

CIGNA Government Services Part B

837 v. 4010A1 Inbound Professional Claim

Companion Document/ Trading Partner Agreement

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 CIGNA Government Services (CGS), Idaho 05130, North Carolina 05535, and Tennessee 05440. The information in this document is subject to change. Changes will be communicated in the standard CGS monthly news bulletin and on CGS Web site: <http://www.cignagovernmentservices.com>. This companion document supplements, but does not contradict, any requirements in the X12N 837 Professional implementation guide.

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 will be rejected.	
	R	Claims that contain percentage amounts with values in excess of 99.99 will 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	CGS 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 will 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	CGS may reject an interchange (transmission) submitted with more than 9,999 loops.	
	O	CGS will reject an interchange (transmission) submitted with more than 9,999 segments per loop.	
	O	CGS may reject an interchange (transmission) with more than 5000 CLM segments (claims) submitted per transaction.	
	R	Compression of files using PK-Zip is supported for transmissions between the submitter and CGS. Note: This requires testing before going into production.	
	R	Only valid qualifiers for Medicare should be submitted for Medicare processing on incoming 837 claim transactions. Any qualifiers submitted which are not defined for use in Medicare billing will cause the claim to be rejected.	
	R/O	You may send up to four modifiers; however, the last two modifiers may not be considered. The CGS processing system may only use the first two modifiers for adjudication and payment determination of claims.	
	O	CGS will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Professional Implementation Guides.	



Description			Language	Page	
Interchange Control Header					
	ISA 05	Interchange ID Qualifier	O	CGS will reject an interchange Transmission that does not contain ZZ in ISA05.	B.4
	ISA 06	Interchange ID Qualifier	O	CGS will reject an interchange (transmission) that does not contain a valid ID (Stratus Mailbox number) in ISA06.	B.4
	ISA 07	Interchange ID Qualifier	O	CGS will reject an interchange (transmission) that does not contain ZZ or 27 in ISA07.	B.4
	ISA 08	Interchange ID Qualifier	O	CGS will reject an interchange (transmission) that does not contain the carrier code for the state you are sending a file, 05440 Tennessee, 05130 Idaho , or 05535 North Carolina, in ISA08.	B.5
Functional Group Header					
			O	CGS 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	CGS will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).	
	GSO03	Application Receiver's	O	CGS will reject an interchange (transmission) that is submitted with an invalid value in GS03 Application Receivers Code for Tennessee 05440, Idaho 05130, North Carolina 05535.	B.8
Loop	Transaction Set				
			O	CGS 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	CGS 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	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 will cause the file to be rejected.	66
1000A	NM109	Submitter ID	R	CGS 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	CGS may reject an interchange (transmission) that is not submitted with a valid carrier name (NM1).	75
1000B	NM109	Receiver Primary Identifier	R	CGS will reject an interchange (transmission) that is not submitted with a valid carrier code Tennessee-05440, North Carolina-05535, Idaho-05130.	75
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 atient Hierarchical Level (2000C loop) is not used. Sending the 2000C Loop will cause the file to reject.	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
Loop	Claim Information				
2300	CLM02	Total Submitted Charges	R	Negative values submitted in CLM02 will not be processed and will 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	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 will not be processed and will result in the claim being rejected. AMT02.	220
2300	AMT02	Total Purchased Service Amount	O	Negative values submitted in the following fields will not be processed and will result in the claim being rejected: AMT02.	221



Description				Language	Page
2300	REF02	Prior Authorization & Referral Number	R	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 will not be processed and will 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	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 will not be processed and will result in the claim being rejected: AMT02.	332, 333
2400	SV102	Line Item Charge Amount	R	Negative values submitted in the following fields will not be processed and will 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 will be rejected. (SV104)	400
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
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 will not be processed and will result in the claim being rejected: SV104.	403
2400	CR102, CR106	Ambulance Transport Information	R	Negative values submitted in the following fields will not be processed and will 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.	489
2400	PS102	Purchased Service	R	Negative values submitted in the following fields will not be processed and will 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					
			R/O	We suggest retrieval of the ANSI 997 functional acknowledgment files on or before the first business day after the claim file is submitted, but no later than five days after the file submission.	B.15
			R/O	CIGNA Government Services will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997.	

