TO: Ellen Abshire
FROM: John Peters
DATE: 5/9/2003
SUBJECT: Responses to Questions/Comments on 837 Professional Claim Transaction Specifications

Thank you for forwarding questions from Hawaii DOH. Our responses are in bold print after each question or comment.

General Comment: It would be helpful to have the Loops and segments noted as required for Med-QUEST where applicable. For example, Loop 2000B Subscriber Hierarchical Level – two elements are explained in the document but would not apply for all services. The assumption is that these are situational for Med-QUEST but it would be helpful if this was noted.

Two of the 2000B elements, PAT07 and PAT08 involve patient weight. Their mislabeling and misplacement in the Companion Document is noted in Item 1 below and will be corrected.

Use of Patient Weight is quite different in the original Implementation Guide and in the Addenda. In the 837 Professional Addenda adopted by Med-QUEST, Patient Weight is in pounds rather than grams and no longer represents a birth weight. Instead, it is, in the words of the Addenda:

Required on:
(1) claims/encounters involving EPO (epoetin) for patients on dialysis
(2) Medicare Durable Medical Equipment Regional Carriers certificate of medical necessity (DMERC CMN) 02.03 and 10.02

At this time, we don't yet know how the translator handles the edits implied by these requirements. We suggest submitting Patient Weight on EPO claims. DMERC CMNs appear to be a Medicare requirement. What is Med-QUEST's policy?

The other three Loop 2000B elements listed are required on all claims.

It would also be helpful if all Loops that are Required were also noted in the Document so that this is a complete reference for Med-QUEST and an even better companion to the Implementation Guide. In addition to identifying the required loops, it would be helpful to note that suggested values are the only accepted value for an element when this is true.

Whether a loop is required or not is not a Med-QUEST decision. The Implementation Guide lists and identifies loops that are required or situational within a hierarchical context. Companion Documents do not attempt to list every transaction data element or even every element required by Med-QUEST. They discuss only elements that are not fully described in Implementation Guides.

Med-QUEST claim data requirements are documented in the Med-QUEST Fee-for-Service Provider Manual. These requirements are still valid, but within 837 Transactions as described by the 837 Implementation Guide and the Med-QUEST Companion Document.

In general, claim data requirements for Med-QUEST adjudication have not changed as a result of HIPAA. Additional qualifier and control elements must be included as required by Implementation Guides. And there's a place for a great deal more if a submitter wants to put it in.

Do you require a Diagnosis? Should this be in Loop 2300 – Health Care Diagnosis segment at the claim header level? Or in Loop 2400 – Comp Diagnosis Pointer at the service line level?

Diagnosis Code requirements will continue as they are at present. ICD-9-CM Diagnosis Codes will appear in Loop 2300. Service line Loop 2400 does not carry the Diagnosis Codes themselves but "pointers" to up to four claim level Diagnoses that relate to the service line Procedure.

1. p. 24, Loop 2000A – this actually refers to Loop 2000 B

   Yes, the error will be corrected and the elements placed appropriately.

2. p. 25, Loop 2000B – assume that for Medicaid services for an adult, this will always be 18 or self.

   This is a correct assumption for Med-QUEST at the present time. Recipients are always individuals rather than dependents of other subscribers.

3. p. 27, Loop 2300 – AMT02, assume that the patient paid amount has been adjudicated at the provider level so that the charge to Med-QUEST has been adjusted (patient paid amount has been deducted from) and is the remaining total charge amount, i.e., the amount that we expect Med-QUEST to pay for the service. This is not how some payors use this. The total charge amount is really the total charge with patient paid amount being deducted along with any other COB amount and the Balance due amount is what we expect Med-QUEST to pay. Please clarify.

   We have analyzed the question of what's in a Charged Amount more closely for the 835 Claim Remittance Advice Transaction. What you suggest is correct and corresponds to the practice of AHCCCS providers. Charged Amounts represent what providers charge for their services rather than what they expect to collect from a particular carrier. Amounts paid by patients (e.g., Share of Cost Amounts) and by other insurance carriers are included in Charged Amounts even if they have been paid when the claim is submitted to Med-QUEST or AHCCCS.

   The 837 Companion Document will be revised to explain the situation correctly.

4. p. 28, Loop 2300 – REF01 in Original Reference Number segment, is this required ? or only for resubmission?

   An REF01 Original Reference Number is required only for replacement and void claims. Otherwise, the Original Reference Number REF Segment is not needed.

5. p. 28, Loop 2300 – REF01, in Demonstration Project Identifier, assume that this is required only for those in the SSD Demonstration Project.

   The assumption is correct.

6. p. 28, Loop 2310A – Referring Provider, assume that this is a situational loop but need to confirm this.

   Med-QUEST requires the 2310A Loop if a referring provider is present at the claim level.

7. p. 29, Loop 2310B – Rendering Provider, is this required or situational for MedQUEST?

   Loop 2310B is situational for Med-QUEST. It is needed when the rendering or service provider is different from the billing provider because the billing provider is a provider group or billing agent. If the rendering and billing provider are the same, the 2300B Loop is not needed.

8. p. 29, Loop 2310D – Service Facility Location – or is this required instead of Rendering Provider since providers are tracked mostly as Facilties not individuals?

   If the Rendering Provider is a facility and is not the same as the billing provider, it should appear as the Rendering Provider in Loop 2300B. On professional 837s, the 2310D Loop is required when the location at which the service was performed is different from the provider's address in the 2010AA Loop and is not the patient's home.

9. p. 34, Loop 2400 – Copay status code – is this required for Med-QUEST?

   Not at this time. The element is used to indicate exemption from co-payments that would otherwise be imposed. Med-QUEST may not have this situation now but may in the future.

10. p. 34, Loop 2400 – Prior Authorization Number, is it required to enter prior authorization numbers here as well as in Loop 2300, REF02 – Prior Authorization Number?, i.e., both at the claim header and the service line levels?

    Although the 837 Professional Transaction permits entry of PA Numbers at both claim and service line levels, HPMMIS maintains them only at the line level. If a PA Number is submitted at the claim level on an 837, it will apply to all service lines except for lines with a different PA Number. PA Numbers submitted at the line level will apply only to a particular line.

    A further consideration is that the PA Number is not really used by HPMMIS when the system matches claims to authorizations. Other criteria are used instead. We suggest, for purposes of record keeping, including PA Numbers on 837s, at the claim level if all service lines are affected, otherwise at the line level.

11. p. 34, Loop 2410 – is this a required loop for Med-QUEST or only if you are paying for the drugs?

    Med-QUEST does not require use of the 2410 Loop at this time, but will capture any information sent for reporting purposes. It can be used to enter information about drugs prescribed in association with a procedure.

12. p. 34, Loop 2420A Rendering Provider Name – assume that this is situational ?

    The 2420A Loop is situational and not appropriate for Med-QUEST. HPMMIS can only handle a single rendering or service provider per claim. Service lines with different Rendering Provider will be denied by HPMMIS although they may be HIPAA compliant.

    The Companion Guide will be revised to explain this situation more clearly.

13. p. 35, Loop 2420D – Supervising Provider, assume that this is situational? Or, under what circumstances is it needed?

    Requirements for supervising provider data are up to Med-QUEST and are not changed by the 837 Transaction.