

## **Electronic Claim Submission (ECS) Guidelines**

On August 14, 2000, the Department of Health and Human Services (DHHS) issued a Final Rule for Standards for Electronic Transmissions. A summary of the rule is: "This rule adopts standards for eight electronic transactions and for code sets to be used in those transactions. It also contains requirements concerning the use of these standards by health plans, health care clearinghouses, and certain health care providers.

The use of these standard transactions and code sets will improve the Medicare and Medicaid programs and other Federal health programs and private health programs, and the effectiveness and efficiency of the health care industry in general, by simplifying the administration of the system and enabling the efficient electronic transmission of certain health information. It implements some of the requirements of the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996."

Delaware Medical Assistance Program (DMAP) implemented these electronic standards on July 1, 2002. X12 has released a new mandated version of the X12 guides. This version, 5010, goes in to effect no later than 1/1/2012. If the provider is using the HP supplied Provider Electronic Solution (PES) software, it has all of the requirements that are outlined below already incorporated.

The ASC X12 standards required by the Final Rule are formulated to minimize the need for users to reprogram their data processing systems for multiple formats by allowing data interchange through the use of a common interchange structure.

The HIPAA implementation guides provide assistance in developing and executing the electronic transfer of health encounter and health claim data. With a few exceptions, the implementation guide does not contain payer-specific instructions. Payers are required by law to have the capability to send/receive all HIPAA transactions. However, that does not mean that the payer is required to bring that data into their adjudication system. The payer, acting in accordance with policy and contractual agreements, can ignore data within the data set.

The following items that are specific for the Delaware Medical Assistance Program should be taken into consideration when creating HIPAA compliant transactions for DMAP.

## All X12 Transactions

ISA01- Value "00" is expected in this field

ISA02- No data is expected in this field.

ISA03- Value "00" is expected in this field

ISA04 - No data is expected in this field.

ISA05- Value "ZZ" is expected in this field.

ISA06-The Electronic Transmitter Identification Number (ETIN) number assigned to the submitter is expected in this field. This is the same as your ECMS Bulletin Board ID.

ISA07- Value "ZZ" is expected in this field.

ISA08- HPES ETIN number "345724166" is expected in this field for Production. HPES ETIN number "445296158" is expected in this field for Testing.

ISA12- Value "00501" is expected in this field.

ISA14- Value "0" is expected in this field.

ISA15- Value "P" is expected for production data and value "T" is expected for test data.

ISA16- A colon (:) is expected as the component element separator.

### **Note:** All X12 Claim Transactions

- ❖ Professional, Dental, and Institutional transactions cannot be mixed within the same ST-SE envelope.
- ❖ Transactions (ST-SE envelopes) are limited to a maximum of 5000 CLM segments.
- ❖ Electronic Transmitter Identification Number (ETIN) – This is the number that is assigned to the provider/submitter to uniquely identify their electronic transaction. This may also be referred to as the Electronic Claims Submission (ECS) number. This number should be provided in the transaction in following locations:
  - ISA06
  - Loop 1000A, segment NM109
  - Loop 1000B, segment NM109 must contain the value of HPES ETIN "345724166" for production data and "445296158" for test data.
- ❖ BHT- Beginning of Hierarchical Transaction
  - BHT06 should contain value "CH" chargeable if the transmission contains FFS claims.
  - BHT06 should contain value "RP" which is only used to report encounter data.
- ❖ Units are accepted in whole numbers only.
- ❖ Dependant loops will not be processed.

## 276 Claim Status Request

Loop	Element	Name	Instructions
<b>2100A</b>	<b>NM1</b>	<b>Payor Name</b>	
	NM101	Entity Type Code	PR=Payer
	NM102	Entity Type Qualifier	2=Non Person
	NM103	Payer Name	
	NM108	Identification Code Qualifier	
	NM109	Payer Identifier	
<b>2100B</b>	<b>NM1</b>	<b>Information Receiver Name</b>	
	NM101	Entity Identifier Code	41=Submitter
	NM102	Entity type Qualifier	1=Person 2=Non Person
	NM103	Name Last or Organization Name	
	NM104	Name First	
	NM108	Identification Code Qualifier	46=Electronic Transmitter Identification Number (ETIN)
	NM103	ETIN	
<b>2100C</b>	<b>NM1</b>	<b>Provider Name</b>	
	NM101	Entity Identifier Code	1P=Provider
	NM102	Entity Type Qualifier	1=Person 2=Non Person
	NM103	Name Last or Organization Name	
	NM104	Provider First Name	Required when NM102=1
	NM08	Identification Code Qualifier	
	NM109	Provider Number	
<b>2100D</b>	<b>NM1</b>	<b>Subscriber Name</b>	
	NM101	Entity Identifier Code	IL=Insured or Subscriber
	NM102	Entity Type Qualifier	1=Person
	NM103	Name Last	
	NM104	Name First	
	NM108	Identification Code Qualifier	MI=Member ID Number
	NM109	Subscriber Member ID	
<b>2200D</b>	<b>TRN</b>	<b>Claim Status Tracking Number</b>	
	TRN01	Trace Type Code	
	TRN02	Current Transaction Trace Number	
	<b>REF</b>	<b>Payer Claim Control Number</b>	
	REF01	Reference Identification Qualifier	1K=Payer's Claim Number or ICN
	REF02	Payer Claim Control Number or ICN	
	<b>REF</b>	<b>Institutional Bill Type Identification</b>	<i>Note: Required when needed to refine the search criteria on Institutional Claims.</i>
	REF01	Reference Identification Qualifier	BLT=Billing Type
	REF02	Reference Identification	

	<b>REF</b>	<b>Patient Control Number</b>	
	REF01	Reference Identification	EJ=Patient Control Number
	REF02	Patient Control Number	
	<b>REF</b>	<b>Pharmacy Prescription Number</b>	
	REF01	Reference Identification Qualifier	XZ=Pharmacy Prescription Number
	REF02	Pharmacy Prescription Number	
	<b>AMT</b>	<b>Claim Submitted Charges</b>	
	AMT01	Amount Qualifier Code	T3=Total Submitted Charges
	AMT02	Total Claim Charge Amount	
	<b>DTP</b>	<b>Claim Service Date</b>	
	DTP01	Date Time Qualifier	472=Service
	DTP02	Date Time Period Format Qualifier	D8=CCYYMMDD RD8=CCYYMMDD-CCYYMMDD
	DTP03	Claim Service Date	
		<b>277 Claim Status Response</b>	
<b>2100A</b>	<b>NM1</b>	<b>Payer Name</b>	
	NM101	Entity Identifier Code	PR=Payer
	NM102	Entity Type Qualifier	2=Non Person
	NM103	Payer Name	
	NM108	Identification Code Qualifier	PI=Payer Identification
	NM109	Payer Identifier	
<b>2100B</b>	<b>NM1</b>	<b>Information Receiver Name</b>	
	NM101	Entity Identifier Code	41=Submitter
	NM102	Entity Type Qualifier	1=Person 2=Non Person
	NM103	Name Last or Organization Name	
	NM104	Name First	Required when NM102=1
	NM108	Identification Code Qualifier	46=Electronic Transmitter Identification Number (ETIN)
	NM109	ETIN	
<b>2100C</b>	<b>NM1</b>	<b>Provider Name</b>	
	NM101	Entity Identifier Code	1P=Provider
	NM102	Entity Type	1=Person 2=Non Person
	NM103	Name Last or Organization Name	
	NM104	Name First	Required when NM102=1
	NM108	Identification Code Qualifier	
	NM109	Atypical Provider Number or NPI	
<b>2100D</b>	<b>NM1</b>	<b>Subscriber Name</b>	
	NM101	Entity Identifier Code	IL=Insured or Subscriber
	NM102	Entity Type Qualifier	1=Person
	NM103	Subscriber Last Name	

	NM104	Subscriber First Name	
	NM108	Identification Code Qualifier	MI=Member ID
	NM109	Member ID	
<b>2200D</b>	<b>TRN</b>	<b>Claim Status Tracking Number</b>	
	TRN02	Referenced Transaction Trace Number	
	<b>STC</b>	Claim Level Status Information	
	STC01-1	Health Care Claim Status Category Code	
	STC01-2	Status Code	
	STC02	Date	
	STC04	Total Claim Charge Amount	
	STC05	Claim Payment Amount	
	STC06	Claim Paid Date	
	STC08	Remittance Date	
	STC09	Remittance Trace Number	This is the check or EFT Trace Number
	<b>REF</b>	<b>Payer Claim Control Number</b>	
	REF01	Reference Identification Qualifier	1K=Payer's Claim Number
	REF02	Payer Claim Control Number or ICN	
	<b>REF</b>	<b>Institutional Bill Type Identification</b>	
	REF01	Reference Identification Qualifier	BLT=Billing Type
	REF02	Bill Type	
	<b>REF</b>	<b>Patient Control Number</b>	
	REF01	Reference Identification Qualifier	EJ=Patient Control Number
	REF02	Patient Control Number	
	<b>REF</b>	<b>Pharmacy Prescription Number</b>	
	REF01	Reference Identification Number	XZ=Pharmacy Prescription Number
	REF02	Pharmacy Prescription Number	
	<b>DTP</b>	<b>Claim Service Date</b>	
	DTP01	Date Time Qualifier	472=Service
	DTP02	Date Time Period Format Qualifier	RD8=CCYYMMDD-CCYYMMDD
	DTP03	Claim Service Period	