

Utah Medicaid

5010 Companion Guide Version 1.0

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1. INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) require all entities exchanging health data to comply with the Electronic Data Interchange (EDI) standards for healthcare as established by the Secretary of Health and Human Services. The Accredited Standards Committees (ASC) X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3) are the standard of compliance. The reports are published by the Washington Publishing Company (WPC) and are available at <http://www.wpc-edi.com/>.

1.1. Purpose

This Companion Guide is intended to provide information regarding the exchange of EDI with Utah Medicaid. This includes claims, eligibility inquiry, claim status, premium payments, benefits enrollment and other administrative transactions. It also includes information about EDI enrollment, testing, and customer support.

Medicaid is publishing this Companion Guide to clarify, supplement, and further define specific data content requirements to be used in conjunction with, and not in place of, the ASCX12N TR3s for all transactions mandated by HIPAA. The Companion Guide can be accessed at <https://health.utah.gov/hipaa/guides.htm>.

1.2. Overview

The Companion Guide was written to assist providers in designing and implementing transaction standards to meet Utah Medicaid's processing methodology. This information is organized in the sections listed below:

- Implementation Guides: Section includes information on how to obtain the 5010 TR3 for all transactions.
- Getting Started: Section includes information on enrolling as a Utah Medicaid Provider, EDI enrollment, and testing process.
- Connectivity/Communications: Section includes information on Medicaid's transmission procedures, as well as communication and security protocols.
- Control Segments/Envelopes: Section contains information needed to create the ISA/IEA, GS/GE, and ST/SE control segments to be submitted to Utah Medicaid.
- Acceptance Testing for 5010: Section includes detailed transaction testing information. Web services connection is needed to send transactions.
- EDI Transactions: Section contains information on all EDI transactions such as

837s, 270/271, 276/277, 999, 277CA, 278, 820, and 834. It also contains additional information needed to meet Medicaid claims processing methodology.

- General Information: Section contains pertinent information relating to claims processing, replacements/voids, attachments, and Coordination of Benefits.
- Real Time Transaction: Section includes instructions for Real Time transactions.
- Contact Information: Section includes Medicaid's telephone numbers, mailing and email addresses, and other contact information.
- Applicable Websites and Resources: Section includes various websites referred to in this Companion Guide, i.e. Medicaid, Utah Health Information Network (UHIN), WPC, and Centers for Medicare and Medicaid Services (CMS).
- Terminology: Section describes the different terms used in this Companion Guide.

1.3. Scope

The Companion Guide addresses Medicaid's technical and connectivity specifications for EDI reports such as professional, institutional, and dental claims, claim acknowledgments, claim remittance advice, claim status inquiry and responses, and eligibility inquiry and responses.

1.3.1 The following is a list of EDI transactions utilized by Utah Medicaid.

Transactions	Version
270/271 Health Care Eligibility Benefit Inquiry and Response	005010X279A1
276/277 Status Inquiry and Response	005010X212
278 Health Care Service Review	005010X217
820 Premium Payment	005010X218
837 Health Care Claim: Professional	005010X222A1
837 Health Care Claim: Institutional	005010X223A2
837 Health Care Claim: Dental	005010X224A2
834 Benefits Enrollment and Maintenance	005010X220A1
835 Health Care Claim: Payment/Advice	005010X221A1
999/TA1 Implementation Acknowledgment for Health Care Insurance	005010X231A1
277CA Health Care Claim Acknowledgement	005010X214

1.3.2. A 277CA (Claim Acknowledgement) report will be sent.

2. IMPLEMENTATION STANDARDS

2.1. 5010 ASC X12 TR3 Guides

- 2.1.1. Due to the copyright protection of the 5010 TR3s, Utah Medicaid will not publish TR3 transaction segments and data elements.
- 2.1.2. The TR3s may be purchased through WPC at <http://www.wpc-edi.com/>.

2.2. Standards and Specification

- 2.2.1. All payers in Utah, including Medicaid, have adopted the UHIN Standards and Specifications set forth by the Utah Health Insurance Commission. UHIN is an independent, not-for-profit, value added network serving providers and payers in Utah.
- 2.2.2. The UHIN Standards can be found at <http://www.uhin.org/pages/standards-specifications.php>

3. GETTING STARTED

3.1. Enroll as a Utah Medicaid Provider

- 3.1.1. Provider Enrollment forms and contact information are available on the Medicaid website at: <http://health.utah.gov/medicaid/provhtml/providerenroll.htm>
- 3.1.2. The National Provider Identifier (NPI) and Tax ID used on transactions must match data submitted in the enrollment.
- 3.1.3. 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.
- 3.1.4. Medicaid requires providers to receive Electronic Funds Transfer (EFT), ie. Direct Deposit.
 - 3.1.4.1. Register to receive EFT by completing the EFT enrollment form on the website: <http://health.utah.gov/medicaid/pdfs/EFTapril2005.pdf>.
 - 3.1.4.2. EFT is sent independent from the 835 EDI Electronic Health Care Claim Payment/Advice (See Section 7.7).
- 3.1.5. The Medicaid Provider Enrollment team may be reached at (801) 538-6155 or (800) 662-9651, menu 3, menu 4, or fax (801) 536-0471.

3.2. Obtain a Trading Partner Number (TPN)

3.2.1. All EDI transactions pass through UHIN.

3.2.2. Contact UHIN at www.uhin.org or call (801) 716-5901 for membership enrollment information and Web Services connection. UHIN will assign a Trading Partner Number (TPN) for EDI.

3.2.3. Providers who elect to submit/receive electronic transactions using a third party such as a billing agent, clearinghouse or network service do not need to contact UHIN or acquire a TPN if the billing agent, clearinghouse or network service is a member of UHIN.

3.2.3.1. Obtain the billing company's TPN to complete the EDI enrollment.

3.3. Complete the Medicaid EDI Enrollment Form (online only)

3.3.1. In order to transmit and receive electronic data, Utah Medicaid requires all trading partners to complete an EDI Enrollment Form online at <https://mmcs.health.utah.gov/hcfenroll2/index.jsp>

3.3.1.1. Enter the NPI and the Tax ID (Atypical providers must use the 12-digit Medicaid Contract Number and Tax ID).

3.3.1.2. Associate the TPN, obtained through UHIN, to each transaction (based on business needs). Different TPNs may be used for each transaction.

3.3.1.3. Providers, who submit through a billing agency or clearinghouse, enter the TPN(s) obtained from that organization.

3.3.1.4. Clearinghouse or billing agency may complete the EDI enrollment for the provider.

3.3.2. Providers already enrolled for EDI transactions who are requesting a 5010 format of the remittance (835), prior to January 2012, must e-mail Medicaid's EDI team at HCF_OS&D@utah.gov for transition. Once transitioned to the 5010 format, a 4010 format will not be available. Effective January 2012, all providers will be transitioned to the 5010 format.

3.3.3. Prior to January 2012, if a 270, 276, 837 or 278 transaction is submitted in the 5010 format, a 5010 format response will be returned.

3.4. Obtain EDI software that meets 5010 requirements

3.4.1. Utah Medicaid does not offer EDI Software. Some software vendors charge for each transaction type (claims, eligibility, reports, and remittance advice). There is no regulation as to what software vendors can charge for the software license or services. It is the responsibility of the provider to shop around for the best deals based on their business needs. The following are suggested questions:

3.4.1.1 Fees and function – What EDI transactions are included in the software?

3.4.1.1.1 Claims (Professional 837P, Institutional 837I, and Dental 837D)

3.4.1.1.2 Client Eligibility Inquiries/Response (270/271)

3.4.1.1.3 Claim Status/Response (276/277)

3.4.1.1.4 Acknowledgment Reports (999 and 277CA)

3.4.1.1.5 Health Care Claim Payment/Advice (835)

3.4.1.1.6 Health Care Service Review (278)

3.4.1.2 Software license – Is it a monthly subscription with a license to use the software? Will the license include free regulation updates?

3.4.1.3 Technical Support – Is installation, set-up, and subsequent assistance included with your purchase or subscription?

3.4.1.4 System requirements – Will the software function with your current operating system (practice management system) or will new hardware be necessary?

3.4.1.5 Reports – Are all data elements on received transactions viewable, ie. 835 remittance remark codes, PLB segments, etc?

3.4.2. UHIN provides UHINt software for their members. Members of UHIN can download the UHINt software from www.uhin.org or contact UHIN for assistance.

3.4.1.6 UHINt download requires user name and password. Contact UHIN at (801) 716-5901 or (877) 693-3071 for more information.

3.4.3. Providers using a billing company or clearing house, contact the billing company or clearing house for software.

3.4.4. Proprietary software can be used provided it meets HIPAA 5010 standards.

4. CONNECTIVITY/COMMUNICATIONS

4.1. Web Services Connection

4.1.1. Web Services connection is required to send 5010 transactions. For more information, see the standard at <http://www.uhin.org/pages/standards-specifications/web-services-network-connection-specification.php> or

4.1.2. Contact UHIN at (801) 716-5901 or (877) 693-3071 for more information.

4.2. Medicaid Trading Partner Numbers (TPN)

4.2.1. Providers, billers, and clearinghouses must separate batches by receiving TPN (HT000004-001, HT000004-005 and HT000004-801). If submitted as one batch, claims will be applied to the first receiver TPN on the submission.

4.2.2. HT000004-001 – Fee for Service

4.2.3.1 This is Medicaid’s main mailbox. Unless listed below, transactions should be submitted to this TPN.

4.2.3. HT000004-005 - Medicaid/Medicare Crossover

4.2.3.1 Submit all Medicaid/Medicare COB crossover claims to this mailbox.

4.2.3.2. Services not covered by Medicare should be billed to Medicaid Fee for Service using the policy and procedures of Medicaid (See Section 8.5 Coordination of Benefits for additional information).

4.2.4. HT000004-801 - Atypical Providers Only

4.2.4.1. Providers who have been enrolled by the Medicaid Provider Enrollment team as “Atypical” must bill using their Medicaid 12-digit Payment Contract Number.

4.2.4.2. Atypical providers must submit to and receive EDI acknowledgment reports from this TPN.

4.2.5. TPNs for electronic attachments.

- 4.2.5.1. Claim Attachments TPNs
 - HT000004-901 – Manual Review
 - HT000004-902 – Emergency Only
 - HT000004-906 – Other (Medicaid)

- 4.2.5.2. Prior Authorization TPNs
 - HT000004-903 – Home Health
 - HT000004-904 – Dental
 - HT000004-905 – Medical Supply
 - HT000004-907 – Wheelchairs
 - HT000004-908 – MRI, OT, PT
 - HT000004-909 – Surgery
 - HT000004-910 – Pharmacy

- 4.2.5.3. Other Service TPNs
 - HT000004-911 – Audits
 - HT000004-913 – Hearings

4.3. Claims Process Flow

4.3.1. You may transmit transactions anytime 24 hours a day, 7 days a week.

- 4.3.1.1. Medicaid's cut-off for claims is usually the end of business Thursday.
- 4.3.1.2. Clean claims received before the cut off should be included in the week's adjudication.
- 4.3.1.3. Claims received after the cut off will miss the current week's adjudication cycle and will process the following weekend.
- 4.3.1.4. Customer Service Staff cannot access claims until after the adjudication cycle.

4.3.2. Only EDI Transactions submitted through UHINet will be accepted.

- 4.3.3. 999 Implementation Acknowledgment – Edits for syntactical quality of the functional group and the implementation guide compliance.
 - 4.3.3.1. The 999 Implementation Acknowledgment is available for download within two hours after receipt of a batch transmission
 - 4.3.3.2. An accepted 999 means the transaction file was accepted.
 - 4.3.3.3. A rejected 999 means the file transmitted does not comply with the HIPAA standards identified by the syntactical analysis or implementation guide compliance. The report will identify the location of the errors.
 - 4.3.3.3.1. The error(s) must be corrected before resubmitting the file.
 - 4.3.3.3.2. All claims within the transmission must be re-billed
- 4.3.4. 277CA Health Care Claim Acknowledgment - Reports status of all claims submitted the day before.
 - 4.3.4.1. The 277CA acknowledgment is available for download the next business day after the transmission of the 837. If a 999 acceptance was received and a 277CA transaction is not generated, contact Medicaid EDI.
 - 4.3.4.2. An accepted claim is assigned a Transaction Control Number (TCN/ICN) and sent to the adjudication system.
 - 4.3.4.3. A rejected claim is an unprocessed claim due to errors. The claim will not be in our system for future calls or claim status inquiry.
 - 4.3.4.3.1. The error(s) must be corrected before resubmitting.
 - 4.3.4.3.2. Use the Claim Status Codes from the HIPAA Code listing at <http://www.wpc.com/content/view/715/1> to determine why the claim was rejected.
- 4.3.5. 835 Health Care Claim Payment/Advice - Reports **paid** and **denied** claims only.
 - 4.3.5.1. The 835 report is available for download on Monday morning. If an 835 transaction is not generated, contact Medicaid EDI.
 - 4.3.5.2. Denial reasons can be found using the Adjustment Reason Codes and the Remittance Advice Remark Codes from the HIPAA Code listing at <http://www.wpc-edi.com/content/view/711/401/>.

5. CONTROL SEGMENTS/ENVELOPING

- 5.1. Utah Medicaid has specific requirements for the ISA/IEA and GS/GE control segments. The Utah standard is available on the UHIN website at <http://www.uhin.org/pages/standards-specifications/sender-and-receiver-identification-in-the-isa-and-gs-segments-specification.php>.

6. ACCEPTANCE TESTING FOR 5010

6.1. Testing with UHIN

- 6.1.1. Medicaid requires all providers to test with UHIN prior to submission of 5010 transactions. Contact UHIN at (877) 693-3071 to coordinate 5010 acceptance testing
- 6.1.2. UHIN will authorize submission of 5010 transactions through their gateway.

6.2. Testing with Utah Medicaid

- 6.2.1. Utah Medicaid does not have a testing environment. Contact Medicaid EDI before your first transmission. Providers can submit production transactions after UHIN acceptance testing
- 6.2.2. Once a provider feels their testing is successful, the X12 4010 standard format can be discontinued (this may occur prior to January 1, 2012).
- 6.2.3. Providers using the UHINt software are not required to test.
- 6.2.3.1. Contact UHIN Member Relations Team at (801) 466-7705 ext. 211 for technical support.
- 6.2.4. Providers using third party software
- 6.2.4.1. Providers using a third party software or a practice management software need to work directly with their software vendor for software upgrade and technical support.

7. EDI TRANSACTIONS

7.1. Claims

7.1.1. 837P - Professional Claims

- 7.1.1.1. See provider manuals for specific billing instructions. Manuals are available at <http://health.utah.gov/medicaid/accept.php>.
- 7.1.1.2. You may send up to 50 service lines in a claim. Medicaid recommends submitting 6 or fewer service lines for each Professional claim. Claims submitted with more than 6 service lines will be split .TCN/ICN will be returned in the 277CA for each claim.
- 7.1.1.3. Diagnosis Code is required. Be sure and report to the furthest detail (up to 5 digits).
- 7.1.1.4. Report NDC code in addition to HCPCS/CPT code if billing physician administered drugs.
- 7.1.1.5. When billing as a Group Practice, include the servicing/rendering provider NPI.
- 7.1.1.6. When NPI and tax ID are used for multiple contracts, include the physical location in the billing address and/or taxonomy as entered in the provider contract.
- 7.1.1.7. When billing for anesthesia procedures (including 41899), the time should be reported in minutes. Procedure code 01996 is the only anesthesia code reported as a single unit; multiple units not allowed for this code.
- 7.1.1.8. The first CLIA number will be used for processing.

7.1.2. 837I - Institutional Claims

- 7.1.2.1. See provider manuals for specific billing instructions. Manuals are available at <http://health.utah.gov/medicaid/accept.php>.
- 7.1.2.2. Up to 999 service lines can be submitted. Institutional claims may be split in the Medicaid system. TCN/ICN will be returned in the 277CA for each claim.
- 7.1.2.3. Outpatient claims require the reporting of HCPCS/CPT for most Revenue Codes.

- 7.1.2.4. Inpatient claims require the Present On Admission indicator for Diagnosis Codes.
- 7.1.2.5. 30 day re-admits should be combined if for same/like service.
- 7.1.2.6. To avoid duplicate denials, do not bill the same procedure code for the same date of service on separate claims.

7.1.3. **837D - Dental Claims**

- 7.1.3.1. See provider manuals for specific billing instructions. Manuals are available at <http://health.utah.gov/medicaid/accept.php>.
- 7.1.3.2. You may send up to 50 service lines in a claim. Dental claims submitted with more than 15 service lines may be split. TCN/ICN will be returned in the 277CA for each claim.

7.2. **999 Acknowledgment for Health Care Insurance**

- 7.2.1. The 999 Implementation Acknowledgment is available for download within two hours after receipt of a batch transmission.
- 7.2.2. An accepted 999 means the transaction file was accepted.
- 7.2.3. A rejected 999 means the file transmitted does not comply with HIPAA standards identified by the syntactical analysis or implementation guide compliance. The report will identify the location of the errors.
 - 7.2.3.1. The error(s) must be corrected before resubmitting the file.
 - 7.2.3.2. All claims within the transmission must be re-billed

7.3. **277CA Health Care Claim Acknowledgement**

- 7.3.1. A 277CA Health Care Claim Acknowledgment reports status of all claims submitted the previous business day.
- 7.3.2. The 277CA is available for download the next business day after the transmission of the 837. If an accepted 999 is received and a 277CA transaction is not generated, contact Medicaid EDI.
- 7.3.3. An accepted claim is assigned a TCN and sent to the adjudication system.
- 7.3.4. A rejected claim on this report is being returned as an unprocessed claim, therefore the claim must be corrected and resubmitted.

- 7.3.4.1. Claims returned as unprocessed are not in our system for future calls and claims status inquiry.
- 7.3.4.2. Use the Claim Status Codes from the HIPAA Code listing at <http://www.wpc-edi.com/content/view/715/1> to determine why the claim was rejected.
- 7.3.5. The Patient Control Number in the 837 transaction needs to be unique to each claim/encounter. This number is returned in the 277CA for matching to the claim/encounter.
- 7.3.6. When Medicaid splits an 837 healthcare claim, the provider is notified through the 277CA.

7.4. 835 Health Care Claim Payment/Advice

- 7.4.1. The 835 remittance reports Paid and Denied claims only. The 835 is used to report the final financial statement of adjudicated claims/encounters.
- 7.4.2. The 835 is available for download on Monday morning and will remain available for pickup for one month. If an 835 transaction is not generated, contact Medicaid EDI.
- 7.4.3. Suspended claims are not reported on the 835.
 - 7.4.3.1. For status of suspended claims, submit a 276/277 transaction (See 7.6 above).
- 7.4.4. Denial codes used in the 835 are the Adjustment Reason Codes and Remittance Advice Remark Codes available at <http://www.wpc-edi.com/content/view/711/401/>.
- 7.4.5. When Medicaid splits an 837 healthcare claim, the provider is notified through the 277CA. The 835 will report each portion of the split claim as it adjudicates.
- 7.4.6. Adjustments reported in any PLB segment of the 835 decreases the payment when the adjustment amount is positive, and increases the payment when the adjustment amount is negative. Verify with your software vendor whether they translated this information for your 835 reporting.
- 7.4.7. For an 835 transaction to balance, the sum of all submitted charges minus the sum of all provider adjustments must equal the total payment amount.
- 7.4.8. A crosswalk identifying Medicaid's internal edits to National standard codes is available on the Utah Medicaid website located at

http://health.utah.gov/medicaid/pdfs/835_errorcodes7.pdf.

- 7.4.9. Medicaid requires EFT for payments (See Section 3.1.4).
- 7.4.10. Providers should ensure reports generated from the 835 contain all essential data elements (including the PLB segments and remark messages).

7.5. 270/271 Health Care Eligibility Benefit Inquiry and Response

- 7.5.1. Submit 270 eligibility inquiry transactions 24 hours a day, 7 days a week. .
- 7.5.2. A 999 will be available for pickup (download) within two hours of transmission for all batch 270 transactions. If you find no 999, contact Medicaid EDI Customer Support (801) 538-6155 or (800) 662-9651 option 3, option 5, option 2.
- 7.5.3. A rejected 999 is the same as a transmission that was never received.
- 7.5.4. Providers must be enrolled with Utah Medicaid for the date submitted in the inquiry for client eligibility.
- 7.5.5. Medicaid clients are always listed as the Subscriber.
- 7.5.6. Medicaid will match based on information submitted. The Medicaid Identification Number of the recipient is the preferred method. Other data used in determining eligibility is:
 - 7.5.6.1. First Name
 - 7.5.6.2. Last Name
 - 7.5.6.3. Date of birth
- 7.5.7. Eligibility and benefit information will be returned based on service type code submitted. If no service type code is submitted, general benefit information will be returned.
- 7.5.8. The 271 will return the trace number submitted in the 270 for matching response to the inquiry.

7.6. 276/277 Health Care Claim Status Request and Response

- 7.6.1. Submit 276 claim status requests 24 hours a day, 7 days a week.

- 7.6.2. The NPI/provider number on the inquiry must match the NPI/provider number on the claim.
- 7.6.3. It is recommended that the 276 request include Medicaid's TCN. The TCN can be found in the 277CA response. Do not submit hyphens or spaces.
- 7.6.4. Other identifying information can be utilized for matching purposes (See UHIN standard for the 276).
- 7.6.5. Do not submit a 276 Claim Status Request until the claim has processed through an adjudication cycle.
- 7.6.6. Providers must submit a Claim Status Tracking Number Segment. This number is used to match the response to the inquiry.
- 7.6.7. A 999 Functional Acknowledgment will be available for pickup (download) within two hours of transmission for all 276 transactions. If there is no 999, contact Utah Medicaid EDI.
- 7.6.8. A rejected 999 is the same as a transmission that Medicaid never received.
- 7.6.9. A claim level response is generated for a claim level request. Line level information may be supplied when a paid claim contains denied lines.
- 7.6.10. A line level response is generated when a line level request is received.
- 7.6.11. Utilize the Claim Status Codes found at <http://www.wpc-edi.com/content/view/715/1> to determine why the claim was rejected.
- 7.6.12. All paid, denied or suspended claims matching the request are reported in the 271 response

8. GENERAL INFORMATION

8.1. Claims

- 8.1.1. The Patient Control Number needs to be unique to each claim/encounter. This number is returned in the 277CA which identifies the claim/encounter.
- 8.1.2. Medicaid Customer Service agents are unable to see claims that have not processed through a weekend adjudication cycle.
- 8.1.3. The subscriber is always the patient. There are no dependents in the Medicaid program.
- 8.1.4. The NPI and Tax ID must match to a single Medicaid contract.

- 8.1.4.1. 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.
- 8.1.5. Utah Medicaid does not 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).
- 8.1.6. Units should be reported in full units. The Division of Medicaid and Health Financing's policy is to round to the nearest unit.
- 8.1.7. When submitting a National Drug Code (NDC), enter all 11 digits. Zero fill if not 5-4-2 format (example: 186-868-44 report as 00186086844). Do not submit hyphens, spaces or special characters.

8.2. Timely Filing

- 8.2.1. Claims and adjustments for services must be received by Medicaid within 365 days from the date of service.
 - 8.2.1.1. The timely filing period is determined by the date of service:
 - 8.2.1.1.1. Institutional Claims use the "through" date of service.
 - 8.2.1.1.2. All other claim types use the "from" date of service.
- 8.2.2. Original claims received past the 365 day filing deadline will be denied.
- 8.2.3. Replacement/Adjustment of a claim must also be processed within the same 365 day time frame (See Section 8.3).
- 8.2.4. Providers may request a change to correct a claim outside of the timely deadline. However, no additional reimbursement will be made. Example: Claim to be replaced was denied, the payment on the replacement claim will be zero.
- 8.2.5. Medicare/Medicaid Crossover Claims and adjustments must be received within 365 days or six months (180 days) from notification of the Medicare decision.
 - 8.2.5.1. The Medicare paid date must be submitted on the claim.

8.3. Replacement and Void Claims

- 8.3.1. Providers should submit their own corrections by submitting either a replacement or void claim.

- 8.3.2. If the original claim was denied, it is not necessary to submit a replacement claim. Make the necessary correction(s) and resubmit claim as an original claim.
- 8.3.3. Use “7” as the Claim Resubmission Code for Replacement claim and “8” for Void claims.
- 8.3.4. The provider number on the original claim must match the provider number being submitted on the replacement claim, or the claim will reject.
- 8.3.5. The TCN of the claim to be replaced or voided must be reported. Do not submit hyphens or spaces.
 - 8.3.5.1. 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.
- 8.3.6. Replacement claim(s) void the original claim. The replacement claim is then processed in the Medicaid system as an original claim.
- 8.3.7. 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 showing only the services not paid on the original claim.
- 8.3.8. If additional units are being added to an already paid procedure code, or you are changing procedure codes, a replacement claim must be submitted.
- 8.3.9. If wanting to replace a total original claim that was split by Medicaid for processing, it is necessary to submit a void claim for each of the split claims relating to the original claim. A new original claim would then be submitted for processing and split in the Medicaid system.
 - 8.3.9.1. If replacing only the information for a single portion of a split claim, you may replace just that specific claim portion, realizing the individual claim and charges will be voided and the new claim treated as an original.
- 8.3.10. If a claim was paid under the wrong provider number, submit a void claim with the NPI/Atypical Provider Number of the original claim and a new original claim with the correct NPI/Atypical Provider Number.
- 8.3.11. Reprocessed or corrected claim will return the same TCN as on the original claim in the 835.

8.4. Attachments

8.4.1. A HIPAA electronic standard has not been mandated for attachments. There are multiple methods of submitting supporting documentation:

8.4.1.1. Electronic

8.4.1.1.1. Fax

8.4.1.1.2. E-mail

8.4.1.1.3. UHIN software. Please contact UHIN for software options.

8.4.1.2. Paper

8.4.2. All documentation submitted for review through Fax, E-mail or paper, must be submitted with a completed Utah Medicaid Documentation Submission Form. The form is available at <http://health.utah.gov/medicaid/provhtml/forms.htm> . Electronic software submissions must provide metadata matching the data on the document submission form.

8.4.2.1. The form must be the first page of the documentation and must be filled out completely.

8.5. Coordination of Benefits

8.5.1. Before submitting a claim to Medicaid, a provider must submit and secure payment from all other liable parties such as Medicare Part A and B. (For more information refer to the Medicaid Manual, General Information Section, 11-4).

8.5.2. Claims denied from Medicare as non-covered services should be submitted to Medicaid Fee-for-Service, not to Crossovers.

8.5.3. On Crossover claims, report third party payment information the same as the Medicare EOMB (at line level if possible).

8.5.4. Fee-for-Service uses claim level third party payment information for adjudication.

8.5.5. Report all Reason Codes as reported by other payer(s) and amounts (contractual obligation or write-offs). If no reason codes given by other payer, report all contractual obligations using "CO:45". If no reason code is available from other payer(s) to identify the patient responsibility use "PR:01" reason code. Report

the total payments and the final patient responsibility. Medicaid calculates payment based on Patient Responsibility.

- 8.5.6. Do not include co-payments received from the patient in the Third Party Liability (TPL) reporting.
- 8.5.7. A service paid by a primary payer may be billed under a different procedure code than Medicaid requires for adjudication. Providers must follow Medicaid billing guidelines on their FFS secondary claims.
- 8.5.8. Third party payment information must be submitted for all prior payers. Ensure your software allows for reporting of multiple payer coordination of benefits information.
- 8.5.9. The TPN for claim submission:

HT000004-001 - Medicaid Fee-for-Service
 HT000004-005 - Utah Medicaid Crossovers

If primary payer	When primary payer is	Transmit electronic claim to TPN
pays	Medicare	HT000004-005
	Commercial	HT000004-001
pays zero	Medicare	HT000004-005
	Commercial	HT000004-001
denies	Medicare	HT000004-001
	Commercial	HT000004-001

9. REAL TIME TRANSACTIONS

- 9.1. Real time processing of the 270/271, 276/277 and 278 will be available early 2012. Submission requirements will be the same as for batch submissions.

10. CONTACT INFORMATION

10.1. Telephone Number

10.1.1. Utah Medicaid’s main number is (801) 538-6155 or (800) 662-9651.

10.1.2. Utah Medicaid will broadcast messages on our phone system such as announcements of MIBs, system down time and technical issues, delay in transmitting EDI reports, etc.

- 10.1.3. The EDI customer support team can be reached at (801) 538-6155 or (800) 662-9651 option 3, option 5, option 2.
- 10.1.4. Hours of operation are Monday through Friday 8 to 12 pm and 1 to 5 pm.
- 10.1.4.1. Customer Service representatives are not available until 11 A.M. on Thursdays.
- 10.2. Medicaid Address - Items mailed to our street location are not delivered by the post office.
- Bureau of Medicaid Operations
PO Box 143106
Salt Lake City, UT 84114-3106
- 10.3. Utah Medicaid List Serve - To receive Medicaid notices of program changes, announcements of MIBs, 5010 status, updates and other information, please sign up for the Medicaid email list serve at http://health.utah.gov/medicaid/provhtml/what_s_new.html
- 10.4. Utah Medicaid Website - Medicaid Information Bulletins, Provider Manuals, Fee Schedule, and many other helpful resources are available on the Medicaid website at <http://health.utah.gov/medicaid/>.
- 10.5. E-mail Address - Medicaid's E-mail address is medicaidops@utah.gov. To ensure security is maintained, a secure E-mail must be utilized when sending any Protect Health Information (PHI) data.
- 10.6. UHIN Alerts
- 10.6.1. Medicaid recommends trading partners sign up to receive UHIN alerts at <http://www.uhin.org/pages/membership/newsletter-alerts.php> for urgent broadcast and notification.

11. APPLICABLE WEBSITES AND RESOURCES

Utah Medicaid Home Page: <http://health.utah.gov/medicaid/>.

Utah Medicaid 5010 Companion Guide: <http://health.utah.gov/hipaa/guides.htm>

Enroll as a Utah Medicaid Provider:
<http://health.utah.gov/medicaid/provhtml/providerenroll.htm>

Utah Medicaid EDI Enrollment: <https://mmcs.health.utah.gov/hcfeenroll2/index.jsp>

UHN Home Page: <http://www.uhin.org>

Washington Publishing Company (WPC): <http://www.wpc-edi.com/>

WPC Code List: <http://www.wpc-edi.com/codes>

WPC complete product list:
<http://www.wpc-edi.com/content/view/661/393/>

CMS Versions 5010 and D.0 information: <http://www.cms.gov/Versions5010andD0>

CMS transaction and Code Sets Standards:
<http://www.cms.gov/TransactionCodeSetsStandards>

CMS Electronic Billing & EDI Transactions Help Lines (Part A and B)
[http://www.cms.gov/ElectronicBillingEDI Trans](http://www.cms.gov/ElectronicBillingEDITrans)

Accredited Standards Committee (ASC): <http://www.x12.org>

ASC X12 Interpretations Portal: <http://www.x12.org/portal>

NCPDP (Version D.0) data: <http://www.ncpdp.org>

12. TERMINOLOGY

Submitter: Entity that owns the submitter ID associated with the healthcare data being submitted. It is most likely the provider, hospital, clinic, supplier, etc., but could also be a third party submitting on behalf of one of these entities. A submitter must be directly linked to each billing NPI. Often the terms submitter and trading partner are used interchangeably because a Trading Partner Number is defined as the entity engaged in the exchange or transmission of electronic transactions. Thus, the entity that is submitting electronic transactions to Utah Medicaid is the Trading Partner.

Provider: Entity that renders services to beneficiaries and submits health care claims to Utah Medicaid.

Vendor: Entity that provides hardware, software and/or ongoing technical support for covered entities. In EDI, a vendor can be classified as a software vendor, billing or network service vendor or clearinghouse.

Billing Service: Third party that prepares and/or submits claims for a provider/supplier.

Clearinghouse: Third party that submits and/or exchanges electronic transactions (claims, claim status or eligibility inquiries, remittance advice, etc.) on behalf of a provider/supplier.

EDI Trading Partner: Any Medicaid customer (e.g., provider/supplier and their billing service, clearinghouse or software vendor) that transmits to or receives electronic data from Utah Medicaid.