

**Private Business Professional Companion Document**

Usage	Language
R	Negative values submitted in the following fields <b>[may not]</b> be processed and <b>[may]</b> result in the claim being rejected: Total Claim Charge Amount (2300 Loop, CLM02), Patient Amount Paid (2300 Loop, AMT02), Patient Weight (2300 and 2400 Loop, CR102), Transport Distance (2300 and 2400 Loop, CR106), Payer Paid Amount (2320 Loop, AMT02), Allowed Amount (2320 Loop, AMT02), Line Item Charge Amount (2400 Loop, SV102), Service Unit Count (2400 Loop, SV104), Total Purchased Service Amount (2300 Loop, AMT02), and Purchased Service Charge Amount (2400 Loop, PS102).
R	The only valid values for CLM05-3 (Claim Frequency Type Code) are '1' (ORIGINAL) and '7' (REPLACEMENT). Claims with a value of '7' will be processed as original claims and <b>[may]</b> result in duplicate claim rejection. The claims processing system does not process electronic replacements.
R	The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 <b>[may]</b> be rejected.
R	Claims that contain percentage amounts submitted with values in excess of 99.99 <b>[may]</b> be rejected.
R	Claims that contain percentage amounts submitted with more than two positions to the left or the right of the decimal <b>[may]</b> be rejected.
R	Data submitted in CLM20 (Delay Reason Code) <b>[may]</b> not be used for processing.
R	<b>[Private Business]</b> will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Private Business processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.
R	You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set <b>[may]</b> cause the interchange (transmission) to be rejected at the carrier translator.
R	The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.
R	Currency code (CUR02) must equal 'USA'.
R	Diagnosis codes have a maximum size of five (5). Private Business does not accept decimal points in diagnosis codes.
R	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).
R	Do not use Credit/Debit card information to bill Private Business (2300 loop, AMT01=MA and 2010BD loop).
R	Service unit counts (units or minutes) cannot exceed 999.9 (SV104).
R	Unless notified by the Provider of services or Private Business that a business need exists to do otherwise, the clearinghouse or billing agent must populate their unique submitter number at the ISA 06 (Interchange Sender ID), GS 02 (Application Senders Code) and at the Loop 1000A NM109 (Identification Code). Failure to populate the submitter number in the prescribed manner <b>[will]</b> cause the file to reject.
R	If notified by the Provider of services or Private Business that a business need exists, the clearinghouse or billing agent must transmit a separate file for each such provider of services with the clearinghouse or billing agent's submitter number populated at the ISA 06 and GS 02 and the individual Provider of services' submitter number at the 1000A NM109. Failure to populate submitter numbers in the prescribed manner <b>[will]</b> cause the file to reject.
O	The incoming 837 transactions utilize delimiters from the following list: ~, *, and : Submitting delimiters not supported within this list <b>[may]</b> cause an interchange (transmission) to be rejected.
O	Only loops, segments and data elements valid for the HIPAA Professional Implementation Guides will be translated. Submitting data not valid based on the Implementation Guide <b>[may]</b> cause files to be rejected.
O	Only loops, segments and data elements valid for the HIPAA Professional Implementation Guides will be translated. Non-implementation guide data <b>[will]</b> not be sent for processing consideration.
O	Any data submitted in the PWK (Paperwork) segment <b>[may]</b> not be considered for processing Loop 2300.

**Private Business Professional Companion Document (cont.)**

Usage	Language
O	Purchased diagnostic tests (PDT) amounts should be submitted at the detail line level (Loop 2400), not at the header claim level (Loop 2300). PDT amounts submitted at the header claim level (Loop 2300) [may] be ignored.
O	Peer Review Organization (PRO) information should be submitted at the header claim level (Loop 2300). PRO information submitted at the detail line level (Loop 2400) [may] be ignored.
O	All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date [will] result in rejection of the claim or the applicable interchange (transmission).
O	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).
O	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).
O	[Private Business] will only process one transaction type (records group) per interchange (transmission); a submitter must only submit one GS-GE (Functional Group) within an ISA-IEA (Interchange).
O	[Private Business] [will] reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.
O	[Private Business] [will] reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the carrier definition.
O	[Private Business] [may] reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.
O	[Private Business] [will] reject an interchange (transmission) that is not submitted with a valid carrier code. Each individual Contractor determines this code.
O	[Private Business] [will] reject an interchange (transmission) submitted with more than 9,999 loops.
O	[Private Business] [will] reject an interchange (transmission) submitted with more than 9,999 segments per loop.
O	[Private Business] will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) [may] cause the transaction to be rejected.
O	[Private Business] will only process one transaction per functional group; a submitter must only submit one ST-SE (Transaction Set) within a GS-GE (Functional Group).
O	[Private Business] [will] reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.
R/O(b)	You may send up to eight diagnosis codes per claim; however, the last four diagnosis codes [may] not be considered in processing.
R/O(b)	Only valid qualifiers for Private Business should be submitted for Private Business processing on incoming 837 claim transactions. Any qualifiers submitted not defined for use in Private Business billing [may] cause the claim to be rejected.
R/O(b)	You may send up to four modifiers; however, the last modifier [may] not be considered. The [Private Business] processing system [may] only use the first three modifiers for adjudication and payment determination of claims using the 99 first.
R/O(a)	[Private Business] will return the version of the 837 inbound transaction in GS08 (Version/Release/Industry Identifier Code) of the 997.
R/O(b)	We suggest retrieval of the ANSI 997 functional acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission.
R/O(a)	Compression of files is not supported for transmissions between the submitter and [Private Business].