EDI Claims Companion Guide for 5010

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Introduction

In order to make claims submission easier for providers, and for required compliance with the Health Insurance Portability and Accountability Act's (HIPAA's) Transaction and Code Set standards, we process electronic claims in the X12N 837 version 5010 Errata format.

HIPAA requires that WellSense and all other health insurance payers in the United States comply with electronic data interchange standards for health care as established by the Secretary of Health and Human Services. The X12N 837 version 5010 Errata implementation guides for Health Care Claims have been established as the standard for claims transactions compliance. The implementation guides for this format are available electronically at http://www.wpc-edi.com.

This document has been prepared as a WellSense-specific companion document to that implementation guide and will clarify when conditional data elements and segments must be used for WellSense reporting. It also will identify those situations and data elements that do not apply to WellSense. This companion guide document supplements but does not supersede any requirements in the 837 version 5010 Errata implementation guides.

The intended audiences for this document are the billing departments and the technical areas responsible for submitting electronic claims transactions to WellSense. In addition, this information should be communicated to and coordinated with the provider's billing office in order to ensure that the required billing information is provided to the billing agent/submitter.

Important Reminders

To ensure that your claims are processed through to adjudication:

1. WellSense can accept ICD-10 codes with upper-case characters only and without decimal points. Claims submitted with both ICD-9 and ICD-10 diagnosis codes will be denied.

2. In accordance with HIPAA rules, WellSense accepts the National Provider Identifier (NPI); Please note that all NPIs must be registered with WellSense. In addition, WellSense reads NPIs in combination with tax IDs or Social Security numbers (tax IDs take precedence) to identify rendering providers, so we must have that combination on file for adjudication purposes (except in certain Behavioral Health or specialty situations, depending on providers' contracted situations). Visit our website to learn how to submit your NPI information: http://www.wellsense.org

3. **If your NPI and/or Tax ID is not provided or is not in the correct place the claim will be rejected.** Your rendering/servicing provider NPI must be in the equivalent of UB-04 Form Locator 51 or CMS-1500 Box 24J or CMS-1500 Box 33. *Please note*: 5010 compliance rules state that if the rendering provider information is the same as the billing provider information, rendering provider information should *not* be sent in the 837. Please see Appendices B and C for valid locations for the WellSense Provider ID on the 837 format.

4. A valid Plan-assigned member identification number (e.g., a B number, such as B12345678) must be provided. *If this number is not provided or is in the wrong place the claim will be rejected.* Please see Appendices B and C for valid locations for the member ID on the 837 format. Please note that claims for members of our Clarity plans should include the two-digit suffix (e.g., C1234567801) along with the correct name, date of birth and sex of the member/patient that is receiving the services.

5. Modifiers must be appended to the CPT/HCPCS codes in the line items where they apply.

6. Claims requiring attachments (e.g., EOBs, invoices, etc.) cannot be submitted via EDI at this time.

7. Anesthesia claims must use ASA codes. Units must be in minutes—not in fractions of hours or days.

8. WellSense can accept claim replacement (frequency code 7) and void

(frequency code 8) transactions in the 837 formats, but adjustments or voids of any claims that have been split MUST be submitted on paper. See Page 18 for details.

9. WellSense accepts 837 Institutional and 837 Professional files written to the 5010 Errata specifications (005010X223A2 for 837I, 005010X222A1 for 837P) only.

10. WellSense can accept 25 total diagnosis codes for 837I (UB-04) claims and 12 total diagnosis codes for 837P (CMS-1500) claims.

11. The filenames of electronic claims files can be *no longer than 50* characters, including the extension.

12. Claims with information in the 2320 (Other Subscriber Information) and 2330A through 2330I (Other Subscriber Name – Other Payer Billing Provider) loops may pend for COB investigation; thus, if your claims generation software populates those loops with information that matches the subscriber data (Loop 2010BA), the claim might be pended and delayed even though there is really no COB.

    Example: SBR*P*18*81720500151**MC****MC~
    DMG*D8*YYYYMMDD*M~
    OI***Y*B**Y~ NM1*IL*1*LASTNAME*FIRSTNAME****MI*B12345678~
    N3*STREET ADDRESS~
    N4*CITY*MA*0000~ REF*SY*123456789~
    NM1*PR*2*MEDICAID*****PI*MASSHEALTH~

13. NDC codes required effective with 6/1/2012 date of service:

    To meet compliance standards outlined in the Deficit Reduction Act (DRA) of 2005 and the Commonwealth of Massachusetts regulations, **effective with date of service June 1, 2012**, WellSense (WellSense) will require the 11 digit national Drug Code Number (NDC) to be reported on all qualifying claim forms when injectable physician-administered drugs are administered in the office or an outpatient setting; this requirement excludes applicable vaccines/immunizations.

    Providers will need to submit claims with both HCPCS and NDC codes to WellSense with the exact NDC that appears on the medication packaging in the 5-4-2 digit format (i.e., xxxxx-xxxx-xx), as well as the NDC units and descriptors. This coding requirement will apply only to all WellSense MassHealth members. Failure to submit the exact applicable NDC number, units and descriptors administered to the MassHealth member will result in a front-end

rejection and/or denial of the claim line that required NDC reporting.

For more information, please see Network Notification M-131 (dated March 27, 2012) on our web site (http://www.bmchp.org/providers/network-notifications).

Submitting Electronic Claims

WellSense has partnerships with the following clearing houses, Trizetto Provider Solutions, NEHEN/NEHEN*Net*, and Gateway EDI and currently accepts and processes provider claims electronically for all providers and billing agencies. Providers who submit claims using any of the Clearinghouses listed in the TPS table below may continue but should contact their clearinghouse support team to verify the information. If you do not use a clearinghouse or billing agency, or your clearing house or billing agency is not listed you can contact Trizetto at TTPSSupport@cognizant.com, or register online by clicking here or copy and paste this link into your browser https://www.trizettoprovider.com/Boston-Medical-New-User-Request**.** WellSense will not be accepting any Direct connections for electronic claims submissions.

Clearinghouse Contacts

Type of Connection	Payer ID	Contact Name	Telephone Number	Email Address
Trizetto Payer Solutions Click here	Professional Claims: 13337 Institutional Claims:	Providers should contact the support team here:		TTPSSupport@cognizant.com
NEHEN/NEHEN*Net* Nehen.org Nehennet.org	N/A	*Existing NEHEN clients:* Contact your site administrator *NonClients:* Sales deparmtment	781-290-1290	neheninfo@nehennet.org nehennet@csc.com

- Ability
- Administep
- AKAMAI Practice Management
- Allscripts
- Availity
- Capario/Healthcare Exchange
- Change Healthcare
- Claim MD
- ClaimRemedi Inc
- ClaimLogic
- ClaimsLynx
- Cortex EDI Inc
- ENS/Optum
- Eprovider Solutions
- GE Healthcare
- Globalcare
- Health e-Web
- Health Fusion
- MedAssets
- MD-Online
- Office Ally
- Practice Insight
- Quadax Inc
- Relay Health
- Smart Data
- SSI Group
- TKSoftware
- Navicure
- Zirmed

Testing

Testing will be conducted with the Clearinghouse directly, no files will be exchanged with WellSense and the provider directly.

Reporting

This section identifies and describes reports issued by WellSense related to claims submitted electronically. The reports include confirmation that claim files have been received, and preliminary claim rejections (missing elements or segments) and acceptances.

WellSense's Claims Transmission Acknowledgement, 999s, TA1s, and Initial Claims Status reports are put in the **reports** directory in the submitter's FTP folder. Reports remain in that directory until the submitter removes them or until a regularly scheduled Plan archiving process takes place. Thus, submitters can remove reports from the directory whenever they are downloaded, or reports can be kept on the server for reference until some later time when WellSense may archive the folder. Even after WellSense's archiving process has occurred, you can always request a previously available report.

WellSense Claims Transmission Acknowledgement report

Upon receipt of an 837 from a submitter, WellSense generates a confirmation file, referred to as the —Claims Transmission Acknowledgement report. ||The filename of the Claims Transmission Acknowledgement report is automatically assigned by WellSense's processes, with the characters —.ack ||appended. A typical Claims Acknowledgement report filename is ABCDE.20120229.89898.ack, where:

- *ABCDE* is trading partner name agreed upon beforehand
- *20120229* is the date of receipt by WellSense, and
- *89898* is an automatically incremented number used to create unique filenames

Sample WellSense Claims Acknowledgement report:

```
********************************************************
*                  EDI ACKNOWLEDGEMENT                  *
********************************************************

    Received By: Boston Medical Center HealthNet Plan
  Received Date: mm/dd/yyyy

         Status: Successful
           File: abcde20120229.asc
      Submitter: ABCDE
   Total Claims: 358
  Total Charges: $52,839.29
    EDI Version: 5010
```

Please note that the Claims Transmission Acknowledgement report indicates only that WellSense successfully received the file. The Total Claims and Total Charges lines do *not* mean that all the claims were accepted into the system nor that all the charges were adjudicated to the listed dollar volume. The totals shown on the Claims Transmission Acknowledgement report are provided so that submitters can check to make sure WellSense received the correct file.

999/TA1FunctionalAcknowledgements

A 999 is the Functional Acknowledgment Transaction Set commonly exchanged with 837s, but is not easily readable. 999s are typically used to indicate whether a payer was unable to process particular claims in the file. Claims shown as rejected in a 999 should be fixed per the rejection reason in the 999 and resubmitted (as new claims). A TA1 that shows a rejection (a.k.a., a negative TA1) indicates that there was a problem in the header levels of the 837, meaning that none of the claims in the 837 were processed. Receipt of a negative TA1 can be most easily resolved by contacting WellSense representative listed in the Contacts > Direct section above.

A typical Plan 999 is named similarly to our Claims Transmission Acknowledgement report: 999_##_#_ABCDE.20120102.999999.edi, where:

- *##_#* is a system-generated incremental identifier
- *ABCDE* is WellSense Health Plan's internal trading partner mnemonic
- *20120102* is the date of receipt by WellSense, and
- *999999* is an automatically incremented number used to create unique filenames

Sample WellSense 999:

```
ISA*00*          *00*          *30*043373331      *30*#########
*120103*1133*^*00501*000000001*0*P*:~
GS*FA*043373331*#########*20120103*11330043*1*X*005010X231A1~
ST*999*1001*005010X231A1~
AK1*HC*118922*005010X222A1~
AK2*837*0001*005010X222A1~
IK5*A~
AK2*837*0002*005010X222A1~
IK5*A~
AK2*837*0003*005010X222A1~
IK3*NM1*27*2310*I9~
CTX*SITUATIONAL TRIGGER*NM1*11*2310*9~
CTX*CLM01:ABC123~
IK5*R*I5~
AK9*P*3*3*2~
SE*13*1001~
GE*1*1~
IEA*1*000000001~
```

If you need help interpreting a 999, please contact WellSense representative listed in the Contacts > Direct section above.

A typical Plan TA1 is named similarly to our Claims Transmission Acknowledgement report: TA1_#_ABCDE.20120102.999999.edi, where:

- *#* is a system-generated incremental identifier
- *ABCDE* is WellSense Health Plan's internal trading partner mnemonic
- *20120102* is the date of receipt by WellSense, and
- *999999* is an automatically incremented number used to create unique filenames

Sample WellSense TA1:

```
ISA*00*          *00*          *30*043373331      *30*#########
*120102*1215*^*00501*000000002*0*P*:~
TA1*000118922*120102*0415*A*000~
IEA*0*000000002~
```

If you need help interpreting a TA1, please contact WellSense representative listed in the Contacts > Direct section above.

WellSense Initial Claims Status report

WellSense processes claims starting at 9:00 P.M. EST Monday through Friday. Once a submitter's claims file has been processed, an Initial Claims Status report is generated and made available in the **reports** folder of the submitter's FTP

directory before noon the following business day. WellSense cannot produce a 277CA file at this time.

The filename of the Initial Claims Status report is the same as the submitted filename, but with a date/timestamp and the characters —.err ‖appended. Thus, if you submit a file named **20120229104.asc**, the Initial Claims Status report for that file will be named **20120229104.asc_20122295611.err**, where the 20122295611 is the yyyymdhmss date format of when the file was produced

WellSense's Initial Claims Status reports are in a proprietary yet simple to understand format; the data elements are separated by commas, meaning you can open it in spreadsheet programs like Microsoft Excel. Any changes in format will be communicated to and tested with submitters well before changes affect production.

WellSense's Initial Claims Status report lets a submitter know if each of the submitted claims was accepted into WellSense's system for processing, or if it was rejected. If a claim was rejected, the reason will be given (i.e., the NPI and/or the patient's ID was not recognized by our system). Please note that any claims reported as rejected in a 999 report will *not* be included in the Initial Claims Status report once 5010 Compliance checking is turned on for a trading partner.

Each claim is listed on the report with the following information:

Field Name	Note
Status	—ACCEPTED‖ or —REJECTED‖ If you are submitting replacement (frequency code 7) and/or void (frequency code 8) requests (see Page 18), the words —REPLACE‖ or —VOID‖ will precede the two status words above, separated by a colon. For example, —VOID:ACCEPTED‖ or —REPLACE:REJECTED‖
Ext Claim No	The ID # for the claim supplied by the submitter or the submitter's clearinghouse or billing agency
Patient Account Number	
Receive Date	The date WellSense received the claim
Service From Date	
Service To Date	
Member ID	The Member ID supplied by the submitter; if the claim was rejected for Member ID not on File, submitters can check to see what number was actually submitted for the claim
Member First Name	As supplied by the submitter
Member Last Name	As supplied by the submitter
Member Mid Initial	If supplied
Member Date of Birth	As supplied by the submitter
Provider ID	If the claim was rejected for processing because the submitted NPI/Tax ID combination was not recognized, this field will be empty. Otherwise, WellSense's IDfor the servicing provider is displayed here.

Error Number	0............Claim accepted and processing) 51303.....Member ID not on File 51303.....Subscriber/Member ID Invalid 51303..... Patient Last Name Invalid 51303.....Patient First Name Invalid 51303.....Patient DOB Invalid 51303.....Member Name Invalid 51303.....Member Name and DOB Invalid 51304.....Provider ID not on File The following errors only apply to replacement (frequency code 7) and void (frequency code 8) requests (see Page 18): 10010.....Original Claim ID not supplied 10020.....Submitted Original Claim ID is not valid 10030.....Submitted Original Claim ID has already been adjusted; resubmit request on paper 10040.....Provider ID on replacement/void must match provider ID of original claim 10050.....Subscriber ID on replacement/void must match subscriber ID of original claim 10060.....Submitted Original Claim ID has not been finalized; wait for remittance then resubmit
Error Description	text explanations as above
Charge Amt	The submitted total charge amount for the claim

Rejected claims can be fixed and resubmitted electronically (as new claims, not as corrections), or dropped to paper and sent by regular mail.

Effective January 1, 2016, we extended our member verification process so that the following member demographic elements must match on all claims sent to WellSense for reimbursement:

- Member ID
- Member first and last name
- Member date of birth

If the above data elements do not match, the claim will reject and require resubmission with the correct information. The new rejection reasons are listed in the table above (under the 51303 error number); please note —Member ID not on File ‖ is WellSense's existing error reason for when the supplied Member ID is not in our system, and that error reason —Subscriber/Member ID Invalid ‖ indicates that the Member ID including the suffix supplied on the claim refers to a member name that does not match the member name supplied on the claim.

—Provider not on File ‖ rejections are usually caused by the NPI/Tax ID combination not being on file with WellSense, or the NPI being in the wrong place. If you submit Professional (i.e., CMS-1500) claims, please see the sections *Professional Claims (837P) Data Requirements* and *Appendix B* for specific placement information; if you submit Institutional (i.e., UB-04) claims, please see the sections *Institutional Claims (837I) Data Requirements* and *Appendix C* for specific placement information. If you have an NPI but haven't registered it with WellSense, or if you're billing for an entity that has a different Tax ID than you've billed for before, please call your Plan Provider Relations Representative, or call our provider line at 888-566-0008.

Reporting Summary

Report	File Name	Purpose	Turnaround from time of Submission
WellSense Claims Transmission Acknowledgement report	xxxx.ack, where xxxx shows trading partner initials, date received by WellSense, and a unique numeric	Acknowledgement of file receipt, showing date, filename, total claim volume, total claim dollars.	Available within 2 hours of receipt.
999 Functional Acknowledgement/ TA1	999_##_#_ABCDE.20120102.999999.edi, where ##_# is a system-generated incremental identifier, ABCDE shows WellSense's internal trading partner mnemonicand 999999 is an incremental filename identifier. The date the file is received by WellSense is included. TA1_#_ABCDE.20120102.999999.edi, where # is a system-generated incremental identifier, ABCDE shows WellSense's internal trading partner mnemonic, and 999999 is an incremental filename identifier.	Standard acknowledgement files showing successful processing of claims file or problems that stopped the file from processing	Available no later than 36 hours after receipt of a claims file.

WellSense Initial Claims Status report	Default = xxxx_ yyyymdhmss.err, where xxxx is the original submission filename and yyymdhmss is the date/timestampe of when the report was produced	List of accepted claims, and claims that cannot be processed due to missing or invalid elements or segments.	Available no later than 36 48 hours after receipt of file

Operational Requirements Summary

Submitters must be able to produce 837 files, encrypt them with PGP if they transmit the files to WellSense via regular FTP, or use secure FTP to send the files to WellSense. Testing will validate each of these capabilities, as well as the accuracy of the claims information in the 837 files and the format of the 837 files. *Please note that claims must have a valid member ID (Plan-assigned numbers are preferred) and properly located NPI/tax ID combination that has been registered with WellSense to be accepted into our system. Claims must also pass HIPAA 5010 compliance rules.*

During the testing stages described above, files should be submitted into the **test** directory in the FTP area assigned to the submitter. In addition, when submitters use live claims data for testing, paper copies of those live claims *must* be submitted to WellSense in the normal manner for payment; *test claims will NOT be processed for payment by WellSense.* Once a submitter moves out of the testing stage and into —live production, claims files should be submitted into the **inbox** directory in the FTP area assigned to the submitter.

In both testing and production phases, WellSense will produce a Claims Transmission Acknowledgement report and a 999/TA1 upon receipt of a file. In production, electronic claims are processed each business night along with paper claims. The morning after each run, Initial Claims Status reports will be generated and made available; processing delays sometimes occur, but 999/TA1 and Initial Claims Status reports will be generated no later than 48 hours after claims files are received. During

testing, both reports will be in the **test** directory; when a submitter goes live the reports are made available in the **reports** directory. It is the submitters' responsibility to periodically archive and remove files from the **reports** directory, though WellSense will clean those directories from time to time.

Individual claims that cannot be processed are reported in the Initial Claims Status report. These claims are not correctable by WellSense; if you can resolve the problem yourself, the claims can be resubmitted electronically (as new claims, not replacement/corrections).

Any questions or problems submitters encounter during the testing/implementation phase should be directed to ITOpsSupport@wellsense.org

Electronic Replacement and Void requests

WellSense can accept electronic claims with Claim Frequency Codes of 7 (replacement) or 8 (void) in a specific location in the 837:

Loop 2300
Segment CLM
Position 05-3

Example: **CLM*A37YH556*500***11::7*Y*A*Y*Y*C~**

*the **7** indicates the claim is a replacement*

We *cannot* accept frequency codes of 6 (correction). Late charges should use a frequency code of 5, not 7.

Please note:

- The 7 frequency code is for replacements only, NOT for late charges.
- The 837 format allows providers to submit frequency codes in 837 Professional claims (analogous to CMS-1500 claims) as well as 837 Institutional claims (analogous to UB-04 claims).

Void requests and replacement requests MUST include WellSense's original claim # in a specific location in the 837:

Loop 2300
Segment REF-- Payer Claim Control Number
"F8" must be in Position 01 (the Reference Identification Qualifier), and the BMC claim number must be in Position 02

Example: **REF*F8*E00999999900~**

Void/replace claims without this information will be rejected.

Voids and replacements will only be accepted for claims that are in a finalized status. Replacements for claims that have been split MUST be sent in on paper–we cannot process those electronically. Void/replace claims for non-finalized claims will be rejected.

Replacement claims can only be processed for the same member ID and provider NPI/Tax ID that were on the original claim. If a claim needs to have a different member or provider identifier, a void request must be submitted with the original claim number first, followed by a *new* claim (frequency code 1) with the new member/provider information.

Replacement claims must be complete, with ALL header and line item information that the submitter wants to see on the new claim. For instance, if the submitter wants to replace an original claim that had seven lines with a claim that has 10 lines, all 10 lines must be submitted on the replacement claim, NOT just the three new lines.

Summary

Electronic replacement (frequency code 7) and void (frequency code 8) requests MUST meet the following requirements for processing:

- Replacement/Void claims must include the original WellSense claim number in Loop 2300's Payer Claim Control Number REF segment, with an —F8 ‖in Position 01.
- The original WellSense claim referenced by that ID number MUST be in a finalized status.
- The Member ID and provider NPI/Tax ID on the replacement/void claims must be the same as what was submitted in the original claim.
- Electronic replacement claims for original claims that WellSense has split cannot be accepted.

Any replacement/void claims that do not meet ALL of these requirements will be rejected and reported accordingly in WellSense's initial claims status reports.

WellSense Specific Conditional Data Requirements

Professional Claims (837P) Data Requirements

While electronic submission of claims means that your claims will get to WellSense faster, supplying the necessary data elements in clean fashion also will help get those claims through the adjudication process quicker. The following guidelines will show you the minimal information that WellSense needs to quickly process your professional (CMS-1500) claims.

> If you use a clearinghouse, third-party billing agency, or software that converts your claims into ASC X12N 837 (005010X222A1) 837P format, please see *Technical Appendix B: Professional (CMS-1500) Claims Mapping to 837P format* for specific file placement requirements.

Please note that WellSense accepts 837s only in the HIPAA-required Errata format (005010X222A1).

Below is the information required to process your professional claims:

Data Element	CMS-1500 Box Number
National Provider Identifier (NPI)	**24J or 33a** *see Note 1*
Provider Tax ID or SSN	**25**
WellSense Member ID	**1a**
Diagnosis Codes	**21** *see Note 2*
Total Charge	**28**
From/To Service Dates	**24A**
Place of Service (POS)	**24B**
Charges	**24F**
Units	**24G**
Procedure	**24D**
Procedure Modifier(s)	**24D**

Notes:

1. The Rendering Provider NPI must be provided in either Box #24J or #33 (or their equivalents on your software). WellSense always takes the NPI in Box 24J first, so if a submitter wants us to read the NPI in Box 33 there should *not* be an NPI in Box 24J. If a submitter is contracted with WellSense so that individual practitioners' or clinicians' NPIs are not on file at WellSense, submitting those individual NPIs in 24J will prevent WellSense from reading the group NPI in Box 33. WellSense also reads NPI/Tax ID combinations, so if we have the correct NPI on file but not with the Tax ID in Box 25, the claim will still reject. If an NPI/Tax ID combination is not found on file, the electronic claim *will reject.*
2. 5010 compliance rules state that provider information in Loop 2310B (Rendering Provider Name – claim-level) is required when the Rendering Provider information is different than that carried in Loop 2010AA (Billing Provider); if not required, do not send. Additionally, provider information in Loop 2420A (Rendering Provider Name – line-level) is required when the Rendering Provider NM1 information is different than that carried in Loop 2310B (Rendering Provider – claim-level) OR when Loop 2310B is not used AND this particular line item has different Rendering Provider information than that which is carried in Loop 2010AA (Billing Provider); if not required, do not send.
3. WellSense will only accept ICD-10 codes with upper case characters; claims submitted with any lower case characters will be denied. ICD-10 codes should not be submitted with decimal points.

   Claims submitted with both ICD-9 and ICD-10 diagnosis codes will be denied.
4. WellSense cannot accept more than 12 diagnosis codes in the 837P.

Special Claims

Claim types outlined below will require additional data or specifications, as noted.

- **Adjustments, voids, replacements, etc.**
    - Any replacement or void requests for previously submitted claims (e.g., claims frequency codes of 7 and 8) must satisfy the requirements starting on Page 18. Changes to split claims must be submitted on paper.
- Anesthesia
    - Units must be in minutes, not fractions of hours or days.
    - Use ASA codes, not surgical codes.
- COB
    - Please include as much COB-related information (e.g., accident indicators, accident locations) as you can. WellSense cannot accept attachments such as other EOBs electronically at this time.
- **Behavioral Health / Durable Medical Equipment Claims**
    - Behavioral Health providers should call Beacon Health Strategies at 866- 444-5155 or send e-mail to edi.operations@beaconhs.com for information about submitting electronic claims. Please note that early intervention (EI) claims should be sent directly to WellSense, *not* Beacon Health Strategies.
    - Durable medical equipment, prosthetic, orthotic and medical supply (DMEPOS) providers should call Northwood, Inc. at 866-802-6471 or visit the company's website at www.northwoodinc.com for information about submitting electronic claims.
    - *Nonspecific, unlisted and invoice priced codes require attachments;* therefore, WellSense cannot accept these claims electronically at this time since there is an attachment.
- **Immunizations**
    - Claims seeking additional reimbursement for immunizations normally supplied by the State require an invoice and should not be submitted electronically at this time since there is an attachment.
- Invoices
    - Any claim requiring an invoice attachment must be sent on paper at this time.

- Modifiers
  - Modifiers must be included in the appropriate location (CMS-1500 Box 24D MODIFIER) next to the CPT/HCPCS code on the line items where they apply.
  - If you use multiple modifiers, pricing modifiers should be in the first modifier position (i.e., statistical modifiers should be placed after a pricing modifier). Please make sure that multiple modifiers are separated by accepted HIPAA delimiting characters (e.g., :,^, or >).

- **Newborn Claims**
  - Claims for newborns should be submitted separately from the mother's claims, and with the unique subscriber/member number instead of the mother's.

- NDC Codes
  - To meet regulatory requirements, claims with a June 1, 2012 date of service and beyond must include NDC codes when injectable physician- administered drugs are administered in the office or an outpatient setting; this requirement excludes applicable vaccines/immunizations. For more information, please see Network Notification M-131 (dated March 27, 2012) on our web site (http://www.bmchp.org/providers/network- notifications).
  - WellSense accepts NDC codes electronically, but we do not use them for adjudication purposes.

- **Year-spanning Claims**
  - Claims with service dates that span a calendar year should be split into two separate claims. For example, a hospital stay beginning on December 27 and ending January 6 should be billed on two separate claims, one covering December 27-31, the other covering January 1-6.

WellSense Specific Conditional Data Requirements *(continued)*

Institutional Claims (837I) Data Requirements

While electronic submission of claims means that your claims will get to WellSense faster, supplying the necessary data elements in clean fashion will help get those claims through the adjudication process quicker. The following guidelines will show you the minimal information WellSense needs to quickly process your institutional (UB-04) claims.

> If you use a clearinghouse, third-party billing agency or software that converts your claims into ASC X12N 837 (005010X223A2) 837I format, please see *Technical Appendix C: Institutional (UB-04 Claims Mapping to 837I format)* for specific file placement requirements for this information.

Please note that WellSense accepts 837s in the HIPAA-required Addenda format (005010X223A2).

Below is the information required to process your institutional claims.

Data Element	**UB-04 Form Locator**
National Provider Identifier (NPI)	**56**
Provider Tax ID	**5**
WellSense Member ID	**60**
Type & Class	**4** (0 in first digit) **4** (second digit) &
Frequency	**4** (fourth digit)
Diagnosis Codes	**66** *see Note 1*
Total Charge	*last line of line items* **(47)**
From/To Service Dates	**6**
Charges	**47**
Units	**46**
Revenue Code	**42** *see Note 2*
HCPCS Code	**44**
Procedure Modifier(s)	**44**
DRG	**71** *see Note 3*

Notes:

1. WellSense will only accept ICD-10 codes with upper case characters; claims submitted with any lower case characters will be denied. ICD-10 codes should not be submitted with decimal points.

   Any claims submitted with both ICD-9 and ICD-10 diagnosis codes will be denied.

2. WellSense cannot accept more than 25 diagnosis codes in the 837I.

3. DRG information is required for inpatient claims for MassHealth compliance.

Special Claims

Claim types outlined below will require additional data or specifications, as noted.

- **Adjustments, voids, replacements, etc.**
  - Any replacement or void requests for previously submitted claims (e.g., claims frequency codes of 7 and 8) must satisfy the requirements starting on Page 18. Changes to split claims must be submitted on paper.
- Anesthesia
  - Units must be in minutes, not fractions of hours or days.
  - Use ASA codes, not surgical codes.
- COB
  - Please include as much COB-related information (e.g., accident indicators, accident locations) as you can. WellSense cannot accept attachments such as other EOBs electronically at this time.

<> **Behavioral Health / Durable Medical Equipment Claims**

- Behavioral Health providers should call Beacon Health Strategies at 866- 444-5155 or send e-mail to edi.operations@beaconhs.com for information about submitting electronic claims. Please note that early intervention (EI) claims should be sent directly to WellSense, *not* Beacon Health Strategies.
- Durable medical equipment, prosthetic, orthotic and medical supply (DMEPOS) providers should call Northwood, Inc. at 866-802-6471 or visit the company's website at www.northwoodinc.com for information about submitting electronic claims.
- Codes ending with 99 require an invoice; therefore, WellSense cannot accept these claims electronically at this time since there is an attachment.

<> **Immunizations**

- Provider claims seeking additional reimbursement for immunizations normally supplied by the State require an invoice and should not be submitted electronically at this time because of the attachment.

<> Invoices

- Any claim requiring an invoice attachment must be sent on paper at this time.

<> Modifiers

- Modifiers must be appended to the HCPCS code (UB-04 Form Locator 44) on the line items where they apply. Modifiers *cannot* be appended to the WellSense Provider ID number.
- If you use multiple modifiers, pricing modifiers should be in the first modifier position (i.e., statistical modifiers should be placed after a pricing modifier). Please make sure that multiple modifiers are separated by accepted HIPAA delimiting characters (e.g., : or >).

<> NDC Codes

- To meet regulatory requirements, claims with a June 1, 2012 date of service and beyond must include NDC codes when injectable physician- administered drugs are administered in the office or an outpatient setting; this requirement excludes applicable vaccines/immunizations. For more information, please see Network Notification M-131 (dated March 27, 2012) on our web site (http://www.bmchp.org/providers/network- notifications).

  - WellSense accepts NDC codes electronically, but we do not use them for adjudication purposes.

- Newborn Claims
  - Whenever possible, claims for newborns should be submitted separately from the mother’s claims, and with the unique subscriber/member number instead of the mother’s.

- Year-spanning Claims
  - Claims with service dates that span a calendar year should be split into two separate claims. For example, a hospital stay beginning on December 27 and ending January 6 should be billed on two separate claims, one covering December 27-31, the other covering January 1-6.

Appendices

The following appendices are meant to be supplemental material to the official Implementation Guides for the 837 transactions and codesets required by HIPAA.

Appendix A – Control and Identifier Segments for the 837P and 837I files

ISA: Interchange Control Header Segment

837 Implementation Guide Data				
Position	**Segment ID/ Data Element Number**	**Description**	**837 Requirements**	**WellSense Specific Data/Comments**
Loop	**ISA**	**Interchange Control Header**		
Header	**ISA01**	Authorization Information Qualifier	00	As advised by TR3s
	ISA02	Authorization Information	null	
	ISA03	Security Information Qualifier	00	As advised by Implementation Guides
	ISA04	Security Information	null	
	ISA05	Interchange ID Qualifier	30 = U.S. federal tax identification number	ZZ is also acceptable if confirmed with WellSense before sending
	ISA06	Interchange Sender ID	*Submitter's* tax ID #	no dash

	ISA07	Interchange ID Qualifier	30 = U.S. federal tax identification number	***Must*** be a 30; we *cannot* process files that have ZZ here
	ISA08	Interchange Receiver ID	043373331	*BMCHP's* Tax ID #
	ISA11		^ or |	As advised by TR3s
	ISA12		00501	As advised by TR3s

GS: Functional Group Header Segment

837 Implementation Guide Data				
Position	**Segment ID/ Data Element Number**	**Description**	**837 Requirements**	**WellSense Specific Data/Comments**
Loop	**GS**	**Functional Group Header**		
Header	**GS02**	Application Sender's Code	*Submitter's* tax ID #	no dash
	GS03	Application Receiver's Code	043373331	WellSense Tax ID #
	GS08		005010X222 A1 (for 837P) 005010X223 A2 (for 837I)	

Submitter & Receiver Name Loops

837 Implementation Guide Data				
Position	**Segment ID/ Data Element Number**	**Description** **837 Requirement**	**837 Requirement**	**WellSense Specific Data/Comments**
Loop	**NM1**	**Submitter Name**		
1000A	**NM103**	Submitter Name	Name or abbreviation of submitter's name	This is used by WellSense for manual verification of file's origin in case of processing difficulties.
	NM109	Submitter Identifier	*Submitter's* tax ID #	no dash

Loop	NM1	Receiver Name		
1000B	**NM103**	Receiver Name	WellSense	
	NM109	Receiver Primary	043373331	WellSense Tax ID #

Appendix B - Professional (CMS-1500) Claims Mapping to 837P format

Notes:

1. Claims submitted via EDI to WellSense require a valid NPI/Tax ID combination that is registered at WellSense *and* a valid Plan-assigned Member ID for acceptance.
2. WellSense looks for the NPI in the following loop order: 2420A (rendering provider—service line), 2310B (rendering provider), 2010AA (billing provider). Once an NPI is found, other NPIs are not used for adjudication purposes.
3. In addition to the NPI, WellSense uses the rendering provider's tax ID to identify the correct provider for adjudication. WellSense looks for the rendering provider's tax ID in the following loop order: 2420A, 2310B, 2010AA (the same loop order as we look for the NPI). Once a tax ID is found, other tax IDs are not used for adjudication purposes.
4. We accept 837Ps only in the HIPAA-required Addenda format (005010X222A1).

837P Implementation Guide Data				
Position	**Segment ID/ Data Element Number**	**Descriptions**	**837 Requirements**	**WellSense Specific Data/Comments**
Loop	**NM1**	**Rendering Provider Name**		
2310 B or 2420 A	**NM108**	Identification Code Qualifier	XX = Healthcare Financing Administration National Provider Identifier	If you supply an NPI in the 2420A loop, that info will override any NPI you supply in the 2310B or 2010AA loops. Thus, if the NPI you have registered with WellSense is in the 2010AA loop, please make sure that there is no NPI in the 2420A or 2310B loops, since we will read the NPI in those —lower levelǁ loops first and ignore the NPI in 2010AA for adjudication purposes. See Note 1 above.
	NM109	Identification Code	10-digit NPI	See Notes 1 & 2 above

837P Implementation Guide Data				
Position	**Segment ID/ Data Element Number**	**Descriptions**		**837 Requirements**
Loop	**NMI**	**Subscriber Name**		
2010B A	**NM108**	Identification Code Qualifier	MI = Member ID #	
	NM109	Subscriber Primary Identifier	Nine-digit member identifier or 11-digit member identifier (9 + 2-digit suffix) for Employer Choice plan members	Required. See Note 1 above. WellSense prefers the IDs we assign to members. Member IDs for Employer Choice members should include the 2-digit suffix
Loop	**CLM**	**Claim Information**		
2300	**CLM01**	Patient Account Number		Necessary for Remittance s.
	CLM02	Total Claim Charge Amount		
Loop	**HI**	**Claim Information**		
2300	**HI01-1**	Diagnosis Type Code	BK = Principal diagnosis	WellSense can only accept 12 diagnosis codes in total
	HI01-2	Diagnosis Code		No decimal points.

837P Implementation Guide Data				
Position	**Segment ID/ Data Element Number**	**Description**	**837 Requirement**	**WellSense Specific Data/Comments**
Loop	**REF**	**Claim Identification Number**		
2300	**REF01**	Reference Identification Qualifier	D9 = Claim number	*Optional*
	REF02	Clearinghouse Trace Number		Usually used by Clearinghouses: any unique internal reference number the Submitter can use to identify a claim that errors.
Loop	**Claim Information for Replacement/Void Requests**			
2300	**CLM05-3**	Claim Frequency Code	7 = replacement 8 = void	See Page 18above
	REF01	Original Reference Number (ICN/DCN)	F8 = Original reference #	
	REF02	Claim Original Reference Number		The original WellSense Claim ID number
Loop	**SV1**	**Professional Service – Service Lines**		
2400	**SV101-2**	Procedure Code		
	SV101-3 **SV101-4**	Procedure Code Modifier(s)		
	SV102	Line Item Charge Amount		
	SV103	Unit or Basis for Measurement Code		For Anesthesia, use MJ (= minutes).

	SV104	Service Unit Count		For Anesthesia, use # of minutes; no fractions.
	SV105	Place Of Service Code		
Loop	**DTP**	**Date – Service Date**		
2400	**DTP03**	Service Date		Single date or From/To Service
Loop	**LIN**	**Drug -Identification**		
2410	**LIN02**	Product/Servic eID Qualifier	N4	Must be used if the claim qualifies for NDC code reporting
2410	**LIN03**	Product/Service ID		The NDC code
Loop	**CTP**	**Drug Quantity**		
2410	**CTP04**	Quantity		Quantity for the NDC billed
2410	**CTP05-1**	Unit or Basis for Measurement Code		F2 = International Unit GR = Gram ME = Milligram ML

Appendix C - Institutional (UB-04) Claims Mapping to 837I format

Notes:

1. Claims submitted via EDI to WellSense require a valid **NPI/Tax ID combination that is registered at WellSense *and* a valid Plan-assigned Member ID** for acceptance.
2. WellSense looks for the NPI in the following loop order: 2010AA (billing provider), 2010AB (pay-to provider), 2310E (service facility), 2310A (attending physician). Once an NPI is found other NPIs are not used for adjudication purposes.
3. In addition to the NPI, WellSense uses the provider's tax ID to identify the correct provider for adjudication. WellSense looks for the rendering provider's tax ID in the following loop order: 2010AA, 2010AB, 2310E, 2310A (the same loop order as we look for the NPI). Once a tax ID is found other tax IDs are not used for adjudication purposes.
4. We accept 837Is only in the HIPAA-required Addenda format (005010X223A2).

5.

837I Implementation Guide Data				
Position	**Segment ID/ Data Element Number**	**Description**	**837 Requirement**	**WellSense Specific Data/Comments**
Loop	**NMI**	**Subscriber Name**		
2010BA	**NM108**	Identification Code Qualifier	MI = Member ID #	
	NM109	Subscriber Primary Identifier	Nine-digit member identifier or 11-digit member identifier (9 + 2-digit suffix) for Employer Choice plan members	Required. See Note 1 above. WellSense prefers the IDs we assign to members. Member IDs for Employer Choice members should include the 2-digit suffix
Loop	**CLM**	**Claim Information**		
2300	**CLM01**	Patient Account Number		Necessary for Remittances.
	CLM02	Total Claim Charge Amount		

	CLM05-	Facility Type		
	CLM05-3	Claim Frequency Code		
Loop	**DTP**	**Claim Information – Statement Dates**		
2300	**DTP03**	Statement From or To Date		Statement dates loop.
Loop	**HI**	**Claim Information – Diagnosis Information**		
2300	**HI01-1**	Code List Qualifier Code	BK = Principal Diagnosi	WellSense can only accept 25 maximum
	HI01-2	Diagnosis Code		No decimal points.
Loop	**HI**	**Claim Information – Drug Information**		
2300	**HI01-1**	Code List Qualifier Code	DR = Diagnosis Related Group	
	HI01-2	DRG Code		

837I Implementation Guide Data				
Position	**Segment ID/ Data Element Number**	**Description**	**837 Requirement**	**WellSense Specific Data/Comments**
Loop	**REF**	**Claim Identification Number**		
2300	**REF01**	Reference Identification Qualifier	D9 = Claim Number	*Optional*
	REF02	Value Added Network Trace Number		Usually used by Clearinghouses: any unique internal reference number the Submitter can use to identify a claim that errors.
Loop	**Claim Information for Replacement/Void Requests**			
2300	**CLM05-3**	Claim Frequency Code	7 = replacement 8 = void	See Page 18 above
	REF01	Original Reference Number (ICN/DCN)	F8 = Original Reference Number	
	REF02	Claim Original Reference		The original WellSense Claim ID number
Loop	**SV2**	**Institutional Service Line – Service Line #**		
2400	**SV201**	Service Line Revenue Code		Four digits (zero-filled at the beginning) if possible
	SV202-2	Procedure Code		
	SV202-3 SV202-4	Procedure Code Modifier(s)		

	SV203	Line Item Charge		
	SV204	Unit or Basis for Measurement Code		For Anesthesia, use MJ (= minutes).
	SV205	Service Unit Count		For Anesthesia, # of minutes; no fractions.
Loop	**LIN**	**Drug - Identification**		
2410	**LIN02**	Product/Service ID Qualifier	N4	Must be used if the claim qualifies for NDC code reporting
2410	**LIN03**	Product/Service ID		The NDC code
Loop	**CTP**	**Drug Quantity**		
2410	**CTP04**	Quantity		Quantity for the NDC billed
2410	**CTP05-1**	Unit or Basis for Measurement Code		F2 = International Unit GR = Gram ME = Milligram ML = Milliliter UN = Unit