# EDI 5010 Claims Submission Guide

In support of Health Insurance Portability and Accountability Act (HIPAA) and its goal of administrative simplification, MHNet encourages physicians and medical providers to submit claims electronically. Electronic claims submission can have a significant, positive impact on the productivity and cash flow for your practice.

- **Reduces Paperwork and Costs** associated with printing and mailing paper claims.
- **Reduces Time** to receive a claim by eliminating mailing time.
- **Reduces Delays** due to incorrect claim information by returning errors directly to you through the same electronic channel. These claims can be corrected and re-submitted electronically.
- **Improves Accuracy** by decreasing the chance for transcriptions errors and missing/incorrect data.
- **Tracks and Monitors Claims** through claim status reports received electronically.

Electronic claim submission to the MHNet payers is easy to establish. **Contact your practice management system vendor or clearinghouse to initiate the process**. Electronic claim submissions will be routed through Emdeon who will review and validate the claims for HIPAA compliance and forward them directly to MHNet.

Providers can also submit directly to Emdeon. Emdeon will provide the electronic requirements and set-up instructions. Providers should call **877-363-3666** or go to www.emdeon.com for information on direct submission to Emdeon.

EDI claim submitters should review the electronic claim submission requirements starting on the next page.

MHNet encourages and recommends regular review of all EDI Acknowledgement and Reject reports returned to you. We have staff available to assist you with EDI claim filing. For more details on each of these topics please select from the topics below.

This document was created Sept 2011.

## 1. EDI Specifications -

The 837 claim transaction is utilized for electronic professional, institutional, and dental claims and encounters. MHNet uses the ASC X12N 837 Professional Health Care Claim (005010X233) and the ASC X12N 837 Institutional Health Care Claim (005010X222) implementation guides. The official implementation guides for claim transactions are available electronically from the Washington Publishing Company website at www.wpc-edi.com.

This MHNet document contains clarifications and payer specific requirements related to data usage and content with submitting an EDI claims to MHNet. Please note that this document is intended to list only those elements where MHNet feels clarifications apply or additional information is helpful.

The loop, segment and data element references below in *italics* relate to the 005010X223A2, 005010X224A2, or 005010X222A1 format. If you submit your electronic claims using a different format, you should check with your software vendor or clearinghouse to ensure that your data is mapped to the proper data elements.

## 2. MHNet Specific Payer Edits at Emdeon:

All EDI claims submitted through Emdeon will be subject to these MHNet specific payer edits (unless indicated for one transaction only) that are in place at Emdeon. Submitters will receive any reject edits below on their level 1 payer rejection reports.

- The patient and/or subscriber id must be at least two characters in length or the claim will reject.
- To allow zero dollar line charges and zero dollar claim charges.
- The billing provider id may not contain a value of 999999999 or the claim will reject.
- If the procedure code begins with 0, then Anesthesia Minutes are required or the claim will reject (Prof Only). Excluding procedure code is 01995 or 01996 then service units are required and the Anesthesia Minutes should contain 00 or the claim will reject. If the procedure code begins with a 0 and ends with a T, then service units are required and the Anesthesia Minutes should contain 00 or the claim will reject (Prof Only).
- If the procedure code does not begin with a 0, then service units are required and the Anesthesia Minutes should contain 00 or the claim will reject (Prof Only).
- The discharge hour must contain a numeric value of 00-23 or 99 if the batch type contains an inpatient value of x10, x11, x14 or x17 and the statement period from date is equal to the statement period thru date (Inst Only).

NOTE:

**Refer to 2011 Claim Submission Logo Grid to locate the respective Emdeon payer ID and paper mailing address for all MHNet health plans. MHNet has consolidated most of our Emdeon Payer IDs into a single payer id to make claim submission easier. Please refer to the consolidated Emdeon Payer ID on the logo grid for the Health plans included.**

## 3. Professional/Dental EDI Claim Submissions Information

**Key Information required by HIPAA/MHNet or clarified as to MHNet's use of the data:**

**Billing Provider (2010AA)**

- **Federal Tax ID (TIN) of Billing Provider** (9 digit number).
- **National Provider ID (NPI) is required -** MHNet is expecting that this NPI is typically a Type 2 (organizational provider) NPI. Individuals with a Type 1 NPI are only allowed to be sent as the Billing Provider when services were performed by non-incorporated, independent, individuals.
- **Billing Provider's Last Name** *(NM103)* and **First Name** *(NM104)* are both required if the provider entity type qualifier indicates "person". Provider first name should be submitted completely and not just a first initial. However, as stated in the NPI bullet, MHNet expects this data to reflect an organizational provider (entity type 1) and only be submitted with the NM103 in most cases.
- **Billing Address** must be a street address and cannot contain PO Box or rural route address information. This type of address must be submitted in the Pay To Address loop (see below).
- **Billing Zip Code** must be a full 9 digit zip code**.**
- **Taxonomy** (*PRV*) - recommended on all claims

**Rendering Provider (2310B)**

- **National Provider ID (NPI) is required** for the rendering provider.
- **Rendering Provider Name** *(Loop 2310B)* is required when different than the billing provider *(2010AA)*. Provider first name should be submitted completely and not just a first initial.
- If you submit rendering provider information at the claim header level *(Loop 2310B)*, do not also submit service line level *(Loop 2420A)* rendering provider information. Although MHNet accepts provider data at the claim line level, MHNet will read and file the claim using the provider at the claim header level only.
- **Taxonomy** (*PRV*) - recommended on all claims

*Note: In 5010, when the Rendering Provider is an organizational provider, it must be a separate and external entity to the Billing Provider. The NPI is used to identify the external provider entity, e.g. a clinical reference laboratory, in this loop. There is no change to the Rendering Provider when the Billing Provider is a group of practitioners. The individual practitioner who rendered the service continues to be sent in the Rendering Provider loop and their Type 1 NPI is used to identify them.*

**Pay To Address (2010AB)**

- **Pay-To Address (***Loop 2010AB***)** is used to identify a payment address when that address is different from the Billing Provider's street address.
- No additional provider identifiers can be included in this loop.

  *NOTE: Providers should notify MHNet in advance of any changes in pay to address so our system and inbound claims data will be in sync.*

**Claim Header Information**:

- **Referring Provider** *(Loop 2310A)* always include when known. If the referring provider is a person, both the first name*(NM104)* and last name *(NM103)* are required.
    - **Referring Provider NPI** is preferred.
    - MHNet will use referring provider data at the claim header level only *(Loop 2310A)*.
- **Service Facility Location** *(Loop 2310C)* is required when the service location is different than the location in the billing provider loop *(2010AA)* and is a separate external entity from the billing provider.
    - Service facility location name *(NM1)* is required in 5010, When the place of service is the patient's home, use a default name such as "Patient Home" when no name is available.
    - Service Facility NPI is preferred and should be included.
    - Service Facility Zip code must be a full 9 digit zip code.
    - When reporting ambulance services, do not use this loop. Use Loop ID-2310E - Ambulance Pick-up Location and Loop ID-2310F - Ambulance Drop-off Location.
- **Admission Date** *(Ref02 where REF0=435)* is required per HIPAA guides for inpatient medical visits and ambulance claims when the patient was admitted to the hospital.
- **Ambulance Pick Up and Drop off Location** (2310E/F) is required when billing for ambulance or non-emergency transportation services. PW qualifier is used for pick up location and the 45 is used for the drop off location.
- **Compliant Medical Code Sets** such as HCPCS, ICD-9, and CPT-4 are required on both electronic and paper claims.
- **ICD-9-CM** codes should be submitted with the highest level of specificity (the correct number of digits) for proper adjudication.

**Patient**

- All MHNet members have a unique ID number so information must be sent at the subscriber level (2010BA) in 5010 transactions all subscriber data elements must be populated as required ( e.g., Date of Birth (DMG02 where DMG01=D8) and Gender Code (DMG03)).
- **Member ID Number** as shown on the patient's ID card should be submitted as the Subscriber ID.
    - Newborns are assigned MHNet IDs number at the point they are enrolled by the subscriber. However, providers may need to submit claims prior to obtaining this number. When this occurs, providers should submit the subscriber information in the 2010BA NM1IL loop and the newborn information in the 2010CA NM1QC Loop because the newborn patient cannot be uniquely identified to MHNet when using the subscriber’s ID.

**Special Data Items**

- **Anesthesia EDI Claims**. MHNet requires the submission of time-based CPT codes (formally called ASA codes) for all anesthesia services. Anesthesia claims submitted with surgical CPT codes will be denied during processing.
    - Total Anesthesia Minutes are required on all time-based CPT codes, with the exception of 01995 and 01996. Total Minutes should be entered in the SV104. The qualifier MJ should be entered in the SV103.
    - All non time-based services (01996 included) require units of service. Units should be entered in the SV104, with a Qualifier of UN in the SV103.
    - Obstetrical Anesthesia minutes can be submitted, but are not used in processing at this time.

- **Billed Amounts** -- MHNet requires applicable total charged amounts to be submitted for all encounter/capitated submissions at both the claim header (2300 CLM02) and line level (2400 SV102). *Note: MHNet accepts zero dollar billed amounts for appropriate no charge situations.*

- **Claims with Attachments**. MHNet is able to receive and use in processing the EDI Claim Supplemental Information paperwork segment as defined in the Health Care Claim 837 Implementation Guide. This segment contains paperwork codes to indicate documents available to the payer if needed.
  Specifications for 2300 Loop - PWK Segment
  - PWK01 - Report Type Code (see applicable codes below)
  - PWK02 - Report Transmission Code *must be 'AA'* for available on request at provider site.
  - PWK06 - Attachment Control number (if applicable).
  - PWK07 - Description (optional)(UB claims only)

  MHNet's business practices support the following paperwork codes (PWK01), which will be considered during adjudication:

(03) Report Justifying Treatment beyond Guidelines
(04) Drugs Administered
(05) Treatment Diagnosis
(06) Initial Assessment
(08) Plan of Treatment
(09) Progress Report
(11) Chemical Analysis
(13) Certified Test Report
(15) Justification for Admission
(AM) Ambulance Certification
(AS) Admission Summary
(B2) Prescription
(B3) Physician Order
(CT) Certification
(D2) Drug Profile Document
(DA) Dental Models
(DB) Durable Medical Equipment RX
(DG) Diagnostic Report
(DJ) Discharge Monitoring Report
(DS) Discharge Summary
(EB) Explanation of Benefits
(HR) Health Clinic Records
(LA) Laboratory Results
(M1) Medical Record Attachment
(NN) Nursing Notes
(OB) Operative Note
(OD) Orders and Treatments Document
(OE) Objective Physical Examination Doc
(OX) Oxygen Therapy Certification
(P4) Pathology Report
(P5) Patient Medical History Document
(P6) Periodontal Charts
(PN) Physical Therapy Notes
(PO) Prosthetics or Orthotic Certification
(PQ) Paramedical Results
(PY) Physician's Report
(PZ) Physical Therapy Certification
(RB) Radiology Films
(RR) Radiology Reports
(RT) Report of tests and Analysis Report
(SG) Symptoms Document

  *Please note for claims with attachments:*

  - The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established policies.
  - If the documentation is needed for adjudication, MHNet will contact you and request a faxed copy. This copy must be received within 72 hours of the request or the claim will be denied.
  - The specific paperwork codes in the PWK segment will trigger processors to consider the contents of the supplemental information obtained via fax. Therefore, use of these codes incorrectly may delay the processing of the claim as compared to a like claim without a PWK.
  - MHNet will continue to accept paper claims with attachments.
- **Secondary COB Claims** - secondary claims may be submitted electronically.
  - Send the secondary claim electronically using *Loops 2320 and 2330* for claim header data and *Loops 2420 and 2430* for claim service line data.
  - All COB secondary claims must contain information regarding the other payer approved and allowed amounts. Additionally, we need to receive the applicable

claim adjustment reason codes at the header or line level for other payer amounts.
  - Payer Responsibility Sequence Number Code (SBR01) should indicate the correct level of responsibility on the claim for MHNet.
  - MHNet does not require secondary COB claims to be submitted electronically. Providers may continue to submit COB claims on paper and attach a copy of the paper EOB.

  **NOTE:** MHNet receives Medicare Part A & B primary claims automatically through the cross over process for secondary payment. To eliminate duplicate claim submissions, refer to the EOB/RA from Medicare (look for code "MA-18" on your Medicare Remittance Advice) before submitting secondary claims directly to MHNet. If you do not receive Medicare remits with MA18 codes, please contact customer service to validate you claim has crossed over prior to submitting. We do not receive crossover claims at this time for MHNet Medicaid plans.

- **Resubmitted Claims** - Corrected or replacement claims may be submitted electronically. Use the *Claim Frequency Type Code (CLM05-3)* value equal to "7" to indicate a replacement claim. These claims must also contain a *2300 REF F8* indicating the original MHNet claim number if available or other identification number.
- **Pharmaceutical Claims** - May be submitted electronically. These drug claims should not be for retail pharmacy claims nor can they be in an NCPDP format. If you are submitting a claim for pharmaceutical services, the HCPCS J codes are required to identify the drug. NDC code to be submitted in the LIN segment in the 2410 loop with a qualifier of N4, and the associated data of the NDC code submitted in the CTP segment in the 2410 loop. The associated data for the NDC consists of the **Quantity** (National Drug Unit Count) and the **Unit of Measure** which can be one of the 5 qualifiers: F2 – International Unit, GR – Gram, ML - Milliliter, ME – Milligram, or UN – Unit .
- **Claim Notes** - Although MHNet can accept notes submitted at both the header level (2300) and line level (2400), the 5010 implementation guide discourages the use of narrative information in the 837 file. If the narrative is required, then submit the narrative at either the header level, 2300 NTE segment with qualifier of ADD or at the line level, 2400 NTE segment with qualifier of ADD.
  - The SV101-7 at the line level in the 2400 loop to indicate non-specific procedure codes. Do not use the NTE segment to describe a non-specific procedure code. If an NDC code is reported in Loop 2410, do not use this segment for a description of the procedure code. The NDC in loop 2410 will provide the description.

## 4. Institutional EDI Claim Submission Information

**Key Information required by HIPAA/MHNet or clarified as to MHNet's use of the data:**

**Billing Provider (2010AA)**

- **Federal Tax ID (TIN) of Billing Provider** (9 digit number).
- **National Provider ID (NPI) is required -** MHNet is expecting that this NPI is typically a Type 2 (organizational provider) NPI. Individuals with a Type 1 NPI are only allowed to be sent as the Billing Provider when services were performed by non-incorporated, independent, individuals.
- **Billing Provider's Last Name** *(NM103)* and **First Name** *(NM104)* are both required if the provider entity type qualifier indicates "person". Provider first name should be submitted completely and not just a first initial. However, as stated in the NPI bullet, MHNet

expects this data to reflect an organizational provider (entity type 1) and only be submitted with the NM103 in most cases.

- **Billing Address** must be a street address and cannot contain PO Box or rural route address information. This type of address must be submitted in the Pay To Address loop (see below).
- **Billing Zip Code** must be a full 9 digit zip code**.**
- **Taxonomy** (*PRV*) - recommended on all claims

### Pay To Address (2010AB)

- **Pay-To Address (***Loop 2010AB***)** is used to identify a payment address when that address is different from the Billing Provider's street address.
- No additional provider identifiers can be included in this loop.

  *NOTE: Providers should notify MHNet in advance of any changes in pay to address so our system and inbound claims data will be in sync.*

### Other Providers

- **Referring Provider** *(Loop 2310F)* always include when known. If the referring provider is a person, both the first name*(NM104)* and last name *(NM103)* are required.
  - **Referring Provider NPI** is preferred.
  - MHNet will use referring provider data at the claim header level only *(Loop 2310F)*.
- **Service Facility Location** *(Loop 2310E)* is required when the service location is different than the location in the billing provider loop *(2010AA)*.
  - Service facility location name *(NM1)* is required in 5010, When the place of service is the patient's home, use a default name such as "Patient Home" when no name is available.
  - Service Facility NPI is required and must be a separate external entity from the billing provider.
  - Service Facility Zip code must be a full 9 digit zip code.
- **Attending Provider Name** *(Loop 2310A)* is recommended on all institutional claims.
  - If the attending provider is a person, both the first name and the last name are required.
  - Attending NPI is preferred.
- **Institutional Rendering** (2310D) **-** data is accepted but not used in MHNet claims processing.

### Claim Header Information:

- **Admission Date and Time** is required for all inpatient claims. *DTP03* should be in this format: *CCYYMMDDHHMM where DTP01=435 and DTP02=DT*.
- **Billed Amounts** -- MHNet requires applicable total charged amounts to be submitted for all encounter/capitated submissions at both the claim header (2300 CLM02) and line level (2400 SV102). *Note: MHNet accepts zero dollar billed amounts for appropriate no charge situations*.
- **Service Line Date** is required on outpatient claims. *DTP03 where DTP01=472 in Loop 2400*.

- **Unit or Basis for Measurement Code** *SV204 in Loop 2400* (days, units, international unit or dosage) is required at the service line level.
- **Compliant Medical Code Sets** such as HCPCS, ICD-9, and CPT-4 are required on both electronic and paper claims.
- **ICD-9-CM** codes should be submitted with the highest level of specificity (the correct number of digits) for proper adjudication. These codes should be submitted without the decimal point on electronic claims.
    - ICD-9-CM codes are expected on all outpatient surgery claims.

**Patient**

- All MHNet members have a unique ID number so information must be sent at the subscriber level (2010BA) in 5010 transactions all subscriber data elements must be populated as required ( e.g., Date of Birth (DMG02 where DMG01=D8) and Gender Code (DMG03)).
- **Member ID Number** as shown on the patient's ID card should be submitted as the Subscriber ID.
    - Newborns are assigned MHNet IDs number at the point they are enrolled by the subscriber. However, provider may need to submit claims prior to obtaining this number. When this occurs, providers should submit the subscriber information in the 2010BA NM1IL loop and the newborn information in the 2010CA NM1QC Loop because the newborn patient cannot be uniquely identified to MHNet when using the subscriber's ID. All MHNet members have a unique ID number so information must be sent at the subscriber level in 5010.

## Special Data Items

- **Claims with Attachments**. MHNet is able to receive and use in processing the EDI Claim Supplemental Information paperwork segment as defined in the Health Care Claim 837 Implementation Guide. This segment contains paperwork codes to indicate documents available to the payer if needed.
  Specifications for 2300 Loop - PWK Segment
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(09) Progress Report
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(13) Certified Test Report
(15) Justification for Admission
(AM) Ambulance Certification
(AS) Admission Summary
(B2) Prescription
(B3) Physician Order
(CT) Certification
(D2) Drug Profile Document
(DA) Dental Models
(DB) Durable Medical Equipment RX
(DG) Diagnostic Report
(DJ) Discharge Monitoring Report
(DS) Discharge Summary
(EB) Explanation of Benefits
(HR) Health Clinic Records
(LA) Laboratory Results
(M1) Medical Record Attachment
(NN) Nursing Notes
(OB) Operative Note
(OD) Orders and Treatments Document
(OE) Objective Physical Examination Doc
(OX) Oxygen Therapy Certification
(P4) Pathology Report
(P5) Patient Medical History Document
(P6) Periodontal Charts
(PN) Physical Therapy Notes
(PO) Prosthetics or Orthotic Certification
(PQ) Paramedical Results
(PY) Physician's Report
(PZ) Physical Therapy Certification
(RB) Radiology Films
(RR) Radiology Reports

(RT) Report of tests and Analysis Report (SG) Symptoms Document

*Please note for claims with attachments:*

- The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established policies.
- If the documentation is needed for adjudication, MHNet will contact you and request a faxed copy. This copy must be received within 72 hours of the request or the claim will be denied.
- The specific paperwork codes in the PWK segment will trigger processors to consider the contents of the supplemental information obtained via fax. Therefore, use of these codes incorrectly may delay the processing of the claim as compared to a like claim without a PWK.
- MHNet will continue to accept paper claims with attachments.

- **Secondary COB Claims** - secondary claims may be submitted electronically.
  - Send the secondary claim electronically using *Loops 2320 and 2330* for claim header data and *Loops 2420 and 2430* for claim service line data.
  - All COB secondary claims must contain information regarding the other payer approved and allowed amounts. Additionally, we need to receive the applicable claim adjustment reason codes at the header or line level for other payer amounts.
  - Payer Responsibility Sequence Number Code (SBR01) should indicate the correct level of responsibility on the claim for MHNet.
  - MHNet does not require secondary COB claims to be submitted electronically. Providers may continue to submit COB claims on paper and attach a copy of the paper EOB.

  **NOTE:** MHNet receives Medicare Part A & B primary claims automatically through the cross over process for secondary payment. To eliminate duplicate claim submissions, refer to the EOB/RA from Medicare (look for code "MA-18" on your Medicare Remittance Advice) before submitting secondary claims directly to MHNet. If you do not receive Medicare remits with MA18 codes, please contact customer service to validate you claim has crossed over prior to submitting. We do not receive crossover claims at this time for MHNet Medicaid plans

- **Pharmaceutical Claims** - May be submitted electronically. These drug claims should not be for retail pharmacy claims nor can they be in an NCPDP format. If you are submitting a claim for pharmaceutical services, the HCPCS J codes are required to identify the drug. The NDC code to be submitted in the LIN segment in the 2410 loop with a qualifier of N4, and the associated data of the NDC code submitted in the CTP segment in the 2410 loop. The associated data for the NDC consists of the **Quantity** (National Drug Unit Count) and the **Unit of Measure** which can be one of the 5 qualifiers: F2 – International Unit, GR – Gram, ML - Milliliter, ME – Milligram, or UN – Unit .
- **Claim Notes** - Although MHNet can accept notes submitted the header level (2300), the 5010 implementation guide discourages the use of narrative information in the 837 file. If narrative is required, then submit the information at the header level, 2300 NTE segment with qualifier of ADD.
  - The SV101-7 at the line level in the 2400 loop to indicate non-specific procedure codes. Do not use the NTE segment to describe a non-specific procedure code. If an NDC code is reported in Loop 2410, do not use this segment for a description of the procedure code. The NDC in loop 2410 will provide the description.

## 5. EDI Data Not Used - Professional, Institutional and Dental

**Although MHNet accepts the following data, it is not used in claim adjudication process.**

- **All providers loops and segments at the claim line level (***Loop 2420 A -H***).**
- **Supervising provider information -** Please contact the EDI support number below if your submissions require provider matching based on data in this loop. The MHNet standard is to use the rendering or billing provider information for all claims (*2310D/E*)
- The second iteration of the **referring provider** under code P3 in the NM101 (*Loop 2310A*).
- **Currency**. Information in the *CUR* segment will not be considered in processing. All electronic transactions will be with trading partners in the United States (*Loop 2000A*)
- **Property and Casualty Claim Number** (REF segments *Loops 2010BA* and *2010C*A)
- **Select Patient Information Segment** including **date of death** *(PAT06)*, **Weight** *(PAT08)*, and **Pregnancy Indicator** *(PAT09)*.
- The following claim header **DTP Date segments (***Loop 2300***)** are not referenced from the inbound claim: Initial Treatment Date, Last Seen Date, Acute Manifestation, Last Menstrual Period, Last X-ray Date, Hearing and Vision Prescription Date, Disability Dates, Last Worked, Authorized Return to Work, Assumed and Relinquished Care Dates, Property and Casualty Date of First Contact, and Repricer Received Date.
- The following claim line **DTP Date segments** (*Loop 24*00) are not referenced from the inbound claim: Prescription Date, Certification Revision/Recertification Date, Begin Therapy Date, Last Certification Date, Last Seen Date, Test Date, Shipped Date, Last X-ray Date, and Initial Treatment Date.
- **Responsible Party Information** *(Loop 2010 BC)* information submitted on appropriate legal documentation and maintained in internal files will be used.
- **Participation Indicator** *(Loop 2300 CLM16)* and **Contract Information** (*Loop 2300 and 2400*) - We will use information in our internal provider files.
- **Service Authorization Exception Code** in *Loop 2300 REF*.
- **Ambulatory Patient Group** in *Loop 2300 REF*.
- **Demonstration Project Identifier** in *Loop 2300 REF*.
- **Mammography Certification Number** in *Loops 2300 and 2400 REF*.
- **Peer Review Organization** (PRO) Approval Number in *Loop 2300 REF.*
- **Treatment Code Information** in *Loop 2300 HI*.
- **DMERC CMN Indicator** in *Loop 2400 PW)*.
- **Hospice Employee Indicator** in *Loop 2400 CRC*.
- **Credit/Debit Card Account Holder Name** *(Loop 2010BD),* **Credit/Debit Card Maximum Amount** *(Loop 2300 AMT segment)* , **Sales Tax** (*Loop 2400 AMT*), **Postage** (*Loop 2400 AMT*)
- **Ambulance Pick up and Drop off** at the line level in *Loops 2420 G & H*
- **Obstetric Anesthesia** Additional Units in *Loop 2400 QTY*.
- **Immunization Batch Number** in Loop 2400 REF.

## 6. EDI Acknowledgement and Reject Reports

For every claim filed electronically, the provider should monitor whether or not that claim has been rejected by reviewing EDI Acknowledgement and Reject reports on a regular basis. The following reports should be monitored regularly.

- **Initial Reject Report (Emdeon report Rpt 05 or equivalent vendor report)** - This is a report that shows claims rejected by Emdeon that were not forwarded to Mail Handlers Benefit Plan. These claims should be corrected and re-submitted electronically.
- **Initial Accept Report (Emdeon Envoy Report Rpt 04 or equivalent vendor report)** - This is a report that shows Emdeon accepted the EDI claim and forwarded it to MHNet for processing.
- **Payer Reject Report (Emdeon Report Rpt 11 or equivalent vendor report)** - This report states why the MHNet health plan rejected the claim. These claims should be corrected and re-submitted electronically when possible.

### Monitoring Your EDI Reports

Please note that claims appearing on the **Initial Reject Report** have not met the initial clearinghouse criteria approved by MHNet and have not been sent to MHNet for adjudication. Any claims appearing on this report must be corrected and should be re-submitted electronically as soon as possible to avoid timely filing issues.

Claims displayed on the **Initial Accept Report** have passed the clearinghouse edits and have been forwarded to MHNet for additional payer editing. Do to the size of this report a file summary report might be more appropriate to monitor the number of accepted claims.

It is also important to note that a claim can pass the clearinghouse edits and be displayed on the Initial Accept Report, but still be rejected by MHNet. Claims rejected by MHNet payers will appear on the **Payer Reject Report**. Any claims appearing on this report should be corrected and re-submitted electronically as soon as possible to avoid timely filing issues.

### Timely Filing

MHNet must accept a claim within its timely filing limit or it will be denied for untimely filing. If you are not receiving the described clearinghouse and payer reports on a regular basis, please contact your clearinghouse or Emdeon. A provider can avoid timely filing issues through understanding and regular monitoring of EDI Reports. This process will help to ensure all rejected claims are re-filed timely and electronically.

## 7. Common Rejection Reasons

Review the following tips for assistance with resolving the most common rejections received by providers. The most common claim reject reason for MHNet is “member not found.” **Use the MHNet secure provider portal, *directprovider.com, Emdeon, or an integrated solution through your vendor or clearinghouse* to verify/validate member’s eligibility prior to submitting claims.**

**Member Identification Number**

Submit the ID number as displayed on the patient's ID card.

**Patient Date of Birth (in the subscriber or patient loop as applicable)**

Submit a valid date of birth for the patient.
- Do not send "00" for the month or date.
- Do not send dummy dates such as "17760704".
- Do not send a date of birth greater than the date of service.

A claim will be rejected if a valid date of birth does not match the date of birth on file in the MHNet system. If this is the case, please verify the patient date of birth with the patient or policyholder.

**Date Format**

Submit all dates in the following format CCYYMMDD unless otherwise specified.
- Submit valid dates of service.
- Do not submit future dates of service.

**Monetary Amount Format**

Include the decimal point in all monetary amounts unless otherwise specified.
- Do not submit negative dollar amounts.

**Coding Detail**

Consider the following when verifying service codes and/or modifiers that have been rejected.
- Submit service codes and modifiers appropriate to the age and gender of the patient.
- Submit service codes and modifiers appropriate to the date of service.
- Submit service codes to their greatest level of specificity.

## 8. EDI Assistance

**Your Clearinghouse** - typically, your first point of contact for resolving an EDI issue is your practice's specific clearinghouse or vendor.

**Emdeon** - The Emdeon customer service center can track all EDI submissions received by them. Emdeon also maintains the status message returned on an EDI claim from the health plan. This information is readily available for 45 days after the submission. Information on older submissions is also available but will need forwarded to their research division for follow-up. Emdeon Customer Support can be reached at **(877) 469-3263**. Additionally, Emdeon has a new web-based application, Vision for Claim Management, that compiles claim information received and generated during claim filing and processing. It in an easy to use application for tracking EDI claim submissions. For more information and registration for Vision for Claim Management, go to http://transact.emdeon.com/editrx_services.php

**MHNet** staff is available to assist you with electronic filling concerns as they relate to our submission requirements or status messages. Please contact us at (302) 283-6570 or via email at **EDIClaims@cvty.com**.