

CareFirst of Maryland – Medicare Part A
837I Companion Guide (Date of revision: 12/02/2003)

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health benefit 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 IGs have been established as the standards of compliance for claim transactions. The IGs for each transaction are available electronically at <http://www.wpc-edi.com/hipaa>.

The following information is intended to serve only as a companion document to the X12N 837 IGs adopted for national use under HIPAA. The use of this document is solely for the purpose of Medicare clarification.

The information describes specific requirements to be used for processing data in the Medicare-FISS system of CareFirst Medicare-A Medicare contractor number 00190. The information in this document is subject to change. Changes will be communicated in the standard Intermediary News, periodic news bulletin and on the CareFirst Medicare-A web site: www.marylandmedicare.com. Separate companion documents have been or will be issued for use with other HIPAA transaction standard IGs.

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/instit4.zip>
<http://cms.hhs.gov/providers/edi/instit3.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-9-2003.zip>

For Medicare, submit using the basic or extended character set or the Base or Extended control set as defined in Appendix A, you may choose to submit lower case
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<p>characters but the following can not be used as delimiters: A..Z a..z ' ' 0..9 ' ' ' ' (space). Doing so will cause the interchange (transmission) to not be processed.</p>
<p>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 not be processed.</p>
<p>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 CareFirst Medicare-A.</p>
<p>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 CareFirst Medicare-A.</p>
<p>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 CareFirst Medicare-A.</p>
<p>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 CareFirst Medicare-A. 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 CareFirst Medicare-A.</p>
<p>The maximum size for the service unit count field in the Medicare system is 7 characters. Claims submitted with data that exceeds this limit will be RTP'd or will be errored back to the submitter by CareFirst Medicare-A. Claims submitted with decimal data will be rounded to the closest whole number before being processed.</p>
<p>Data submitted in CLM20 (Delay Reason Code) will be ignored.</p>
<p>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.</p>
<p>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.</p>
<p>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 CareFirst Medicare-A.</p>
<p>Credit/Debit card information (Loop 2010AA REF or 2010BB Loop) will be ignored.</p>
<p>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 CareFirst Medicare-A.</p>
<p>Claims that lack an admission source code when required for CMS adjudication will</p>

be RTP'd or will be errored back to the submitter by CareFirst Medicare-A.

Inpatient claims that lack HCPCS when required for CMS adjudication will be RTP'd or will be errored back to the submitter by CareFirst Medicare-A.

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)).

CareFirst Medicare-A will reject an interchange (transmission) that is not submitted with a valid receiver/submitter code. Each individual Contractor determines this code.

Compression of files is supported for transmissions between the submitter and CareFirst Medicare-A.