Testing and Activation Procedures for 837 Claims and 270 Eligibility Benefit Testing

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‹‹This section describes the testing and activation procedures required for ASC X12N 837 v.5010 claim submissions and ASC X12N 270 Eligibility Benefits to ensure accurate file format, completeness and validity.››

System Testing

Test claims and submitter-provider affiliations are done in the Medi-Cal Provider Portal.

Once registration is complete in the Provider Portal, new submitters must perform test transactions in the Provider Portal to ensure accurate file format, completeness and validity. Any format problems discovered during the testing period must be corrected to receive final approval.

Test submissions should contain a cross section of claim type data that can be expected in a production environment. The test file must consist of a minimum of 10 claims for each claim type to be billed. The test procedure must be completed for each applicable claim type.

A new test must be submitted when software is upgraded or the submission method changes.

‹‹The Telephone Service Center (TSC) is available at 1-800-541-5555 for assistance with the testing process. For more information about testing and activation procedures in the Provider Portal, refer to the *Provider Portal User Guide: Submitter Organization*.››

Note: Claims contained on the test file will not be processed for payment. To test, submitters should use data from previously adjudicated claims.

Remarks Records

‹‹Submitters can include statements to support claim justification. Areas defined for statements are the Medi-Cal *837 Remarks Records*, ANSI ASC X12N 837 v.5010 *Note (NTE) Segments*.›› These fields are optional.

Testing for Multiple Formats

Submitters may test for multiple formats using the same submitter number. Once approval is received for each format, submitters may use the same submitter number for all formats.

Evaluation Criteria

The test file will be evaluated for the following requirements:

- All format types
  - The claim data can be read by the claims processing system.
  - ‹‹Records and mandatory fields required for 837 claims are present and contain valid information (for example, provider number[s], submitter number, control records, claim records).››

Error Message

Test claims with formatting errors are identified and shown in the Provider Portal. If these errors are not corrected, your claims may be returned or denied. For example:

“05Info5” Recipient ID Must Be 9, 10, 14 Or 15 Characters Field Contains <12345678> Count 3 Claim Sequence=0002

This error message identifies the error code (05Info5), data field (Recipient ID) and correct format specification (9, 10, 14 or 15 Characters). It also identifies the actual field contents (12345678) and the sequential location (2) of the first claim found to contain the error, as well as the total count (3) of the error detected in the submission.

Note: Each specific error code, such as “05Info5” above, will be listed only once, regardless of the number of claims found to have this error.

The submitter must make the necessary correction(s) and submit a new file for retesting. Additional testing is required until the claims file passes all applicable edits. Although the test submission may pass the critical test conditions, it is the provider’s responsibility to correct any errors prior to submitting claims for processing.

Billing Services: New Providers

‹‹Billing services that have already tested and received approval for 837 claims are not required to retest for each new provider, as long as they continue to use the same submitter number, format, medium and claim type.››

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.