‹‹Electronic Data Interchange (EDI) 837 Claims Overview››

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‹‹ASC X12N 837 v. 5010 Claims

ASC X12N 837 v.5010 claim submission is the most efficient method of Medi-Cal claims billing. Electronic Data Interchange (EDI) submission offers additional efficiency to providers because these claims are submitted faster and entered into the claims processing system faster.

The 837 claims submission requires that providers have an electronic claims billing system or have contracted with a billing service that operates an electronic billing system.

Generally, the submission requirements for 837 claims are the same as for paper claims. Because 837 claims submission is a “paperless” billing process, there are some special requirements.

Provider Participation Requirements

Participation as an 837 claims submitter is open to all Medi-Cal providers capable of submitted claims on an acceptable medium, in the proper format and claims data meets the criteria for billing.

Providers may employ a billing service to prepare and submit their 837 claims. Providers who wish to submit electronic claims through a billing service must complete registration and affiliate to a submitter billing service in the Medi-Cal Provider Portal.

Contracts between individual providers and independent billing services are required, and copies of these contracts should be retained by both parties. The Department of Health Care Services (DHCS) may conduct periodic audits of provider or billing service records to ensure compliance with Medi-Cal electronic billing requirements.

Billing Service

Submitters must register on the Medi-Cal Provider Portal, test their 837 claims submission ability and be approved for 837 submission in the Medi-Cal Provider Portal. When a submitter registers in the Medi-Cal Provider Portal, a unique three-character submitter ID is assigned. This number identifies all claims submitted by the submitter and is mandatory to submit claims. Refer to the *Testing and Activation Procedures* section of the *CA-MMIS 837 Billing and Technical Manual* for completion instructions.››

Note: Claims contained on the test file will not be processed for payment. To test, submitters should use data from previously adjudicated claims. ‹‹Submitters cannot send claims for adjudication until they are in “Active” status and are authorized for 837 claims billing.››

Claims Networks and Clearinghouses

Introduction

Claims networks/clearinghouses allow providers to send many kinds of insurance claims to one source. These claims services then submit the claims to the appropriate payer.

Developer or Vendor Supplied Billing Software

‹‹Claims software can be purchased to process 837 claims from system developers or vendors. This software is available with a wide range of features and capabilities in varying price ranges.

A benefit of developer/vendor supplied software is that it may have been tested and approved for 837 claims submission. The developer or vendor should confirm.

Note: It is important to verify software compatibility with the Medi-Cal system before purchase. DHCS makes no warranty on any software purchased from third party vendors.››

Provider or Billing Service Developed Billing Software

‹‹Providers or billing services also may develop their own 837 claim billing software using the data specifications offered in the *Medi-Cal X12 Companion Guide* and Federal Technical Report – Type 3 (TR3).››

Provider- or biller-developed software is most common among providers and billers with mid-range or mainframe computers, or providers and billers with programming capability and/or unique system requirements.

Claim Submission

‹‹Electronic Format

Claims submitted electronically must be formatted according to the data record specifications described in the *CA-MMIS 837 Claim Billing and Technical Manual*. While most of the claim fields are completed similar to a hard copy claim by using claim form completion instructions in the appropriate Part 2 manual, a few fields must be completed according to specific 837 standards. These standards are outlined in the *CA-MMIS 837 Claim Billing and Technical Manual* available on the Medi-Cal Providers website.

Submitters are to select the format that corresponds to their claims type as described below:

Table of Electronic Format Claim Types

Electronic Format	Claim Type
ANSI ASC XI2N 837 – v.5010 Professional (005010X222A1)	05, 07
ANSI ASC XI2N 837 – v.5010 Institutional (005010X223A2)	02, 03, 04

Electronic Submissions

The 837 claim may be submitted via the Transaction Center in the Medi-Cal Provider Portal on the Medi-Cal Providers website.

Attachments (Supporting Documentation) for 837 Claims

For submitting attachments (supporting documentation) to 837 claims refer to the *Medi-Cal EDI Companion Guide* available on the Medi-Cal Providers website.››

Claims Adjudication and Payment

‹‹Once 837 claims are input into the claims processing system, these claims are subject to the same edits and audits as paper claims. Claims without data or that have eligibility errors will usually enter the weekly adjudication cycle the same week the claims are received and will be paid in the next scheduled checkwrite. These 837 claims are not exempt from the schedule of one-week checkwrite delays.

Electronic Data Interchange (EDI) Help Desk Telephone Number

The EDI Help Desk can be accessed by calling the Telephone Service Center (TSC) at 1-800-541-5555.››

‹‹Reporting Submitter Status Changes

The FI must be informed of any changes in a submitter's status. Proper written notification is required under the following circumstances.

Provider Changes Business Location

Change of business location requires a letter containing the submitter number plus both old and new addresses and telephone numbers. The letter must include an authorized signature.

Requests must be sent to:

Department of Health Care Services
Provider Enrollment Division
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

Where to Submit Change in Status Correspondence

All correspondence regarding change in status should be sent to the following address:

Attn: EDI Help Desk Unit
California MMIS Fiscal Intermediary
P.O. Box 15508
Sacramento, CA 95852-1508››

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.