Front-End WEDI SNIP Validation

Denver Health Medical Plan's Front-End System, utilizing EDIFECS Validation Engine, will be performing the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) Validation. Any claims that do not pass WEDI SNIP Validations will be rejected. Below are a few examples of the Health Plans SNIP level requirements:

WEDI SNIP Level 1: EDI Syntax Integrity Validation

Syntax errors also referred to as Integrity Testing, which is at the file level. This level will verify that valid EDI syntax for each type of transaction has been submitted. When these errors are received the entire file will be rejected back to the submitter. Errors can occur at the file level, batch level within a file or individual claim level. It is therefore possible that an entire file or just part of a file could be rejected and sent back to the submitter when one of these errors is encountered. Examples of these errors include but are not limited to:

- Invalid date or time
- Invalid telephone number
- The data element is too long (i.e., the claim form field expects a numerical figure 9 characters long but reads 10 or more characters)
- Field 'Name' is required on the Reject Response Transaction (i.e., Field 'ID' is missing. It is required when Reject Response is "R")
- A slash is not allowed as a value for dates (i.e., date of service is expected to be in a numerical format of CCYYMMDD. MM/DD/CCYY is incorrect.)

WEDI SNIP Level 2: HIPAA Syntactical Requirement Validation

This level is for HIPAA syntax errors. This level is also referred to as Requirement Testing. This level will verify that the transaction sets adhere to HIPAA Implementation guides. Examples of these errors include but are not limited to:

- Social Security Number is not valid.
- Procedure Date is required when ICD are reported.
- Claim number limit per transaction has been exceeded.
- 'Name' is required when ID is not sent.
- Revenue Code should not be used when it is already used as a Procedure Code.
- NPI number is invalid for 'Name'.
- State code is required for an auto accident.
- Employer Identification Number (EIN) is invalid.
- Missing/invalid Patient information (E.g., member identification missing or invalid, patient's city, state, or ZIP is missing or invalid.)
- Invalid character or data element. The data element size is invalid or has invalid character limits.

- Missing NPI. Denver Health requires NPI numbers on claims as of May 23, 2008, in accordance with HIPAA guidelines. An NPI must be a valid 10-digit number.

WEDI SNIP Level 3: Balancing Validation

This level is for balancing of the claim. This level will validate the transactions submitted for balanced field totals and financial balancing of claims Examples of these errors include but are not limited to:

- Total charge amount for services does not equal sum of lines charges.
- Service line payment amount failed to balance against adjusted line amount.

WEDI SNIP Level 4: Situational Requirements

This level is for Situation Requirements/Testing. This level will test specific inter-segment situations as defined in the implementation guide, where if A occurs, then B must be populated. Examples of these errors include but are not limited to:

- If the claim is for an auto accident, the accident date must be present.
- Patient Reason for Visit is required on unscheduled outpatient visits.
- Effective date of coverage is required when adding new coverage for a member.
- Physical address of service location is required for all places of service billed.
- Referral number is required when a referral is involved.
- Subscriber Primary ID is required when Subscriber is the Patient.
- Payer ID should match to the previously defined Primary Identifier of Other Payer.

WEDI SNIP Level 5: External Code Set Validation

This level not only validates the code sets, but also ensures the usage is appropriate for any particular transaction and appropriate with the coding guidelines that apply to the specific code set. Examples of these errors include but are not limited to:

- Validated CPT code
- ICD Codes
- ZIP code
- National Drug Code (NDC)
- Taxonomy Code validation
- State code
- Point of Origin for Admission or Status Codes
- Adjustment Reason Codes and their appropriate use within the transaction

WEDI SNIP Level 6: Custom Health Plan Edits

This level is intended for specific business requirements by the Health Plan that are not covered within the WEDI SNIP or the Implementation Guide.

GATEWAY EDI RESOURCE GUIDE

EDI Claims Resolution Process

Providers submitting claims electronically are required to submit claims according to appropriate EDI companion guide and instructions.

For Medicaid and CHP providers in Colorado, companion guides can be found at:
https://hcpf.colorado.gov/edi-support

Providers will receive real-time responses on the status of their EDI claims submission via the 270/271 process. For those provides who have their claims rejected it is important to know that a rejected claim will not be accepted into QNXT. However, EDI reject codes and messages advising how to correct the reject are standard and are provided back to the provider via their clearing house.

However, providers may contact the health plan for assistance. The following steps should be performed to assist providers having trouble understanding why a claim is rejecting:

DHMP Specific Information (Highlighted Business Rules)

All Newborn and Dependents must have Medicaid or Medicare ID as per the States and CMS requirements. The Members' IDs must be in the Subscriber Loops that consist of the following:

- Subscriber Hierarchical (2000B) Loop
- Subscriber Name (2010BA) Loop
- Payer Name (2010BB) Loop Provider:
- The Billing Provider Name in Loop 2010AA may be a health care provider, a billing service, or some other representative of the provider that will receive the payment in the 835 transactions for FFS Claims.
- The Taxonomy Code within the Billing Provider Hierarchical Level (2000A) Loop (PRV) Segment is required for all FFS claim submissions and Encounter Submissions. The Taxonomy reported on the claim must match the Billing Provider's specialty, which is maintained by the Workgroup for Electronic Data Interchange (WEDI).
- Providers who perform care or services must be identified within the Rendering Provider Loop (2310B), when the Rendering Provider is not the same in the Billing Provider's Name (2010AA) Loop. If the Billing Provider (2010AA) and the Rendering Provider are the same, do not populate Loop 2310B. When using the 2310B Loop, the Plan requires that the Taxonomy Code is populated in the PRV Segment. The Taxonomy code must match the Rendering Provider's specialty, which is maintained by the Workgroup for Electronic Data Interchange (WEDI).
- The Plan requires the name and physical address where services were rendered in Service Facility Location Name in Loop 2310C, when the location of the health care service is different than the address within the Billing Provider Loop 2010AA. This loop must not contain a P.O. box in the Address (N3) Segment.

Patient Control Number

The Plan requires that the Patient Control Number in the Claim Information (2300) Loop (CLM01) Segment be unique for each claim submitted.

Subscriber Gender: The Plan will reject any claim that has the Subscriber Gender Code in the Subscriber Demographic Information (2010BA) loop as "U" – Unknown. This element must be "F" (Female) or "M" (Male).

ICD-10 Mandate

As of Oct. 1, 2015, ICD-9 Diagnosis Codes cannot be used for services provided on or after this date. We will only accept ICD-10 Diagnosis Codes on all claims for Service Dates on or after Oct. 1, 2015, and we will reject any claims that have both ICD-9 and ICD-10 codes on the same claim after such date. Please refer to the CMS website for more information about ICD-10 diagnosis codes at www.cms.gov. Please see the NUCC guide for billing details. Please see 837 IG for EDI for correct qualifier to use with the ICD-10 diagnosis codes.

Authorizations and/or Referral Numbers

The Plan requires all submitters to send the Prior Authorizations and/or Referral Numbers when assigned by the Plan. The Plan will deny any services as "Not Covered" if the services require an Authorization and/or Referral.

Valid National Provider Identifiers (NPI)

All submitters are required to use the National Provider Identification (NPI) numbers that are now required in the ANSI ASC X12N 837 as per the 837 Professional (TR3) Implementation Guide for all appropriate loops with the exception of atypical providers. Atypical providers must pre-register with the Plan before submitting claims to avoid NPI rejections. Atypical providers are classified as non-health care providers such as taxi drivers, carpenters, and personal care providers.

Corrected Claim Submission Replacement (Adjustment) Claim or Void/Cancel Claim via EDI

When submitting a "Corrected Claim", use the appropriate Claim Frequency Type Code in the CLM05-3 segment. Please indicate whether for Replacement (Adjustment) of prior claim "7" or a Void/Cancel of prior Claim "8".

Also, per the Implementation Guide – when "7" or "8" is used as Claim Frequency Type Code for Replacement or Void/Cancel of Prior Claim Submission, the Claim Level information in Loop 2300 and segment REF with an F8 qualifier must contain the Plan's Claim Control Number (WCN) or the Plan's Van Trace, (formally known as the Original Reference Number). These numbers can be found in the 277CA (Claims Acknowledgement), which the Plan sends along with the 999 and the corresponding 277U (if requested).

Coordination of Benefits (COB) and Adjudication Information – MOOP

All submitters required to send in all the Coordination of Benefits and Adjudication Loops as per the Coordination of Benefits 1.4.1 section within the 837 Professional (TR3) Implementation Guide.

Providers and Vendors must have the 837 Professional (TR3) Implementation Guide in conjunction with this Companion Guide to create the loops below correctly.

The required loops and segments that are needed to be sent for a Compliant COB are as follows:

- Other Subscriber Information (2320) Loop
- Other Subscriber Name (2330A) Loop
- Line Adjudication Information (2430) Loop
- For out-of-pocket amounts, use Loop ID 2430 220 Position 300 Data Element 782 for Patient Responsibility
- This includes coinsurance, co-pays, and deductibles – Please refer to Code Set 139 for the correct Claim Adjustment Reason Code

National Drug Code (NDC)

Medicaid Claim Submission Only Per the 837 Professional (TR3) Implementation Guide, all Submitters are required to supply the National Drug Code (NDC) for all HCPCS J-codes submitted on the claim. The NDC must be reported in Loop 2410 Segment LIN03. Also, per the Implementation Guide, the Drug Quantity and Price also must be reported within the CTP segment. DHMP uses the REDBOOK, and CMS to validate the NDC codes for the source of truth.

Transportation Vendors

All Transportation Vendors must now use the Ambulance Pickup (2310E) and Drop-Off Location (2310F) Loops.

- Only one claim can be submitted per one-way trip.
- The physical address is required for the pickup/drop-off location.
- Any P.O. box information within this segment will be rejected.