Aetna Better Health® of Illinois
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Aetna Better Health® of Illinois

FAQ for SNIP Level 3 and 4 edits

Edit examples for UB-04 (1450) claim types:

1. 'Discharge Hour' (2300 DTP-01 = 096) was found but was not expected because this claim is for Outpatient Services
    - Outpatient claims should not have discharge hour reported as this is not an inpatient claim.
    - Remove the discharge hour from this outpatient claim.

2. 'Discharge Hour' (2300 DTP-01 = 096) was not found but was expected because the Claim Frequency Code (CLM-05-3) is '1 - Original' or '4 - Last Claim' and this claim is for Inpatient Services.
    - The discharge hour is required for claims with a frequency code of 1 or 4 for interim claims.
    - Add the discharge hour for this claim.

3. Occurrence Code '55' is required when the Patient Status Code (CL103) is equal to '20', '40', '41' or '42'.
    - Occurrence code 55 (Box 31-33 on the 1450 claim form) is required when the discharge status on the claim is 20,40, 41 or 42.

4. Occurrence Codes cannot be duplicated.
    - Occurrence codes (Box 31-33 on the 1450 claim form) cannot be duplicative. Only one of the same occurrence codes/date combinations can be submitted.

5. Occurrence Span Codes cannot be duplicated.
    - Occurrence code dates cannot be duplicated (box 31-33 on the 1450 claim form).

6. The Claim Check or Remittance Date is required when the Line Check or Remittance Date is not used, and this Payer has adjudicated the claim.
    - If other insurance exists, service line payment information or adjustment information must be sent in loop 2430.

7. The Name suffix is to be used only to indicate generation or patronymic data.
    - For the insured/subscribers name in loop 2010BA, if there is generation or patronymic data provided it must be I, II, III, IV, Jr or Sr. Periods are accepted in conjunction with these examples (i.e., Jr.).

8. The Payer Paid Amount does not equal the line level payment amounts less the adjustment amounts.
    - The COB payer amount + adjustment amounts do not equal the billed amount. These must balance out.

9. The Remaining Patient Liability Information was not found but expected because this payer has adjudicated the claim and only claim level information is being sent. Zero (0) is an acceptable value.

    - When a primary payer pays the payment information must be provided on the claim.

10. The Service Date is required on outpatient services when a drug is not being billed and the Statement Covers Period is greater than one day.
    - See below for the verbiage from the ASC X12 837 Implementation Guide.

DTP - DATE - SERVICE DATE	
X12 Segment Name:	Date or Time or Period
X12 Purpose:	To specify any or all of a date, a time, or a time period
Loop:	2400 — SERVICE LINE NUMBER
Segment Repeat:	1
Usage:	SITUATIONAL
Situational Rule:	Required on outpatient service lines where a drug is not being billed and the Statement Covers Period is greater than one day. OR Required on service lines where a drug is being billed and the payer's adjudication is known to be impacted by the drug duration or the date the prescription was written. If not required by this implementation guide, do not send.
TR3 Notes:	1. In cases where a drug is being billed on a service line, date range may be used to indicate drug duration for which the drug supply will be used by the patient. The difference in dates, including both the begin and end dates, are the days supply of the drug. Example: 20000101 - 20000107 (1/1/00 to 1/7/00) is used for a 7 day supply where the first day of the drug used by the patient is 1/1/00. In the event a drug is administered on less than a daily basis (for example, every other day) the date range would include the entire period during which the drug was supplied, including the last day the drug was used. Example: 20000101 - 20000108 (1/1/00 to 1/8/00) is used for an 8 days supply where the prescription is written for Q48 (every 48 hours), four doses of the drug are dispensed and the first dose is used on 1/1/00.
	2. In cases where a drug is being billed on a service line, a single date may be used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).
TR3 Example:	DTP*472*D8*20060108~

11. The Service Line Paid amounts (2430/SVD-02) and all Service Line Adjustment amounts (2430/CAS) do not equal the 'Line-Item Charge' for this Service Line (Loop 2400). Totals in the 2430 loop are accumulated for each unique COB payer (2430/SVD-01).

    - The calculation for each 2430 loop is (sum of Loop ID 2430 CAS Service Line Adjustments) plus (Loop ID 2430 SVD02 service line paid amount) = Loop ID 2400 SV203 'Line-Item Charge Amount.

      Example
      Line 1 Charge - $80.00
      Line 1 Payment - $70.00
      Line 1 Adjustment - $10.00

      Line 2 Charge - $20.00
      Line 2 Payment - $15.00
      Line 2 Adjustment - $5.00

      (Line 1 Adjustments) + (Line 1 Payment) = Line-Item 1 charge

      $10.00 + $70.00 = $80.00
      (Line 2 Adjustments) + (Line 2 Payment) = Line-Item Charge 2
      $5.00 + $15.00 = $20.00

12. Value does not match the format for Service Unit Count. Must be a positive value with no more than 8 numeric digits excluding the decimal, with no more than 3 digits to the right of the decimal.

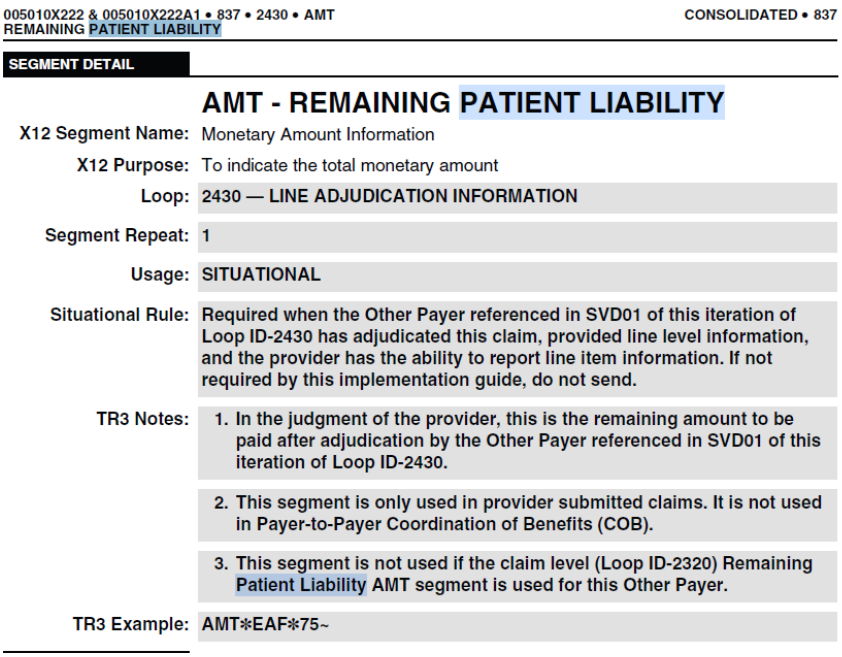
Edit examples for HCFA – 1500 form type edits

1. Missing 'Related Causes Code' in CLM-11. Required for Accidents (when DTP-01=439 is used).
    - This rejection indicates a Related Causes (Accident) code was not included with the claim and is required by this payer for the service billed.

2. 'Referring Provider Name' was not found but was expected because there is a 'Referral Number', and the Claim Level Referring Provider is not present.
    - Referring provider information is missing when referring NPI information is provided.

3. Subscriber Demographic Information was not found but was expected because the Subscriber Relationship (SBR-02) is '18-Self'.
    - When the subscriber relationship is self, demographic information of the subscriber (i.e., address) must be provided.

4. The Claim Level Remaining Patient Liability Amount is not used if the line level Remaining Patient Liability Amount is used.



005010X222 & 005010X222A1 • 837 • 2430 • AMT REMAINING PATIENT LIABILITY — CONSOLIDATED • 837

SEGMENT DETAIL

AMT - REMAINING PATIENT LIABILITY

X12 Segment Name:	Monetary Amount Information
X12 Purpose:	To indicate the total monetary amount
Loop:	2430 — LINE ADJUDICATION INFORMATION
Segment Repeat:	1
Usage:	SITUATIONAL
Situational Rule:	Required when the Other Payer referenced in SVD01 of this iteration of Loop ID-2430 has adjudicated this claim, provided line level information, and the provider has the ability to report line item information. If not required by this implementation guide, do not send.
TR3 Notes:	1. In the judgment of the provider, this is the remaining amount to be paid after adjudication by the Other Payer referenced in SVD01 of this iteration of Loop ID-2430. 2. This segment is only used in provider submitted claims. It is not used in Payer-to-Payer Coordination of Benefits (COB). 3. This segment is not used if the claim level (Loop ID-2320) Remaining Patient Liability AMT segment is used for this Other Payer.
TR3 Example:	AMT*EAF*75~

5. The Clinical Laboratory Improvement Amendment (CLIA) Number at the 2400 should only be sent if different that the CLIA number sent in the claim level.
    - The CLIA number should not be sent in the service line unless it differs from the header level CLIA identifier.

6. The COB Payer Paid Amount was expected because the claim has been adjudicated by the payer identified in Other Payer Loop.
    - H46500 must have the COB payer paid amount if there is a payer identified in the other payer loop (2330B).

7. The Line Level Ambulance Certification is required only when different than the information reported in the Ambulance Certification CRC and the claim level.

- The CR1 segment in Loop ID 2300 applies to the entire claim unless overridden by a CR1 Segment at the service line level in Loop ID-2400 with the same value in CR101.

8. The Name suffix is to be used only to indicate generation or patronymic data.
    - For the insured/subscribers name in loop 2010BA, if there is generation or patronymic data provided it must be I, II, III, IV, Jr or Sr. Periods are accepted in conjunction with these examples (i.e., Jr.).

9. The Payer Claim Control Number was found but not expected because the Claim Frequency Code indicate this is an original claim.
    - If the frequency code of the claim is a 1 (not a 7 or 8) then a payer claim control number in Loop 2300 REF02 should not be present.

10. The Payer Paid Amount does not equal the line level payment amounts less the adjustment amounts.
    - The COB payer amount + adjustment amounts do not equal the billed amount. These must balance out.

11. The 'Prior Authorization Number' for the Service Line should be different from claim level.
    - Required when service line involved a prior authorization number that is different than the number reported at the claim level (Loop-ID-2300). If not required by the 837P Implementation guide, do not send.

12. The Remaining Patient Liability Information was not found but expected because this payer has adjudicated the claim and only claim level information is being sent. Zero (0) is an acceptable value.
    - When a primary payer pays the payment information must be provided on the claim.

13. The Service Line Paid amounts (2430/SVD-02) and all Service Line Adjustment amounts (2430/CAS) do not equal the 'Line-Item Charge' for this Service Line (Loop 2400). Totals in the 2430 loop are accumulated for each unique COB payer (2430/SVD-01).

- The calculation for each 2430 loop is (sum of Loop ID 2430 CAS Service Line Adjustments) plus (Loop ID 2430 SVD02 service line paid amount) = Loop ID 2400 SV203 'Line-Item Charge Amount.

  Line 1 Charge - $80.00
  Line 1 Payment - $70.00
  Line 1 Adjustment - $10.00

  Line 2 Charge - $20.00
  Line 2 Payment - $15.00
  Line 2 Adjustment - $5.00

  (Line 1 Adjustments) + (Line 1 Payment) = 'Line-Item 1 charge

  $10.00 + $70.00 = $80.00
  (Line 2 Adjustments) + (Line 2 Payment) = 'Line-Item Charge 2
  $5.00 + $15.00 = $20.0

14. The Subscriber Group or Policy Number was found but was not expected because it is the same as the value sent as the Subscriber Primary ID.
    - Loop ID-2010BB would not be needed information if it is the same data as the Subscriber primary ID.

15. When a 'Diagnosis Code Pointer' is '4', a 'Diagnosis Code' in 2300/HI-04-2 must exist.
    - If the provider reports 4 diagnosis code pointers in the 2300 Loop, then 4 diagnosis must exist. The pointers and the diagnosis count must be the same.