

## **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.

## 835 Remittance Advice

Loop	Element	Name	Instructions
	<b>BPR</b>	<b>Financial Information</b>	
	BPR01	Transaction Handling Code	I=Remittance Information Only
	BPR02	Total Actual Provider Payment Amount	
	BPR03	Credit or Debit Flag Code	C=Credit
	BPR04	Payment Method	ACH=EFT CHK=Check
	BPR05	Payment Format Code	Required when BPR04=ACH
	BPR06	ID Number Qualifier	01=ABA Transit Routing Number
	BPR07	Identification Number	031100092
	BPR08	Account Number Qualifier	DA=Demand
	BPR09	Account Number	
	BPR10	Payer Identifier	1752548221
	BPR11	DMAP/HP	
	BPR12	ID Number Qualifier	01=ABA Transit Routing Number
	BPR13	Receiver or Provider ID Number	
	BPR14	Account Number Qualifier	DA=Demand Deposit SG=Savings
	BPR15	Account Number	
	BPR16	Check Issue or EFT Date	
	<b>TRN</b>	<b>Reassociation Trace Number</b>	
	TRN01	Trace Type Code	1=Current Transaction Trace Numbers
	TRN02	Check or EFT Trace Number	
	TRN03	Payer Identifier	1752548221
	TRN04	DMAP/HP	
	<b>DTM</b>	<b>Production Date</b>	
	DTM01	Date Time Qualifier	405=Production
	DTM02	Production Date	
1000A	<b>N1</b>	<b>Payer Identification</b>	
	N101	Entity Identifier Code	PR=Payer
	N102	Payer Name	DMAP/HP
	N103	Identification Code Qualifier	XV=Center for Medicare and Medicaid Services Plan ID
	N104	Payer Identifier	HP NPI
	<b>N3</b>	<b>Payer Address</b>	
	N301	Bristol Bldg, University Office Plaza	
	N302	248 Chapman Road, Suite 100	
	<b>N4</b>	<b>Payer Address</b>	
	N401	Newark	
	N402	DE	
	N403	19720	
	<b>PER</b>	<b>Payer Technical Contact</b>	

		<b>Information</b>	
	PER01	Contact Function Code	BL=Technical Department
1000B	<b>N1</b>	<b>Payee Identification</b>	
	N101	Entity Identifier Code	PE=Payee
	N102	Payee Name	
	N103	Identification Code Qualifier	FI=Federal Taxpayer's Identification Number XX=NPI
	N104	Payee Identification Code	
	<b>N3</b>	<b>Payee Address</b>	
	N301	Payee Address Line	
	N302	Payee Address Line	
	<b>N4</b>	<b>Payee City, State Zip Code</b>	
	N401	Payee City Name	
	N402	Payee State Code	
	N403	Payee Zip Code	
	<b>REF</b>	<b>Payee Additional Identification</b>	
	REF01	Reference Identification Qualifier	PQ=Payee Identification
	REF02	Additional Payee Identifier	
2100	<b>CLP</b>	<b>Claim Payment Information</b>	
	CLP01	Patient Control Number or Drug Rx Number	
	CLP02	Claim Status Code	1=Paid 4=Denied 22=Reversal
	CLP03	Total Claim Charge Amount	
	CLP04	Claim Payment Amount	
	CLP05	Copay Amount	
	CLP06	Claim Filing Indicator Code	MC=Medicaid
	CLP07	Payor Claim Control Number	ICN
	CLP08	Place of Service/Type of Bill	
	CLP09	Type of Bill	
	<b>CAS</b>	<b>Claim Adjustment</b>	Segment can be repeated 6 times
	CAS01	Claim Adjustment Code	OA=Other Adjustments CO=Contractual Obligations PR=Patient Responsibility
	CAS02 CAS05 CAS08	Adjustment Reason Code	
	CAS03 CAS06 CAS09	Adjustment Amount	
	<b>NM1</b>	<b>Patient Name</b>	
	NM101	Entity Identifier Code	QC=Patient
	NM102	Entity Type Qualifier	1=Person
	NM103	Patient Last Name	
	NM104	Patient First Name	
	NM108	Identification Code Qualifier	MR=Medicaid Recipient Identification Number

	NM109	Medicaid ID	
	<b>NM1</b>	<b>Service Provider ID</b>	
	NM101	Entity Identifier Code	82=Rendering
	NM102	Entity Type Qualifier	1=Person 2=Non Person
	NM108	Identification Code Qualifier	MC=Medicaid Provider Number XX=NPI
	NM109	DE Provider Number	
	<b>NM1</b>	<b>Corrected Priority Payer Name</b>	
	NM101	Entity Identifier Code	PR=Payer
	NM102	Entity Type Qualifier	2=Non Person
	NM103	TPR Carrie Name	
	NM108	Identification Code Qualifier	PI=Payer Identification
	NM109	TPR Carrier Code	
	<b>REF</b>	<b>Other Claim Related Identification</b>	
	REF01	Reference Identification Number	EA=Medical Record Identification Number
	REF02	Medical Record Number or TPR Policy Number	
	<b>DTM</b>	<b>Statement From or To Date</b>	
	DTM01	Date Time Qualifier	232=Claim Statement Period Start 233=Claim Statement Period End
	DTM02	Claim Date	
	<b>DTM</b>	<b>Coverage Expiration Date</b>	
	DTM01	Date Time Qualifier	036=Expiration
	DTM02	Expiration Date	
	<b>PER</b>	<b>Claim Contact Information</b>	
	PER01	Contact Function Code	CX=Payers Claim Code
	PER02	HP Provider Relations	
	PER03	Communication Number Qualifier	TE=Telephone
	PER04	3024547154	
	PER05	Communication Number Qualifier	TE=Telephone
	PER06	8009993371	
<b>2110</b>	<b>SVC</b>	<b>Service Payment Information</b>	
	SVC01	Composite Medical Procedure Identifier	
	SVC01-1	Product or Service ID Qualifier	HC=HCPCS Code N4=NDC AD=American Dental Assoc. Codes NU=National Uniform Billing Codes
	SVC01-2	Procedure/NDC Codes	
	SCV01-3 SVC01-4 SCV01-5	Procedure Modifiers	
	SCV02	Detail Billed Amount	
	SCV03	Detail Paid Amount	

	SCV04	Revenue Code	
	SCV05	Units	
	<b>DTM</b>	<b>Service Date</b>	
	DTM01	Date Time Qualifier	150=Service Period Start 151=Service Period End 472=Service
	DTM02	Date	CCYYMMDD
	<b>CAS</b>	<b>Service Adjustment</b>	Segment can be repeated 6 times
	CAS01	Claim Adjustment Group	OA=Other Adjustments CO=Contractual Obligations PR=Patient Responsibility
	CAS02 CAS05 CAS08	Adjustment Reason Code	
	CAS03 CAS06 CAS09	Adjustment Amount	
	<b>REF</b>	<b>Service Identification</b>	
	REF01	Reference Identification Qualifier	G1=Prior Authorization Number
	REF02	Prior Authorization Number	
	<b>REF</b>	<b>Line Item Control Number</b>	
	REF01	Reference Identification Qualifier	6R=Provider Control Number
	REF02	Provider Control Number	
	<b>LQ</b>	<b>Health Care Remark Codes</b>	Can repeat up to 12 times
	LQ01	Code List Qualifier	HE=Claim Payment Remark Codes RX=NDC Reject/Payment Codes
	LQ02	Remark Code	
	<b>PLB</b>	<b>Provider Adjustment</b>	
	PLB01	Provider Identifier	
	PLB02	Fiscal Period Date	
	PLB03 PLB05 PLB07 PLB09 PLB11 PLB13	Adjustment Identifier	
	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Adjustment Reason Code	
	PLB04 PLB04 PLB08 PLB10 PLB12 PLB14	Provider Adjustment Amount	