Services via mail to the address noted on page 66.
- f. Once EDI Services has processed your TPA and testing has successfully concluded, we will contact you to establish a date for migrating your submissions to the new format.

Clearinghouse Testing – If you submit claims through a third party, your clearinghouse or billing agent should test the new formats on your behalf. A list of all of the vendors including clearinghouses that have successfully tested with us are posted on the Medicare websites. If you do not find your clearinghouse’s name on this list, we suggest you contact them and inquire as to their testing status with Medicare. All organizations that have successfully tested with us are issued a certification letter, which you may want to request if the clearinghouse’s name is not included in the list.

- a. If you are changing from submitting to us direct to submitting through a clearinghouse or if you are changing from one clearinghouse to another, you must submit a Letter of Authorization form to allow us to accept claims from a third party. A copy of this form is available on the Medicare websites. Failure to complete the required authorizations will result in the rejection of your claims.
- b. Blanket Approval will be given to clearinghouses for all of their clients once they have successfully tested and completed the Blanket Approval form. This form lists all providers/submitters for whom they will transmit which is available on our websites.
- c. The clearinghouse must also complete a TPA before migrating submissions to the new format.

Medicare Software Testing – If you will be keying claims using the MCE Medicare software, the following steps must be completed:

If you already have an EDI Submitter Number...

- a. You may use this number for submission of the new format. You must return the TPA. The completed document must be returned to EDI Services via mail to the address noted on page 66.
- b. Once EDI Services has processed your TPA, we will contact you to establish a date for migrating your submissions to the new format.
- c. You must install the MCE software on your computer system. If you need help in installing the software you may call (866) 582-3247 or (501) 378-2419.
- d. After transmitting your 4010A1 claim file, reports (ANSI 997, Batch Processing Report and/or ANSI TA1) will normally be returned to your Gateway Electronic Mailbox within 30 minutes.

If you do not already have an EDI Submitter Number...

- a. You must first complete the Trading Partner Agreement. The Trading Partner Agreement can be downloaded from any of the Medicare websites. The completed document must be returned to EDI Services via mail to the address noted on page 66, and a submitter ID will be issued to you.
- b. Once you have received your Submitter ID, you must complete a Specialty Testing Form. The Specialty Testing Form can be downloaded from any of the Medicare websites. The completed document must be returned to EDI Services via fax to (501-378-2265).
- c. Within three business days, your Submitter ID will be added to the Gateway.
- d. You must install the MCE software on your computer system. Should you need help in installing the software you may call (866) 582-3247 or (501) 378-2419.
- e. Key in at least 10 but no more than 20 claims relevant to your practice (use real patient data and claim information) to use as your test file.
- f. You must transmit a test file to the Gateway System, which contains all of the specialties you routinely bill.
- g. Reports (ANSI 997, Batch Processing Report and/or ANSI TA1) will normally be returned to your Gateway Electronic Mailbox within 30 minutes. EDI Services will contact you via telephone a few days after transmission to discuss your test.
- h. Once EDI Services has processed your TPA and testing has successfully concluded, we will contact you to establish a date for migrating your submissions to the new format.

Mailing Address

EDI Services
P.O. Box 2181
Little Rock, Arkansas 72203-2181

Website Addresses

Arkansas.....www.arkmedicare.com
Louisiana.....www.lamedicare.com

Q. How often can I submit a claim file to the Gateway?

A. You can submit electronic claim files to the Net-X Gateway as often as needed. The Net-X Gateway is available 24 hours a day, 7 days a week. There is no waiting period before submitting additional electronic claim files.

Q. Can I submit multiple files in one transmission?

A. You can append multiple ISA-IEA's within a single file and transmit the file to the Net-X Gateway. **It is highly recommended to only append three ISA-IEA's within a single transmission, approximately 17 meg.** Therefore, the recommended transmission would be to append only three ISA-IEA's per transmission with a total of 15,000 claims or less.

Q. What type of reports will I get and what is their purpose?

A. You will receive several different reports on the Net-X Gateway about your electronic claim files. You can expect to receive the reports listed below in respect to their line of business. The reports listed below are in the order in which you will receive them on the Net-X Gateway. **Please note that acceptance of these reports do not guarantee payment will be made on your claims. It is imperative that you download your reports.**

Private Lines of Business

Upload Acknowledgment Report – This report verifies that your electronic claim file was successfully received.

Interchange Acknowledgment Report (TA1) – The Interchange Acknowledgment Report, also known as the TA1 report, will only be returned to you if the ISA14 data element within your electronic claim file has a value of 1. Otherwise, you will not receive an Interchange Acknowledgment Report (TA1). If you are not sure whether you should be receiving the Interchange Acknowledgment Report, please contact your software vendor. Your software vendor will be able to confirm if the ISA14 data element contains a value of 1.

997 Functional Acknowledgment Report – The 997 Functional Acknowledgment Report will be returned to you for every electronic transaction

that you submit to the Net-X Gateway. The 997 Functional Acknowledgment Report confirms if your electronic claim file is syntactically correct.

Batch Processing Report (BPR) – The Batch Processing Report will perform additional editing on your claims. The Batch Processing Report will verify the validity of the data submitted in your claims. The Batch Processing Report will indicate any claims that may have rejected out and the reason for the rejection. The claims that have not rejected out on the Batch Processing Report will be forwarded to the appropriate line of business for processing. If you need additional assistance with a rejection on the Batch Processing Report, please call EDI Services at 501-378-2419 or toll free at 866-582-3247.

Medicare Part A

Medicare Part A electronic claim files will receive the Upload Acknowledgment Report, Interchange Acknowledgment Report (TA1) if applicable, 997 Functional Acknowledgment Report, and the Batch Processing Report. In addition to these reports, the Med A Exception Report will also be delivered to your electronic mailbox for you to download. The Med A Exception Report will indicate the provider number submitted in your file, the date, the number of initial bills, the total number of claims received and the total number of claims accepted into the Medicare Part A payment system.

Medicare Part B

Medicare Part B electronic claim files will receive the Upload Acknowledgment Report, Interchange Acknowledgment Report (TA1) if applicable, 997 Functional Acknowledgment Report, and the Batch Processing Report. You will also receive a report called the Batch Detail Control Listing. The Batch Detail Control Listing may also be referred to as your H99 report or Medicare report. The Batch Detail Control Listing will be delivered to your electronic mailbox for you to download. The Batch Detail Control Listing will display information about your electronic claim file such as the total claim count received, the total claim count accepted and total file charges that were accepted into the Medicare payment system. It will also indicate any rejections that you may have in your electronic claim file. If you need assistance with a rejection on your Batch Detail Control Listing, please call

EDI Services at 501-378-2419 or toll free at 866-582-3247.

Q. Will you re-post my report or electronic remittance advice back out to the Net-X Gateway for me to download again?

A. It is no longer necessary to contact EDI Services to re-post your electronic reports. After you have attempted to download your electronic reports, they are automatically stored in the archive directory on the Net-X Gateway. Your report will stay in the archived file for 14 days. If you need to re-download your report, select option 3 for Archived Files on the Main Menu screen. Then follow the instructions on your screen to proceed with the downloading process. If it has been more than 14 days, you will need to contact EDI Services to re-post your reports. If you are using a script to download your reports, please contact your software vendor for assistance. If you are still experiencing problems or need additional assistance, please contact EDI Services at 501-378-2419 or toll free at 866-582-3247.

Q. How long should I wait to download my reports after transmitting a file?

Your reports will be delivered to your electronic mailbox within 24 hours after we have received your electronic claim file.

Q. Why can I only submit one transaction set (ST-SE) within a file?

A. With the issuance of CMS CR1809, carriers were allowed to choose whether to accept or not to accept **multiple transaction sets. Medicare Services has** chosen to only accept one transaction set (ST-SE) within a functional group (GS-GE). Furthermore, Medicare Services opted to only accept one functional group (GS-GE) within a file (ISA-IEA). This rule applies to all lines of business.

Q. How do I reset my password on the Net-X Gateway?

A. Your password for the Net-X Gateway will expire every 30 days. You will be prompted when your password has expired. You do not have to wait for your password to expire before changing your password. You can change your password at anytime. Follow the instructions on pages 18-20 of this User Guide for step-

by-step instructions for changing your password. If you need additional assistance or if you have suspended your password, please contact EDI Services at 501-378-2419 or toll free at 866-582-3247.

Q. What do I need to do if I suspend my password to the Net-X Gateway?

A. You must contact EDI Services at 501-378-2419 or toll free at 866-582-3247 if you have suspended your password to the Net-X Gateway. EDI Services will reset your password to the default password for the Net-X Gateway. The default password is case sensitive and must be entered in uppercase letters. Please call EDI Services to get the default password that must be entered.

Q. How can I find out the current system status for EDI Services?

A. EDI Services has information available on the Medicare websites that will allow submitters to find the current system status. All you need to do is go to one of the Medicare websites and click on EDI Information and then click on View EDI System Status. You can find out the current system status of the Gateway, electronic remittance advices on the Gateway, the Medicare Part B Batch Detail Control Listing (H99) reports on the Gateway, and the status of the remote system for Arkansas Medicare Part A. The websites that you can access to find the current system status are:

www.arkmedicare.com
www.lamedicare.com

Q. What type of guidelines should I follow for selecting a software product?

A. Listed below and on the next few pages are recommendations for selecting a software product.

Software Assessment Guidelines

Once you have determined your practice needs and requirements, you must begin the vendor selection process. Selecting a vendor must be as objective and quantitative as possible. Areas to be evaluated should include technical functionality, flexibility, and customer service. The following steps may be used as guidelines for your Practice as you begin the vendor selection process:

1. Develop a list of potential vendors:
 - Talk to the Medicare carrier or FI;
 - Ask other providers of comparable size/specialties what vendors they use for what services and how satisfied they are;
 - Ask a consultant;
 - Attend standards conferences, follow trade magazines and investigate Web pages.
2. Call or write the vendors selected/recommended to discuss the organization's needs and request a proposal.
3. Tell the vendors how the proposals should be structured so that the various proposals can be more easily compared.
4. Attend demonstrations of at least two to three vendors and pay close attention to:
 - How individual requirements will be met;
 - Ease of understanding;
 - Ease of features - data entry, search features, editing/compliance checking features, help features, error correction features;
 - Security - disaster recovery plans, controls, and audits;
 - Daily Procedures;
 - Reporting/Tracking features.
5. Check vendor references and ask specific questions such as:
 - How long has the business been in operation?
 - How many installations have been completed with the **product** you are evaluating?
 - How long has the system been in place?
 - What is the quality of the training and ongoing support?

Is there a user's group in place?

What are the hours of Customer Support?

What formats are supported?

Have you experienced any problems with the system?

Have you experienced any problems with the vendor?

How long did it take to get up and running?

Are you happy with the system/vendor and would you recommend it/them today?

What additional services are available through the vendor (i.e. statement service)

Make site visits to the vendor as well as other clients of similar size and bill mix that have been running the system for some time.

Evaluating Proposals

Vendor proposals should be evaluated on several levels including company reputation/history, system functionality, flexibility, overall costs, and support provided. You should create a checklist that compares the vendor proposals against their original requirements by assigning a relative weight to each requirement and then rating the vendor's ability to meet each requirement based on their written proposals. Although some aspects of each checklist will be highly individual, the following are some of the elements that should be considered:

Overall costs:

- Software costs;
- Hardware costs (types as well as quality);
- Licensing fees;
- Training costs;
- Installation costs;
- Cabling;
- Phone lines (leased line/toll charges);
- Remodeling/Furniture;
- Forms;
- Conversion costs;
- Electricity costs;
- Supply costs (diskettes, tapes, paper, ribbons);
- Annual hardware maintenance;
- Annual software maintenance;
- Cost of custom program changes; and
- Cost of continuous software support.

Evaluate hardware differences;

Evaluate quality of training and support;

Evaluate system documentation;

Consider the staff size of the vendor;

Determine how well each vendor responded to requirements and questions in the proposals;

Determine flexibility (whether the package is proprietary, whether the software can be easily modified, whether the vendor can accommodate changing payer requirements, and if so, at what cost);

Determine overall system convenience including hours of customer service, technical support, and connection times;

Assess future risks and the vendor mitigation of such risks through system trial periods and source codes placed in escrow.

Negotiating With Vendors

Once a vendor has been selected, you must negotiate the final costs, services, and implementation dates to be provided by the vendor. All agreements reached between the two parties should be obtained in writing.

Q. Where can I locate information for accessing and downloading CMS EDI instructions via the CMS Internet EDI Home Page?

A. Information for accessing and downloading CMS EDI instructions via the CMS Internet EDI Home Page can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp. Simply click on the link for quick access.

Updates

January 2006

Three new Medicare Part B EDI front-end edits became effective on 1-1-06. Listed below is a brief description of the three Medicare Part B EDI front-end edits. Please refer to the Provider Newsletter for the complete articles. The Provider Newsletters can be found on any of our websites or click on the link provided in each EDI front-end edit description.

www.arkmedicare.com
www.lamedicare.com

Reference: Infoman CR19004

Effective January 1, 2006, a revision was made to edit the EIN or SSN. In addition to the current logic validating non numeric bytes or a blank field, these edits will allow dashes and spaces to be submitted in the EIN or SSN. Go to <http://www.arkmedicare.com/provider/provnewslet/pdfformat/mcb200510.pdf> to view the complete newsletter article and editing logic.

Reference: Infoman CR17696

Effective January 1, 2006, all HIPAA 4010A1 MSP electronic claims will no longer be accepted in the Medicare Part B Claims Processing System when claims are submitted with complete header information and incomplete line level information. Go to <http://www.arkmedicare.com/provider/provnewslet/pdfformat/mcb200510.pdf> to view the complete newsletter article and editing logic.

Reference: Infoman CR20149

Effective January 3, 2006, there will be new/revised edits for ANSI 4010A1 claims. When a file is received with a PER segment and the PER03 is TE or FX and the PER04 is not 10-digit numeric, an edit will set and reject as a file delete, batch delete or a claim delete. If the PER05 is TE or FX and the PER06 is not 10-digit numeric, an edit will set and reject the claim(s). If the PER07 is TE or FX and the PER08 is not 10-digit numeric, an edit will set and reject as a file delete, batch delete or claim delete. Go to <http://www.arkmedicare.com/provider/provnewslet/pdfformat/mcb200511.pdf> to view the complete newsletter article and editing logic.

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DATE	ADDITIONS/DELETIONS	PAGE(S)
1-2-03	New Medicare Part B Companion Document added.	35-37
2-2-04	New FTP instructions	21-22
5-24-04	Updated Medicare Part B Companion Document (CR 3177)	33-36
6-2-04	Added the RI mailing address for submitting medical documentation	43
6-2-04	Added the RI customer service phone number for Medicare Part B and Medicare Part A	45
6-2-04	Added the information for RI submitters to submit address changes to EDI Services and Provider Enrollment for Medicare Part A and Medicare Part B	46
6-2-04	New FAQ section added	68-73
6-2-04	Updated supplemental insurance information	63
6-21-04	Updated 276/277 Companion Document. Changed cannot to can. Statement now reads "Multiple functional groups (GS to GE segments) can be sent in one interchange (ISA to IEA segments).	40
7-21-04	Added customer service hours	44
10-1-04	Insert Information about Medicare Part A Remote Entry	66-67
10-13-04	Testing not required for the 276 transaction. Submit a value of P in the ISA15. Only submit a value of T when testing telecommunications.	39
12-29-04	Added statement to the Medicare Part B Companion Document. Incoming 837 transactions that exceed 700 ISA-IEA's appended together in a single transmission will be rejected.	34
12-29-04	Added statement to the Medicare Part B Companion Document. The recommended file size for incoming 837 transactions should not be more than 13 megs. Incoming 837 transactions that exceed 13 megs may be rejected.	34
12-29-04	Added statement to the Medicare Part A Companion Document.	

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	Incoming 837 transactions that exceed 700 ISA-IEA's appended together in a single transmission will be rejected.	38
12-29-04	Added statement to the Medicare Part A Companion Document. The recommended file size for incoming 837 transactions should not be more than 13 megs. Incoming 837 transactions that exceed 13 megs may be rejected.	38
12-29-04	Added statement to the 276/277 Companion Document. Incoming 837 transactions that exceed 700 ISA-IEA's appended together in a single transmission will be rejected.	40
12-29-04	Added statement to the 276/277 Companion Document. The recommended file size for incoming 837 transactions should not be more than 13 megs. Incoming 837 transactions that exceed 13 megs may be rejected.	40
1-28-05	Added new Gateway screen shots.	7, 8, 19
2-16-05	Added statement for additional diagnosis codes.	55
2-18-05	Added statement for patient signature source code.	35
3-11-05	Removed Note under Medical Documentation	43
3-11-05	Removed Note under Procedure Code	43
3-11-05	Revision to NTE segment	54
3-11-05	Revision to the Diagnosis/Nature of Illness or Injury	55-56
3-11-05	Revision to the Procedures, services and supplies.	58
3-11-05	Removed FAQ for the additional information.	69
3-29-05	Arkansas Part B Provider Enrollment Address changed.	46
3-29-05	Revised Table of Contents. Changed Notifying AR BCBS of Changes to Notifying EDI Services/Provider Enrollment of Changes.	3, 45
3-29-05	Removed Arkansas Blue Cross Blue Shield (ABCBS).	5, 33, 37, 46
3-29-05	Changed EDI NetX Gateway and ABCBS NetX Gateway to read NetX Gateway.	5, 6, 23, 27
3-29-05	Changed Arkansas Blue Cross Blue Shield to EDI Services.	6, 46, 67

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3-29-05	Changed item 4 d on page 24 and item 5 d on page 25 from Arkansas EDI to EDI Services.	24, 25, 42
3-29-05	Added the Rhode Island web address.	32, 37
3-29-05	Corrected the Rhode Island web address.	33, 39, 42
3-29-05	Changed Arkansas Blue Cross Blue Shield to Arkansas Medicare Services.	43, 46
3-29-05	Changed Arkansas Blue Cross Blue Shield to Medicare Services.	70
7-1-05	Added new section – SUBMITTER ID NUMBERS AND PASSWORDS	6
7-1-05	Statement added for the ISA13.	45, 48, 50
7-1-05	Updated page with a current example of an accepted Batch Processing Report.	46
7-1-05	Updated page with a current example of a rejected Batch Processing Report.	47
7-1-05	Updated page with a current example of an accepted MCS Prepass Error Report.	49
7-1-05	Inserted a new page. New page has an updated example of a rejected MCS Prepass Error Report.	51
7-1-05	Updated 270/271 information.	62-63
7-1-05	Updated 276/277 information.	61
7-1-05	Added Chapters to format guide.	
7-1-05	Removed default password for the Netx Gateway.	9, 27
7-1-05	Removed the first column from the Med B billing requirements.	68-77
10-15-05	Updated 270/271 information	62-63
1-11-06	Removed NSF references from the Medicare Part B Billing Requirements	68-76
1-11-06	Added an Update section	86
2-28-06	Updated Professional Companion Document per CR 4260	52
4-18-06	Updated information for 270/271.	63
4-18-06	Added additional FAQ for CMS EDI Instructions web address.	86
5-23-06	Updated Institutional Companion Document per CR 4379	57
6-23-06	Updated information for 270/271	63
6-23-06	Added MREP information	68
8-29-06	Updated web address to obtain the 270/271 implementation guide.	65
12-4-06	Added new Medicare Part A Companion Document per CR 5334	57

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12-4-06	Added statement to the 276/277 Companion Document to recommend sending 276 transaction in a continuous string.	63
10-18-07	Added statements to the Med A and Med B companion documents. Medicare Services will process 999 ISA-IEA's per day per submitter. Electronic submitters who transmit more than 999 ISA-IEA's per day will have transactions rejected.	54 & 60
12-1-07	Added information for the H99RAR06 report.	52
12-5-07	Added statement to the Med B companion document. Must send NPI in primary provider fields (2010AA NM109, 2010AB NM109, 2310B/NM109 & 2420A/NM109) per JSM 5034-08070B and JSM 4937-08007B.	55
12-5-07	Added statement to the Med A companion document. Must send NPI in primary provider fields (2010AA NM109 & 2010AB NM109) per JSM 4937-08007A.	61
12-5-07	Updated the 276/277 Companion Document to read "Submitter uses the "XX" qualifier for the National Provider Identifier (NPI) NPI in the NM109." Per JSM 5034-08070B.	64
12-5-07	Updated the 276/277 Companion Document to read "Submitter enters the National Provider Identifier (NPI)." Per JSM 5034-08070B.	64
4-16-08	Added statement to the Medicare Part B Companion Document for the 2010AA/REF02. Medicare Services will reject an interchange (transmission) that has been submitted with any special characters in the EIN or SSN.	56
4-16-08	Added statement to the Medicare Part B Companion Document for the 2010AB/REF02. Medicare Services will reject an interchange (transmission) that has been submitted with any special characters in the EIN or SSN.	56
4-16-08	Added statement to the Medicare Part A Companion Document for the 2010AA/REF02. Medicare Services will reject an interchange (transmission) that has been	62

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	submitted with any special characters in the EIN or SSN.	
4-16-08	Added statement to the Medicare Part A Companion Document for the 2010AB/REF02. Medicare Services will reject an interchange (transmission) that has been submitted with any special characters in the EIN or SSN.	62
4-16-08	Added an updated example of a rejected Batch Processing Report.	47
4-16-08	Added an updated example of an accepted H99RAR04 report.	49
4-16-08	Added an updated example of an H99RAR04 report with a rejection.	51
11-1-08	Remove all reference for OK, NM and MO.	---
4-30-09	Removed all reference for Rhode Island	---
7-1-09	Updated Medicare Part A companion document per CR 6330	56