

## Version 3.6

Utah State Dept. of Health  
Division of Health Care Financing

837 INSTITUTIONAL  
COMPANION GUIDE

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### Utah Specific Transaction Instructions

#### 837 Health Care Claim: **Institutional** ASCX12N 837 (004010X096A1)

The Health Insurance Portability and Accountability Act (HIPAA) requires all health insurance payers in the United States to comply with the Electronic Data Interchange (EDI) standards for healthcare as established by the Secretary of Health and Human Services. The ANSI ASC X12N 837I Version 4010 implementation guide is the standard of compliance -- available at [www.wpc-edi.com](http://www.wpc-edi.com). The following supplemental information is specific to Utah Medicaid and serves as a companion guide to the implementation guide. Utah Medicaid Provider Manuals are available at <http://www.health.utah.gov/medicaid/manuals/directory.php?p=Medicaid%20Provider%20Manuals/>.

#### Electronic Claims:

1. Telephone number for Medicaid EDI customer support (OS&D) is 801-538-6155 or 800-662-9651 menu 3, menu 5. Hours of operation are Monday through Wednesday (7 am to 6 pm) and Thursday (11 am to 6 pm). Telephones are down between 12 noon and 1 pm.
2. AccessNow, telephone automated system for member eligibility, is available from 6 am to 12 midnight Monday through Saturday and 12 noon to 12 midnight on Sundays.
3. Medicaid companion guides are available at <https://health.utah.gov/hipaa/guides.htm>.
4. All EDI must pass through the Utah Health Information Network (UHIN), an independent, not-for-profit, value added network serving all payers in Utah. Contact UHIN at [www.UHIN.com](http://www.UHIN.com) or call 801-466-7705 x200. UHIN will assign a Trading Partner Number (TPN) for EDI.
5. Use your TPN and your National Provider Identifier (NPI) to complete the Online EDI Enrollment Form (EForm) at <https://hcf.health.utah.gov/hcfenroll/index.jsp>. Without an EDI enrollment, the Medicaid computer system will not acknowledge any transmission (e.g. 837, 835, etc).
6. The NPI and Tax ID (or SSN) must match to a single Medicaid contract. If a provider affiliates their NPI to more than one Medicaid Contract, a unique Taxonomy Code or unique address must be affiliated to their Contract. Update contract information with the Medicaid Provider Enrollment team at 801-538-6155 or 800-662-9651, menu 3, menu 4, or fax to 801-536-0471.

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7. Providers, billers, and clearinghouses must separate batches by receiving TPN (HT000004-001 and HT000004-005). If submitted as one batch, claims will be applied to the first receiver TPN on the submission.
8. Medicaid requires the reporting of the National Drug Code (NDC) in addition to the HCPCS/CPT code on provider administered drugs. The drug list requiring NDC is available at [http://health.utah.gov/medicaid/pdfs/NDC\\_required4-08.pdf](http://health.utah.gov/medicaid/pdfs/NDC_required4-08.pdf).
9. Transmit claims anytime 24 hours a day, 7 days a week. Medicaid's cut-off for claims acceptance is before the end of business on Thursday. Transactions received after the end of business on Thursday may miss the adjudication cycle and will process the following weekend.
10. A 997 Functional Acknowledgment will be available for pickup (download) within two hours of transmission for all 837 transactions. If you find no 997, contact OS&D.
11. A 277FE Health Care Claim Status Notification - Front End Acknowledgment will usually be available for pickup (download) the next business day after the transmission of the 837. If you find no 277FE, contact OS&D. This transmission assigns a 17-digit Transaction Control Number (TCN) to any claim that is accepted into the Medicaid Management Information System (MMIS). The lack of a TCN indicates a claim was rejected. Use the Claim Status Codes <http://www.wpc-edi.com/content/view/715/1> to determine why the claim was rejected. Make corrections and resubmit.
12. Medicaid Customer Service agents are **unable** to see claims that have not processed through at least one weekend adjudication cycle. Use the 997 and 277FE reports to determine status of electronic submissions prior to a weekend adjudication cycle. After an adjudication cycle, use the 276 transaction for claim status.
13. Utah Medicaid cannot accept a line with a negative submitted charge (method used by Medicare for adjusting claims). A negative amount will generate the 484 error code (Business Application Currently Not Available). For adjustments, Medicaid requests submission of a void or replace claim (see instructions below).
14. Transmit claims for all Medicaid programs (Non-Traditional Medicaid, Primary Care Network, Select Access, Baby Your Baby, etc.) to Medicaid Fee-For-Service (FFS), HT000004-001 or Medicare/Medicaid Crossover claims to HT000004-005. Services not covered by Medicare should be billed to Medicaid FFS using the policy and procedures of Medicaid.

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15. Units must be reported in full units. Utah Health Care Financing’s policy is to round to the nearest unit. No decimals will be accepted.
16. Providers should submit their own corrections by submitting either a replacement or void claim. If the original claim was denied, submit claim as an original claim. Medicaid will allow for submission of electronic corrections or voids to a previously paid claim. Acceptable Values: “7” – Replacement “8” – Void. The TCN of the claim to be replaced or voided must be reported. Do not submit hyphens or spaces.
- The following is information about replacement/void claims:
- The provider number on the original claim must match the provider number being submitted on the replacement claim, or the claim will reject.
  - If the TCN of the original claim cannot be identified in the Medicaid system, or the claim has already been reprocessed, the replacement/void claim will be rejected.
  - Replacement claim(s) void the original claim. The replacement claim is then processed in the Medicaid system as an original claim.
  - If there is a line item that did not pay on the original claim, it is not necessary to submit a replacement claim. You may submit a new claim for only the services not paid on the original claim. However, if additional units are being added to an already paid procedure code, or you are changing procedure codes, a replacement claim must be submitted.
  - If wanting to replace an original claim that was split by Medicaid for processing, it is necessary to submit a void claim for each of the split claims. A new original claim would then be submitted for processing.
  - If a claim was paid under the wrong provider number, submit a void claim with the provider number of the original claim and a new original claim with the correct provider number.
  - If the original claim was denied, do not submit a replacement claim. Make the necessary correction(s) and resubmit the claim as an original claim.

Page	Loop	Segment	Data Element	Values / Comments
59		BHT06	Claim or Encounter Identifier	“CH” – Used for claims with at least one chargeable item.
62	1000A	NM108	Electronic Transmitter Identification Number (ETIN)	“46” – ETIN
63	1000A	NM109	Submitter Identifier	Submitter’s TPN
68	1000B	NM103	Receiver Name	“Medicaid FFS” OR “Medicaid Crossover”
68	1000B	NM108	Information Receiver Identification Number	“46” – ETIN

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68	1000B	NM109	Receiver Primary Identifier	“HT000004-001” – Medicaid FFS “HT000004-005” – Crossover
72	2000A	PRV02	Reference Identification Qualifier	“ZZ” – Taxonomy Code
72	2000A	PRV03	Reference Identification	Provider Taxonomy Code Required if multiple provider types/services under same NPI.
77	2010AA	NM101	Entity Identifier Code	“85” – Billing Provider
77	2010AA	NM102	Entity Type Qualifier	“2” – Non-Person Entity
77	2010AA	NM108	Identification Code Qualifier	“XX” – NPI
78	2010AA	NM109	Identification Code	NPI
79	2010AA	N301	Billing Provider Address Line	Address that coordinates with Medicaid Contract Service Location
80	2010AA	N401	Billing Provider City Name	City that coordinates with Medicaid Contract Service Location
81	2010AA	N402	Billing Provider State	State that coordinates with Medicaid Contract Service Location
81	2010AA	N403	Billing Provider’s Zip Code	Zip Code+4 Do not submit hyphens or spaces.
83	2010AA	REF01	Reference Identification Qualifier	“EI” – Tax ID
84	2010AA	REF02	Billing Provider Additional Identifier	Tax ID
100	2000B	HL04	Hierarchical Child Code	“0” – The subscriber is always the patient; there are no dependents in Medicaid.
104	2000B	SBR09	Claim Filing Indicator Code	“MC” – Medicaid
109	2010BA	NM102	Entity Type Qualifier	“1” – Person
109	2010BA	NM103	Subscriber Last Name	Patient’s last name. Match the name on the Medicaid Card.
109	2010BA	NM104	Subscriber First Name	Patient’s first name is required. Match the name on the Medicaid Card.
110	2010BA	NM108	Identification Code Qualifier	“MI” – Member Identification Number
110	2010BA	NM109	Subscriber Primary Identifier	Use the 10-digit identifier assigned by Medicaid. Do not submit hyphens or spaces.
127	2010BC	NM103	Payer Name	“Medicaid FFS” OR “Medicaid Crossover”
127	2010BC	NM108	Identification Code Qualifier	“PI” – Payer Identification

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128	2010BC	NM109	Payer Identifier	“HT000004-001” – Medicaid FFS “HT000004-005” – Crossover
139	2000C	HL	Patient Hierarchical Level	The subscriber is always the patient in Medicaid. Do NOT use this loop.
158	2300	CLM01	Patient Account Number	Provider assigned number unique to this particular claim.
159	2300	CLM02	Total Claim Charges	Total Claim Charges
159	2300	CLM05-1	Facility Type Code	Type of Bill
159	2300	CLM05-3	Claim Frequency Code	For original submission (or re-submission of <u>denied</u> claims) use value: “1” – Original  Medicaid will allow for submission of electronic corrections or voids to a previously <u>paid</u> claim. Acceptable Values: “7” – Replacement “8” – Void The TCN assigned to the claim voiding or replacing must be reported in REF02.
165	2300	DTP01	Date/Time Qualifier	“096” – Discharge
165	2300	DTP02	Date Time Period Format Qualifier	“TM” – Hour
166	2300	DTP03	Discharge Hour	Use format HHMM
167	2300	DTP01	Date/Time Qualifier	“434” – Statement
167	2300	DTP02	Date Time Period Format Qualifier	“RD8” – Date Range
168	2300	DTP03	Statement From or To Date	Use format CCYYMMDD– CCYYMMDD
169	2300	DTP01	Date/Time Qualifier	“435” – Admission
169	2300	DTP02	Date Time Period Format Qualifier	“DT” – Date and time
170	2300	DPT03	Admission Date/Hour	Use format CCYYMMDDHHMM
171	2300	CL101	Admission Type Code	Type of admission
172	2300	CL102	Admission Source Code	Source of admission
172	2300	CL103	Patient Status Code	Discharge patient status
180	2300	AMT01	Amount Qualifier Code	“F3” – Patient Responsibility
181	2300	AMT02	Patient Responsibility Amount	Amount Due – As reported by other payer

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191	2300	REF01	Reference Identification Qualifier	“F8” – Original Reference Number
192	2300	REF02	Claim Original Reference Number	When codes “7” or “8” are submitted in Loop 2300 CLM05-3, the TCN assigned to the original claim must be reported. Do not submit hyphens or spaces. Do not submit replacement/void claims until the original TCN processes through a weekend cycle.
198	2300	REF01	Reference Identification Qualifier	“G1” – Prior Authorization. Medicaid does not use referral numbers.
199	2300	REF02	Prior Authorization	Use the 7-digit prior authorization assigned by Medicaid.
200	2300	REF01	Reference Identification Qualifier	“EA” – Medical Record Identification Number
201	2300	REF02	Medical Record Number	Provider assigned number.
208	2300	NTE01	Note Reference Code	“ADD” – Additional Information
209	2300	NTE02	Billing Note Text	Additional claim level notes
228	2300	HI01-2	Principal Diagnosis	Primary diagnosis
228	2300	HI02-2	Admitting Diagnosis	Admitting diagnosis
230	2300	HI01-2	Diagnosis Related Group (DRG) Information	Medicaid calculates the DRG and does not utilize this field.
233	2300	HI01-2	Other Diagnosis	Additional diagnosis
242	2300	HI01-1	Code List Qualifier Code	“BR” – Principal procedure
243	2300	HI01-2	Principal Procedure Code	Principal procedure code
244	2300	HI01-1	Code List Qualifier Code	“BQ” – Other procedure codes
245	2300	HI01-2	Procedure Code	The principal procedure code and 2 others (in order as listed), will be used for claims processing.
267	2300	HI	Occurrence Information	The first 5 occurrence codes will be used for claims processing.
280	2300	HI	Value Information	The first 3 value codes will be used for claims processing. When using value code “68”, a revenue code and units must also be submitted (units should be rounded to full units).
306	2300	QTY	Claim Quantity	Used to report covered and non-covered days.
322	2310A	NM101	Entity Identifier Code	“71” –Attending Physician
322	2310A	NM102	Entity Type Qualifier	“1” – Person
323	2310A	NM108	Identification Code Qualifier	“XX” – NPI
323	2310A	NM109	Identification Code	NPI
329	2310B	NM101	Entity Identifier Code	“72” – Operating Physician

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329	2310B	NM102	Entity Type Qualifier	“1” – Person
330	2310B	NM108	Identification Code Qualifier	“XX” – NPI
330	2310B	NM109	Identification Code	NPI
359	2320	SBR	Other Subscriber Information	If the patient has Medicare or other 3rd party coverage, repeat this loop for each payer. Do not put information about Utah Medicaid coverage/payment in this loop.
367	2320	CAS01	Claim Adjustment Group Code	As reported by other payer. Report Patient Responsibility in Loop 2300 AMT Segment.
367	2320	CAS02	Adjustment Reason Code	As reported by other payer.
367	2320	CAS03	Adjustment Amount – Claim Level	As reported by other payer.
371	2320	AMT01	Amount Qualifier Code	“C4” – Prior Payment - Actual
371	2320	AMT02	Payer Paid Amount	As reported by other payer.
372	2320	AMT01	Amount Qualifier Code	“B6” – Allowed - Actual
372	2320	AMT02	Allowed Amount	As reported by other payer
392	2320	MIA	Medicare Inpatient Adjudication	Remark codes as reported by Medicare.
397	2320	MOA	Medicare Outpatient Adjudication	Remark codes as reported by Medicare.
415	2330B	DTP03	Adjudication or Payment Date	As reported by other payer.
444	2400	LX	Line Counter	Medicaid recommends submitting 59 or fewer service lines for each Institutional claim. Claims submitted with more than 59 service lines may be split, combined, and may encounter processing delays.
446	2400	SV201	Product/Service ID	Use appropriate 4-digit REV codes.
448	2400	SV204	Unit or basis for measurement	“DA” – days “UN” – units
453	2400	PWK01	Attachment Report Type Code	Required if documentation is needed to support the claim. Claim may deny, however once documentation is received the claim is re-processed.
454	2400	PWK02	Report Transmission Code	“BM” – by mail AFX” – by fax AEM” – by e-mail

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454	2400	PWK06	Identification Code	Provider assigned number unique to this attachment. Each attachment associated with the claim must display the same unique number and the Provider ID.
456	2400	DTP	Service Line Date	Report line level date of service as appropriate. Required for home health providers.
37 <sup>A</sup>	2410	LIN02	ID Qualifier	“N4” – NDC
37 <sup>A</sup>	2410	LIN03	NDC Number	NDC is required on all out patient claims for physician administered drugs, in addition to the HCPCS/CPT code. Enter 11 digits. Do not submit hyphens or spaces. Zero fill if not 5-4-2 format (example: 186-868-44 report as 00186086844) in first field.
39 <sup>A</sup>	2410	CTP03	Unit Price	Drug Unit Price
39 <sup>A</sup>	2410	CTP04	Quantity	National Drug Unit Count
39 <sup>A</sup>	2410	CTP05	Unit or Basis of Measurement	“GR” – Gram “F2” – International Unit “ML” – Milliliter “UN” – Unit
40 <sup>A</sup>	2410	REF01	Reference Identification Qualifier	“XZ” – Prescription Applicable if dispensing of the drug has been done with an assigned Rx number.
41 <sup>A</sup>	2410	REF02	Prescription Number	Pharmacy Prescription Number
490	2430	SVD	Line Adjudication Information	Use this loop if line level payment was received from another payer.
491	2430	SVD02	Service Line Paid Amount	As reported by other payer.
495	2430	CAS01	Adjustment Group Code	As reported by other payer. If other payer reported line level patient responsibility, but did not provide a group code, use “PR” to report patient responsibility.
496	2430	CAS02	Adjustment Reason Code	As reported by other payer. If other payer reported line level patient responsibility, but did not provide a reason code, use: “1” – deductible amount “2” – coinsurance amount
496	2430	CAS03	Adjustment Amount – Line Level	As reported by other payer.

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