#1. Are there any special requirements when using procedure code H2012?

For procedure code H2012, the units should always be either 4 or 6. If there is a value other than 4 or 6 as units, the 837 file will be rejected in the translator.

#2. What are these PLB segments in my 835 and can I use the information from these.
PLB*4101*20041231*CS:412004030201*3252.58~
PLB*4103*20041231*CS:412004030201*6403.92~
PLB*4104*20041231*CS:412004030201*1582.34~
PLB*4111*20041231*CS:412004030201*3645.27~

The PLB segment is used to adjust the amount approved for all the services of each provider in the 835. There is one PLB segment for each provider. Because the 835 DMH currently provides is a non-payment 835, the approved amounts have to be adjusted to balance the 835. So these amounts are adjusted in the PLB to zero out the amounts. If we don't use these PLBs, the 835 will be HIPAA invalid.

You can use these PLBs to see how much amount was approved for each provider.

#3. I understand what Suspended (13) and Denied (4) claims are. What does "predetermination pricing only (25)" mean?

The code 25, predetermination pricing only, is used in the 835 because there is no payment accompanying the 835. This 835 is just for information and it does not have any payment information like the check number or any reference to the payment.

#4. My 837 file passed Edifecs/Claredi validation at our site, but the Translator rejected it with a TA1 error. What can be the cause of this?

DMH requires specific values to be used in the Sender and Receiver ID fields in ISA and GS segments. Counties should use "Ccc000000000000" (e.g., for county 1, C01000000000000) for Sender ID and "INFOTECHWEBSVCS" for Receiver ID. If the complete 837 file is HIPAA valid, but the values used in Sender ID and/or Receiver ID do not match the above DMH requirements, then the file will fail HIPAA validation in the Translator, generating a TA1 (997). As the stand alone version of the HIPAA validation tool at the county's site may not be aware of these DMH requirements, the same file passes validation at the county's site.

#5. Are there other situations under which a TA1 error is generated?

TA1 errors are usually generated when something is wrong with the 837 file at a high level like the structure of the 837, incorrect ISA/GS loops, invalid segment terminator etc. HIPAA allows only one character for segment terminator. If the 837 file has more than one character as a segment terminator, it will be rejected. Use only '~' as a segment terminator to avoid TA1s.

#6. If there is information missing in a claim, shouldn't the translator toss the claim out? Why would it find critical items missing at adjudication time and not before then?

We do check for some missing data in the claims before sending them for adjudication. But we do not check for all the fields because there is no HIPAA transaction for reporting these errors. We can report them on the web site or via e-mail, but we left the checking part to the SD/MC because it has more detailed explanations for the errors and counties are used to this kind of error reporting.