

CareFirst of Maryland – Medicare Part A
837I Companion Guide (Date of revision: 7/22/2003)

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 ANSI X12N 837 implementation guides have been established as the standards of compliance for claim transactions. The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion document to the HIPAA ANSI X12N 837 Implementation Guides. The use of this document is solely for the purpose of clarification.

The information describes specific requirements to be used for processing data in the Medicare-FISS system of CareFirst Medicare-A Contractor number 00190. The information in this document is subject to change. Changes will be communicated on the CareFirst Medicare-A Web site: www.marylandmedicare.com.

The following data is required on ANSI 4010 Medicare claims:

ISA 05	Must be “ZZ”
ISA 06	Sender ID assigned by CareFirst of Maryland, Medicare A*
ISA 07	Must be “ZZ”
ISA 08	Receiver ID must be “00190”
GS 02	Sender ID assigned by CareFirst of Maryland, Medicare A*
GS 03	Receiver ID must be “00190”
NM1	Payer ID is “00190” Usage: NM1*40*2*MEDICARE*****46*00190~
REF 02	Transmission type code: Medicare Part A 004010X096A1 (CareFirst will only accept version 4010A1)
SV2 01	“0001” revenue code (totals line) must be present in a claim.

TESTING

CareFirst is actively testing. It is imperative for your organization to start the testing process. To submit or receive test files (837/835).

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IMPORTANT

The files will be edited for proper formats and data specifications. Claims that fail implementation guide edits will not go into the Claims Processing System and will have to be corrected and resubmitted.

Medicare Implementation Guide edits for 837 can be accessed from the following documents:

<http://cms.hhs.gov/providers/edi/instdit3.zip>
<http://cms.hhs.gov/providers/edi/instdit4.zip> (4010A1 - available in May, 2003)
<http://cms.hhs.gov/providers/edi/comm1.zip>
<http://cms.hhs.gov/providers/edi/bill3.zip>

835 Companion Guide:

<http://www.cms.hhs.gov/providers/edi/A835v4010CD-4-2003.zip>

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 institutional translator.

For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MA). Claims containing data in the Patient Hierarchical Level (2000C loop) will be rejected.

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 exceeds this limit will not be processed.

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 not be processed.

Claims submitted with percentage amounts with more than two positions to the left or right of the decimal will not be processed.

Claims submitted with Attending, referring, or operating physician UPIN numbers that exceed 16 positions will not be processed.

Claims with external code set data that does not conform to the format requirements of the external code set maintainer will not be processed. 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 can 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 not be processed).

The maximum size for the service unit count field in the Medicare system is 7 characters. Claims submitted with data that exceeds this limit will not be processed. Claims submitted with decimal data will be rounded to the closest whole number before being processed.

Claims submitted with negative values in amount, unit, or weight fields will not be processed.

Data submitted in Property and Casualty loops will be ignored.

Data submitted in CLM20 (Delay Reason Code) will not be processed.

Diagnosis codes have a maximum size of five (5) characters. Claims submitted with data that exceeds this limit will not be processed. The Medicare system does not process decimal points in diagnosis codes or ICD9-CM procedure codes. CareFirst Medicare-A will strip out decimal points submitted in diagnosis or procedure codes before processing.

Credit/Debit card information (Loop 2010AA REF or 2010BB Loop) will be ignored and will not be processed.
CareFirst Medicare-A will <i>accept</i> an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.
You may send diagnosis codes as described in the implementation guide; however, only the primary and first nine other diagnosis codes <i>may</i> be considered in for adjudication and payment determination.
CareFirst Medicare-A will reject claims submitted with more than 449 (allowing for an additional internal 0001 revenue (total) line for an internal maximum of 450) service lines per claim.
Claims that require a patient status for CMS adjudication must contain patient status information or they will be rejected.
Since the date care starts is considered 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). Any compliant time is acceptable in this field.
Claims that require an admission source code for CMS adjudication but do not contain admission source code information will be rejected.
Inpatient claims that require HCPCS be reported for CMS adjudication but do not contain HCPCS information will be rejected.
CareFirst Medicare-A will only process HL structures as described in the implementation guide front matter. That is Billing Provider HL (parent) followed by the appropriate Subscriber HL (child).
Hospital other (14X) claims that require diagnosis information for CMS adjudication but do not contain this diagnosis information (2300 HI Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information) will be rejected.