ADMH SAIS

837P Companion Guide

Version 2.1

Date 9/12/2024

FEI Systems

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1. GENERAL

1.1. Record of Changes

Table 1: Record of Changes

Version Number	Date	Author/Owner	Description of Change
1.0	7/31/2023	Tim Carroll	Initial draft for review by ADMH
1.1	8/15/2023	Tim Carroll	3.1.1 Instruction Table -Updated Loop 1000B NM103 to "ADMH." -Added Loop 2300 REF F8 Original Reference Number. -Updated Loop 2310B PRV03 to "251S00000X." 3.1.4 Added section, Claim Frequency Codes. App B 837P Import Error Messages Updated error messages and broke out columns for provider/ADMH action.
2.0	4/17/2024	Tim Carroll	4 Moved WITS upload/download instructions to new major section. 5 Moved SFTP instructions to new major section. 6 Moved errors to new major section. App A Added note.
2.1	9/12/2024	Tim Carroll	2.2 Added note, "These requirements may be modified by ADMH as necessary." 3.1.1 Loop 2010BA DMG03: Added note about U code. Loop 2400: Removed CN1 segment.

1.2. Supporting Documents and References

Table 2: Supporting Documents and References

Document Name
Substance Use Contract Billing Manual, effective 4/1/2023
Alabama Medicaid HIPAA Companion Guide for 5010, updated 9/9/2022

1.3. Terms and Definitions

Table 3: Terms and Definitions

Term	Description
ADMH	Alabama Department of Mental Health
AMA	American Medical Association
ANSI	American National Standards Institute
ASC	Accredited Standards Committee
BAA	Business Associate Agreement
CPT	Current Procedural Terminology
EDI	Electronic Data Interchange
EIN	Employer's Identification Number
ETIN	Electronic Transmitter Identification Number
FFS	Fee For Service
HCPCS	Health Care Financing Administration Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act of 1996
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th Revision
MRN	Medical Record Number
PHI	Protected Health Information
SFTP	Secure File Transfer Protocol
TR3	Technical Report Type 3
UAT	User Acceptance Testing
UCN	AL WITS Unique Client Number

2. INTRODUCTION

2.1. Intended Use

This is a companion guide to the HIPAA American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N Technical Report Type 3 (TR3) implementation Guide, 005010X222A1: Health Care Claim: Professional (837). This guide is intended to supplement the ASC X12 TR3 document.

The ANSI ASC X12 Implementation Guides may be purchased at http://www.wpc-edi.com/.

This guide is intended to assist providers under contract by the Alabama Department of Mental Health (ADMH) in implementing transaction standards which meet the claim processing methodology. It provides specific requirements for submitting professional claims (837P) to ADMH, and it contains information about provider enrollment, testing, and support.

2.2. Getting Started

Contracted providers must have the following items in place prior to submitting 837P transactions:

- An established contractual relationship with ADMH to be reimbursed for SUD treatment services.
- A Business Associate Agreement (BAA) with ADMH.
- Login credentials to the AL WITS training environment.
- The ability to create 837P transactions in accordance with the TR3 Implementation Guide and this companion guide.
- Notification to ADMH that 837P transactions will be submitted for reimbursement. The notification must also include:
  - Provider 837P point of contact (name, title, telephone number, and email address).
  - Agreement to complete a testing cycle consisting of three test 837P transactions over a four-week period.

These requirements may be modified by ADMH as necessary.

3. ELECTRONIC DATA INTERCHANGE (EDI) TRANSACTIONS

3.1. 837P Professional Claims

Refer to the ADMH Substance Use Contract Billing Manual for billable services, including procedure codes, modifiers, places of service, rates, and restrictions.

An example 837P is provided in Appendix A.

3.1.1. Instruction Table

Table 4: 837P Instruction Table

Loop	Segment ID	Segment Name	Accepted value(s)	Comments
Interchange Control Header				
	ISA01	Authorization Information Qualifier	00	
	ISA02	Authorization Information		10 spaces
	ISA03	Security Information Qualifier	00	
	ISA04	Security Information		10 spaces
	ISA05	Interchange ID Qualifier	ZZ	Mutually Defined
	ISA06	Interchange Sender ID		ID assigned by ADMH. Use spaces after ID for a total of 15 characters. Refer to the section "Sender, Receiver, and Payor Names/IDs" for additional instructions.
	ISA07	Interchange ID Qualifier	ZZ	Mutually Defined
	ISA08	Interchange Receiver ID	300002373	ID assigned by ADMH. Use spaces after ID for a total of 15 characters. Refer to the section "Sender, Receiver, and Payor Names/IDs" for additional instructions.
	ISA09	Interchange Date		YYMMDD
	ISA10	Interchange Time		HHMM
	ISA11	Repetition Separator	^	Carat
	ISA12	Interchange Control Version Number	00501	
	ISA13	Interchange Control Number		ISA13 must match IEA02.
	ISA14	Acknowledgment Requested	0 1	0 = No Acknowledgment Requested 1 = Interchange Acknowledgment Requested
	ISA15	Interchange Usage Indicator	P T	P = Production Data T = Test Data
	ISA16	Component Element Separator	:	

Loop	Segment ID	Segment Name	Accepted value(s)	Comments
Functional Group Header				
	GS01	Functional Identifier Code	HC	
	GS02	Application Sender's Code		ID assigned by ADMH. Do not include spaces after ID. Refer to the section "Sender, Receiver, and Payor Names/IDs" for additional instructions.
	GS03	Application Receiver's Code	300002373	ID assigned by ADMH. Do not include spaces after ID. Refer to the section "Sender, Receiver, and Payor Names/IDs" for additional instructions.
	GS04	Date	CCYYMMDD	
	GS05	Time	HHMMSS	
	GS06	Group Control Number		Assigned number originated and maintained by the sender. GS06 must match GE02
	GS07	Responsible Agency Code	X	Accredited Standards Committee X12
	GS08	Version Identifier Code	005010X222A1	Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003
Transaction Set Header				
	ST01	Transaction Set Identifier	837	Health Care Claim
	ST02	Transaction Set Control Number		ST02 must match SE02
	ST03	Implementation Convention Reference (Implementation Guide Version Name)	005010X222A1	
Beginning of Hierarchical Transaction				
	BHT01	Hierarchical Structure Code	0019	Information Source, Subscriber, Dependent
	BHT02	Transaction Set Purpose Code	00	Original
	BHT03	Reference Identification (Originator Application Transaction Identifier)		
	BHT04	Date	CCMMYYDD	
	BHT05	Time	HHMM	
	BHT06	Claim or Encounter ID	CH	Chargeable
Loop 1000A Submitter Name				
1000A	NM103	Organization Name (Submitter Name)		Provider agency name
1000A	NM108	Identification Code Qualifier	46	Electronic Transmitter Identification Number (ETIN)

Loop	Segment ID	Segment Name	Accepted value(s)	Comments
1000A	NM109	Identification Code (Submitter Identifier)		ID assigned by ADMH. Do not include spaces after ID. Refer to the section "Sender, Receiver, and Payor Names/IDs" for additional instructions.
1000A	PER01	Contact Function Code	IC	Information Contact PER segment is optional
1000A	PER02	Name (Submitter Contact Name)		PER segment is optional. If used, include the submitter contact name.
1000A	PER03	Communication Number Qualifier	EM FX TE	EM = Electronic Mail FX = Facsimile TE = Telephone PER segment is optional
1000A	PER04	Communication Number		Required when qualifier in PER03 is used.
Loop 1000B Receiver Name				
1000B	NM103	Organization Name (Receiver Name)	ADMH	Refer to the section "Sender, Receiver, and Payor Names/IDs" for additional instructions.
1000B	NM108	Identification Code Qualifier	46	Electronic Transmitter Identification Number (ETIN)
1000B	NM109	Receiver Primary Identifier	300002373	Do not include spaces after ID. Refer to the section "Sender, Receiver, and Payor Names/IDs" for additional instructions.
Loop 2000A Billing Provider Hierarchical Level				
2000A	HL01	Hierarchical ID Number		
2000A	HL03	Hierarchical Level Code	20	Information Source
2000A	HL04	Hierarchical Child Code	1	Additional Subordinate HL Data Segment in This Hierarchical Structure.
Loop 2010AA Billing Provider Name				
2010AA	NM101	Entity Identifier Code	85	Billing Provider
2010AA	NM102	Entity Type Qualifier	2	Non-person entity
2010AA	NM103	Organization Name (Billing Provider Name)		Provider agency name
2010AA	NM108	Identification Code Qualifier	XX	Centers for Medicare and Medicaid Services National Provider Identifier
2010AA	NM109	Identification Code (Billing Provider Identifier)		Provider agency NPI
2010AA	N301	Address Information (Billing Provider Address Line)		Provider agency address

Loop	Segment ID	Segment Name	Accepted value(s)	Comments
2010AA	N401	City Name (Billing Provider City Name)		Provider agency city
2010AA	N402	State or Province Code (Billing Provider State Code)		Provider agency state
2010AA	N403	Postal Code (Billing Provider ZIP Code)		Provider agency 9-digit ZIP Code
2010AA	REF01	Reference Identification Qualifier	EI	Employer's Identification Number
2010AA	REF02	Reference Identification (Billing Provider Tax Identification Number)		Provider agency Federal Tax Identification Number/EIN
Loop 2000B Subscriber Hierarchical Level				
2000B	HL01	Hierarchical ID Number		
2000B	HL02	Hierarchical Parent ID Number		
2000B	HL03	Hierarchical Level Code	22	Subscriber
2000B	HL04	Hierarchical Child Code	0	No Subordinate HL Segment in this Hierarchical Structure
2000B	SBR01	Payer Responsibility Sequence Number Code	P	Primary
2000B	SBR02	Individual Relationship Code	18	Self The subscriber is always the patient.
2000B	SBR09	Claim Filing Indicator Code	11	Other Non-Federal Programs
Loop 2010BA Subscriber Name				
2010BA	NM101	Entity Identifier Code	IL	Insured or Subscriber
2010BA	NM102	Entity Type Qualifier	1	Person
2010BA	NM103	Name Last (Subscriber Last Name)		Client Last Name
2010BA	NM104	Name First (Subscriber First Name)		Client First Name
2010BA	NM105	Name Middle (Subscriber Middle Name)		Client Middle Name or Initial (Optional)
2010BA	NM105	Name Suffix (Subscriber Name Suffix)		Client Name Suffix (Optional)
2010BA	NM108	Identification Code Qualifier	MI	Member Identification Number
2010BA	NM109	Identification Code (Subscriber Primary Identifier)		AL WITS UCN Refer to the section "Subscriber Number" for additional instructions.
2010BA	N301	Address Information (Subscriber Address Line)		Client Address Line 1
2010BA	N401	City Name (Subscriber City Name)		Client City Name
2010BA	N402	State or Province Code (Subscriber State Code)		Client State Code

Loop	Segment ID	Segment Name	Accepted value(s)	Comments
2010BA	N403	Postal Code (Subscriber ZIP Code)		Client ZIP Code
2010BA	DMG01	Date Time Period Format Qualifier	D8	Date Expressed in Format CCYYMMDD
2010BA	DMG02	Date Time Period (Subscriber Birth Date)		Client Birth Date CCYYMMDD
2010BA	DMG03	Gender Code (Subscriber Gender Code)	F M	Client Gender Code F = Female M = Male Note: ADMH does not allow the "U" code (Unknown).
Loop 2010BB Payer Name				
2010BB	NM101	Entity Identifier Code	PR	Payer
2010BB	NM102	Entity Type Qualifier	2	Non-Person Entity
2010BB	NM103	Organization Name (Payer Name)	ADMH	ADMH Refer to the section "Sender, Receiver, and Payor Names/IDs" for additional instructions.
2010BB	NM108	Identification Code Qualifier	PI	PI = Payor Identification
2010BB	NM109	Identification Code (Payer Identifier)	630506021	ADMH EIN (with no hyphen) Refer to the section "Sender, Receiver, and Payor Names/IDs" for additional instructions.
Loop 2300 Claim Information				
2300	CLM01	Claim Submitter's Identifier (Patient Control Number)		Must be unique to each claim/encounter. This number is returned in the 835 to identify the claim.
2300	CLM02	Monetary Amount (Total Claim Charge Amount)		
2300	CLM05-1	Facility Code Value (Place of Service Code)		Refer to the section "Place of Service Codes" for additional instructions.
2300	CLM05-2	Facility Code Qualifier	B	Place of Service Codes for Professional Services
2300	CLM05-3	Claim Frequency Type Code (Claim Frequency Code)	1 7 8	1 = Original claim 7 = Replacement claim 8 = Void claim Refer to the section "Claim Frequency Codes" for additional instructions.
2300	CLM06	Yes/No Condition or Response Code (Provider or Supplier Signature Indicator)	N Y	N = No Y = Yes

Loop	Segment ID	Segment Name	Accepted value(s)	Comments
2300	CLM07	Provider Accept Assignment Code (Assignment or Plan Participation Code)	A	Assigned
2300	CLM08	Yes/No Condition or Response Code (Benefits Assignment Certification Indicator)	Y	Yes
2300	CLM09	Release of Information Code	Y	Yes
2300	REF01	Reference Identification Qualifier	F8	F8 = Original Reference Number Note: This segment should be included only when CLM05-3 indicates a replacement or void to a previously adjudicated claim.
2300	REF02	Reference Identification (Payer Claim Control Number)		Payer Claim Control Number
2300	REF01	Reference Identification Qualifier	EA	EA = Medical Record Identification Number This segment is optional.
2300	REF02	Reference Identification (Medical Record Number)		Medical Record Number
2300	HI01-1	Code List Qualifier Code (Diagnosis Type Code)	ABK	ABK = ICD-10-CM Note: Additional diagnoses may be reported in HI02 through HI12 using ABF
2300	HI01-2	Industry Code (Diagnosis Code)		ICD-10 diagnosis code
Loop 2310B Rendering Provider Name				
2310B	NM101	Entity Identifier Code	82	Rendering Provider
2310B	NM102	Entity Type Qualifier	2	Non-Person Entity
2310B	NM103	Organization Name		Provider Agency Name
2310B	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
2310B	NM109	Identification Code (Rendering Provider Identifier)		Provider Agency NPI
2310B	PRV01	Provider Code	PE	Performing
2310B	PRV02	Reference Identification Qualifier	PXC	PXC = Health Care Provider Taxonomy Code
2310B	PRV03	Reference Identification	251S00000X	Provider Taxonomy Code
Loop 2310C Service Facility Location Name				
2310C	NM101	Entity Identifier Code	77	Service Location
2310C	NM102	Entity Type Qualifier	2	Non-Person Entity
2310C	NM103	Organization Name (Facility Name)		Facility Name

Loop	Segment ID	Segment Name	Accepted value(s)	Comments
2310C	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier Required when the NPI is reported in 2310C NM109.
2310C	NM109	Identification Code (Facility Primary Identifier)		Facility NPI This segment is optional.
2310C	N301	Address Information (Facility Address Line)		Facility Address Line 1
2310C	N401	City Name (Facility City Name)		Facility City Name
2310C	N402	State or Province Code (Facility State Code)		Facility State Code
2310C	N403	Postal Code (Facility ZIP Code)		Facility ZIP Code
Loop 2320 Other Subscriber Information				
This loop should not be included. If the client has TPL, the claim must be handled in AL WITS rather than via the inbound 837P.				
Loop 2330A Other Payer Name				
This loop should not be included. If the client has TPL, the claim must be handled in AL WITS rather than via the inbound 837P.				
Loop 2330B Other Subscriber Name				
This loop should not be included. If the client has TPL, the claim must be handled in AL WITS rather than via the inbound 837P.				
Loop 2400 Service Line Number				
2400	LX01	Assigned Number		Only single line claims are accepted by AL WITS.
2400	SV101-1	Product/Service ID Qualifier (Product or Service ID Qualifier)	HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes. Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.
2400	SV101-2	Product/Service ID (Procedure Code)		Refer to the section "Procedure Codes and Modifiers" for additional instructions.
2400	SV101-3	Procedure Modifier 1		Refer to the section "Procedure Codes and Modifiers" for additional instructions.
2400	SV101-4	Procedure Modifier 2		Refer to the section "Procedure Codes and Modifiers" for additional instructions.
2400	SV101-5	Procedure Modifier 3		Refer to the section "Procedure Codes and Modifiers" for additional instructions.
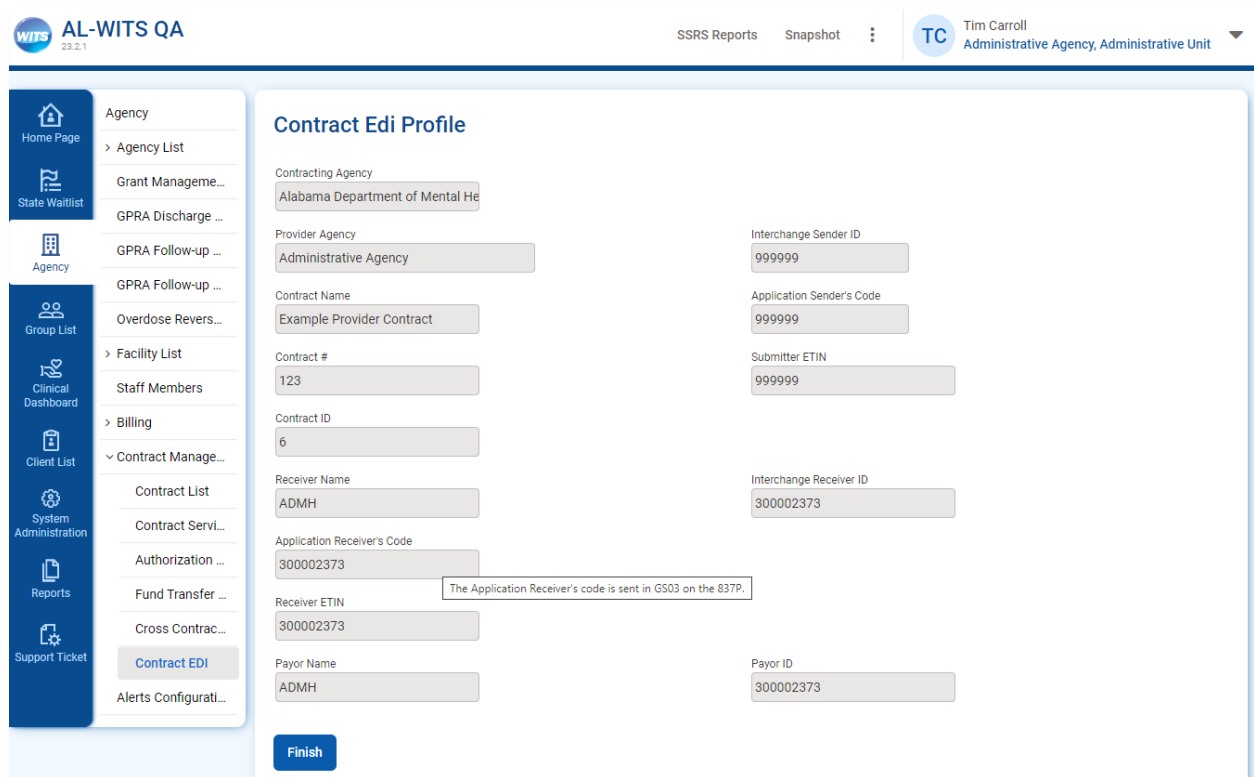
Loop	Segment ID	Segment Name	Accepted value(s)	Comments
2400	SV101-6	Procedure Modifier 4		Refer to the section "Procedure Codes and Modifiers" for additional instructions.
2400	SV102	Monetary Amount (Line Item Charge Amount)		
2400	SV103	Unit or Basis for Measurement Code	UN	Unit
2400	SV104	Quantity (Service Unit Count)		
2400	SV105	Facility Code Value (Place of Service Code)		Required when value is different than value in Loop 2300 CLM05-1. Refer to the section "Place of Service Codes" for additional instructions.
2400	SV107-1	Diagnosis Code Pointer 1		Primary diagnosis for this service line.
2400	SV107-2	Diagnosis Code Pointer 2		Additional diagnosis for this service line.
2400	SV107-3	Diagnosis Code Pointer 3		Additional diagnosis for this service line.
2400	SV107-4	Diagnosis Code Pointer 4		NOT USED AL WITS will ignore the fourth diagnosis pointer if used.
2400	DTP01	Date/Time Qualifier	472	Service
2400	DTP02	Date Time Period Format Qualifier	D8 RD8	D8 = Date Expressed in Format CCYYMMDD RD8 = Range of Dates Expressed in Format CCYYMMDDCCYYMMDD
2400	DTP03	Date Time Period (Service Date)		Service date or date range
2400	REF01	Reference Identification Qualifier	6R	6R = Provider Control Number
2400	REF02	Reference Identification		Line Item Control Number
Loop 2430 Line Adjudication Information				
The 837P should not include Loop 2430. If the client has TPL, the claim must be managed in AL WITS rather than via the inbound 837P.				
Transaction Set Trailer				
	SE01	Number of Included Segments		Transaction Segment Count Must match the number of segments within the transaction set, including the ST and SE segments
	SE02	Transaction Set Control Number		SE02 must match ST02

Loop	Segment ID	Segment Name	Accepted value(s)	Comments
Functional Group Trailer				
	GE01	Number of Transaction Sets Included	1	Only one transaction set is allowed.
	GE02	Group Control Number		GE02 must match GS06
Interchange Control Trailer				
	IEA01	Number of Included Functional Groups	1	Only one functional group is allowed.
	IEA02	Interchange Control Number		IEA02 must match ISA13

3.1.2. Sender, Submitter, Receiver, and Payor Names/IDs

ADMH assigns a provider sender/submitter ID to each provider. AL WITS displays these IDs along with the ADMH receiver/payor names and IDs.

Navigate to the Contract EDI screen under Agency/Contract Management to view contract-specific sender, receiver, and payor names/IDs for your provider agency. Hover-text displays the appropriate loop/segment as shown below:
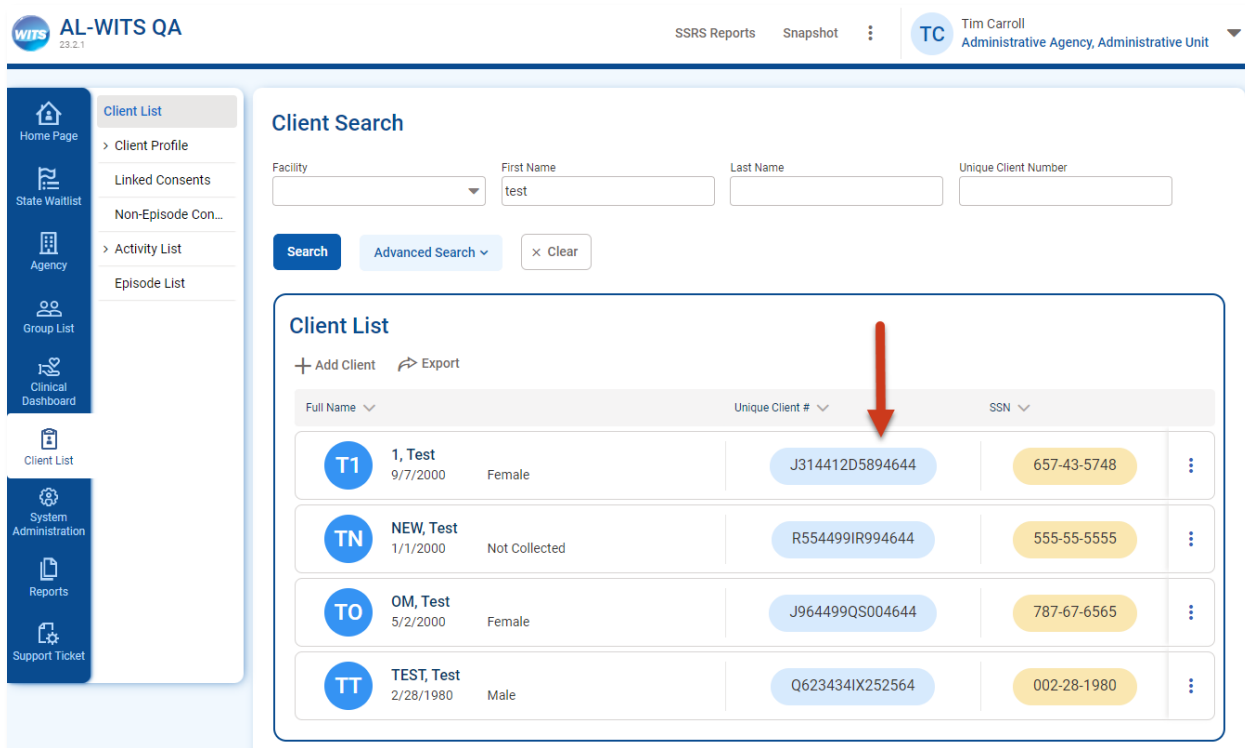
Figure 1: Sender, Receiver, and Payor Names/ID

3.1.3. Subscriber Number

The subscriber number is the AL WITS Unique Client Number (UCN). The UCN is found by navigating to the client list and searching for the client:

Figure 2: UCN on Client List

The UCN is also visible in the header on every client screen.

Figure 3: UCN in Client Header

3.1.4. Claim Frequency Codes

3.1.4.1. Original Claims

Use claim frequency code 1 for original claims.

Table 5: Claim Frequency Code 1: Original Claim

Code	Description	ADMH Action
1	Original Claim	ADMH will adjudicate the claim to pay or deny based on the published schedule.

Example Loop 2300 CLM segment:

```
CLM*ABC1234*25***11:B:1*Y*A*Y*Y~
```

3.1.4.2. Replacement Claims

Use claim frequency code 7 to replace a claim that has been adjudicated (paid/denied) by ADMH or Medicaid. Claims are replaced to make corrections to the original claim. Examples include:

- Billing units
- Procedure
- Modifier(s)
- Place of service
- Diagnosis
- Service date

If the original claim was billed for the wrong client/subscriber, the original claim must be voided and a new original claim should be billed under the correct client/subscriber.

Table 6: Claim Frequency Code 7: Replacement Claim

Code	Description/Instructions	ADMH Action
7	Replacement Claim This code is used to replace a claim that has been adjudicated (paid/denied) by ADMH or Medicaid. Include the Payer Claim Control Number from the 835: Loop 2100, CLP07	ADMH will adjudicate the claim and add or subtract payment as indicated.

Example Loop 2300 CLM and REF segments:

```
CLM*ABC1234*25***11:B:7*Y*A*Y*Y~

REF*F8*99999~
```

3.1.4.3. Void Claims

Use claim frequency code 8 to void a claim that has been adjudicated (paid/denied) by ADMH or Medicaid. Example reasons to void a claim:

- Client was ineligible to receive service
- Client did not receive the service
- Clinical documentation was insufficient to support billing

Table 7: Claim Frequency Code 8: Void Claim

Code	Description/Instructions	ADMH Action
8	Void Claim This code is used to void a claim that has been adjudicated (paid/denied) by ADMH or Medicaid. Include the Payer Claim Control Number from the 835: Loop 2100, CLP07	ADMH will adjudicate the claim and subtract payment as indicated.

Example Loop 2300 CLM and REF segments:

```
CLM*ABC1234*25***11:B:8*Y*A*Y*Y~

REF*F8*99999~
```

3.1.5. File Naming Convention

- 837P file names may be any combination of letters, numbers, and the underscore (_). An error message is displayed when any other special character is used in the file name.
- Files must use a .DAT or .TXT extension.
- Each file name must be unique.

4. WITS INSTRUCTIONS

4.1. Upload 837P

Individual 837P files may be uploaded on the H837 Management screen.

1. Navigate to the H837 Management screen under Agency/Billing and select "Add H837" from the list header.
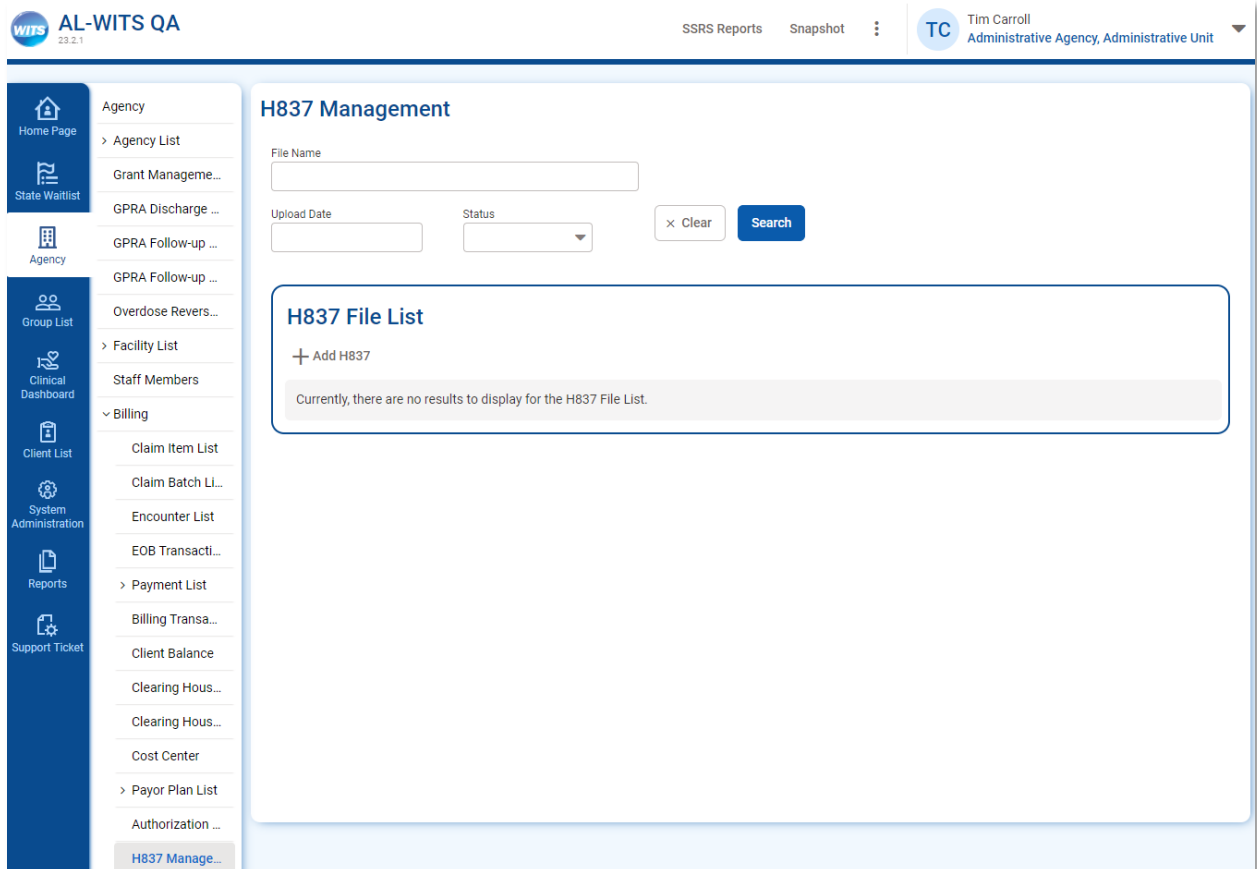
Figure 4: H837 Management Screen

2. Click the "Choose File" button, select the file, and click the "Upload" button.
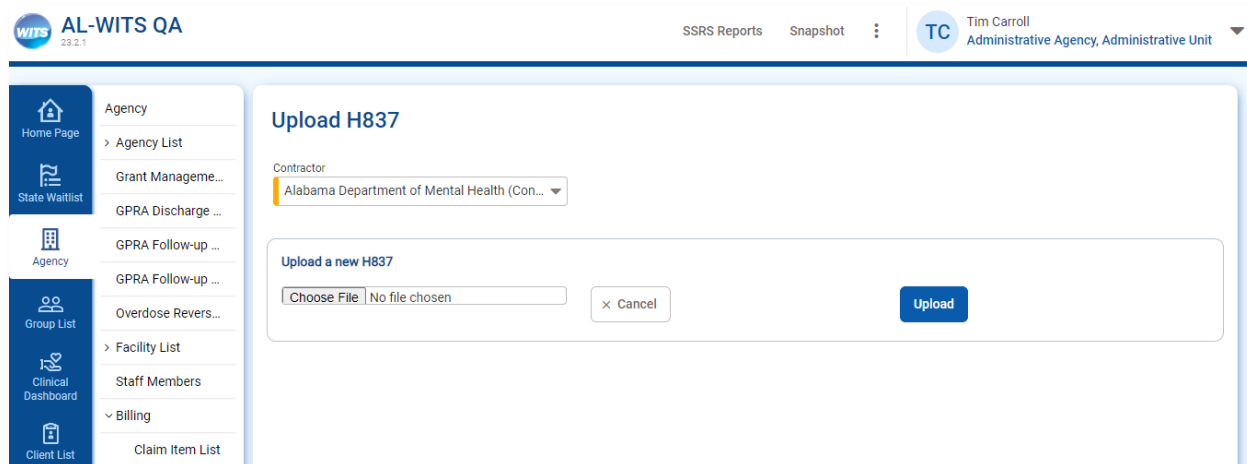
Figure 5: H837 Management Screen- Upload

3. An information message is returned at the top of the screen for successfully uploaded files. The file is initially queued for processing (Status = "Queued").
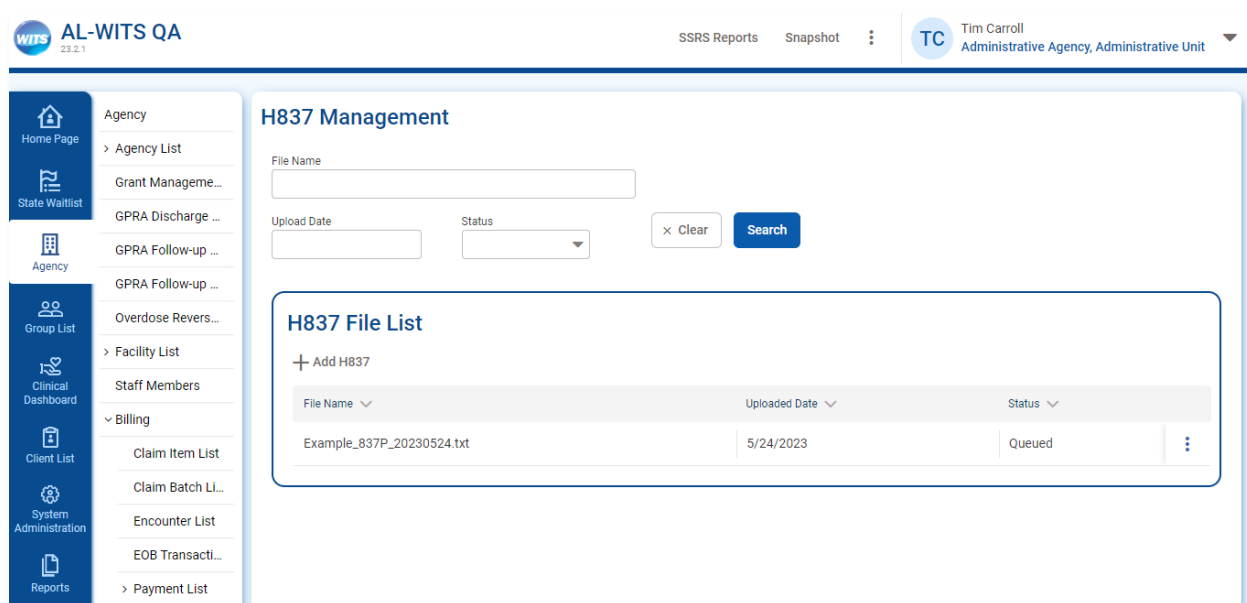
Figure 6: H837 Management Screen- Successful Upload

4. Once processed, the file status changes to "Processed" or "Failed." Failed 837P transactions must be resubmitted by the provider agency. No action is necessary for processed 837P transactions.
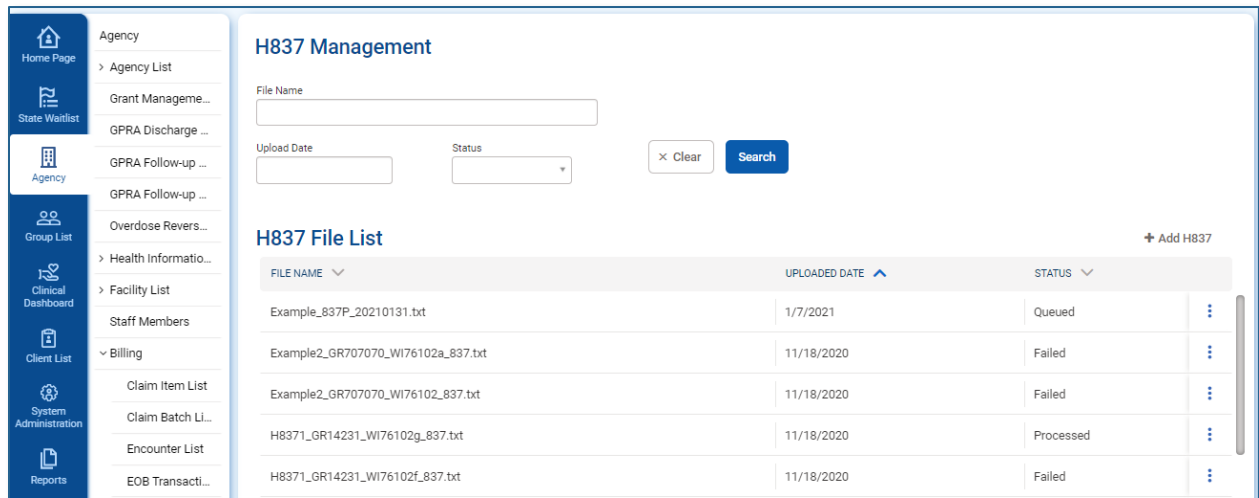
Figure 7: H837 Management Screen- List

AL WITS validates 837P files for syntax and EDI requirements.

- An accepted 999 is generated for accepted 837P files.
- A rejected 999 is generated for rejected 837P files. Providers must make corrections and resubmit rejected 837P transactions. The H837P Profile displays errors for rejected files.
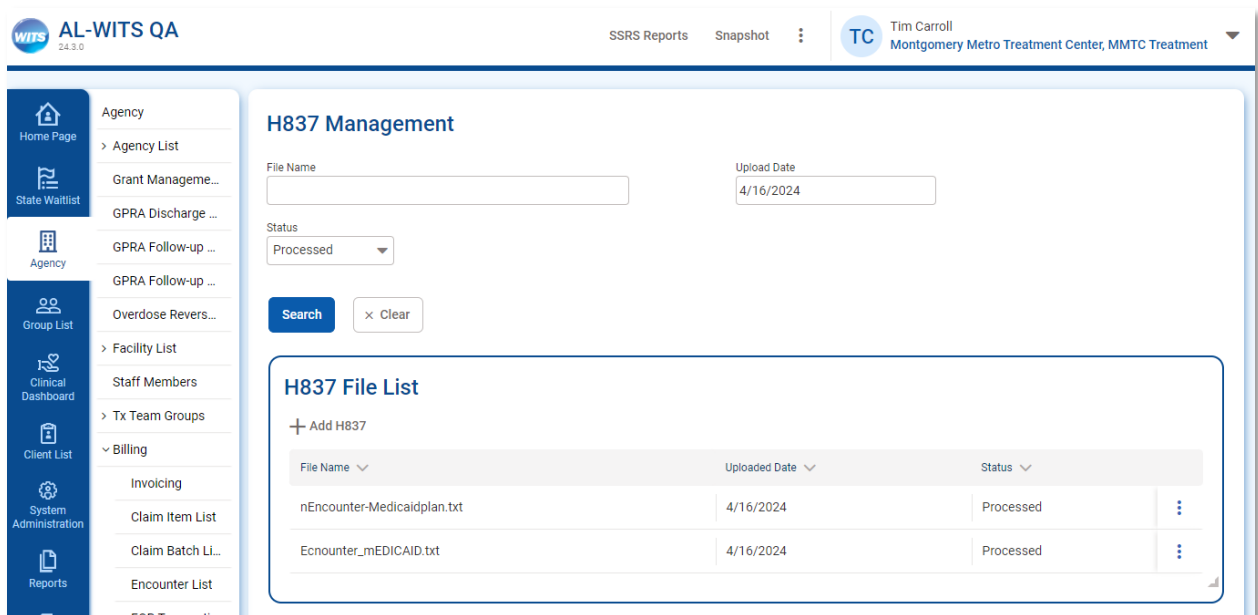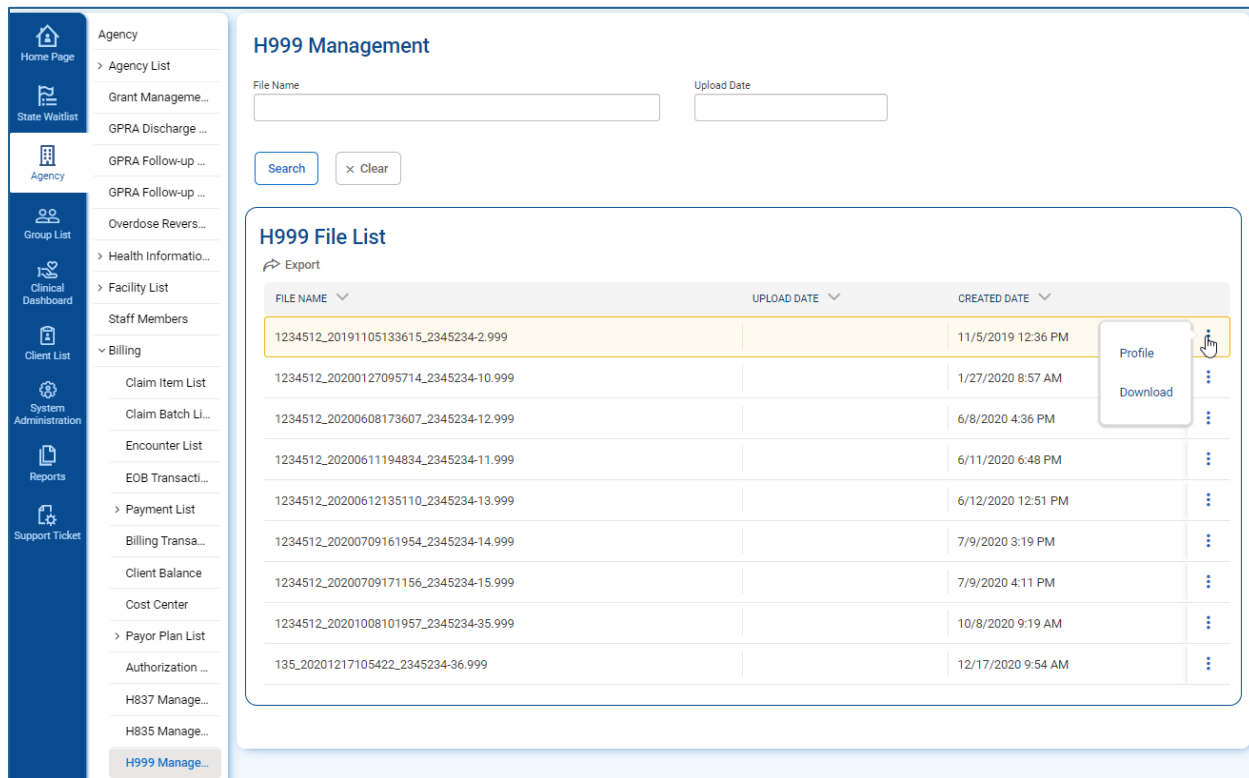
Figure 8: H837 Management Screen, Processed Status

4.2. Download 999

The 999 is returned for all 837P transactions that were successfully processed. Contact ADMH if a 999 is not available for download within the expected timeframe.

Note that a 999 is not returned for failed submissions. Refer to the 837P File-Level Errors section for additional information.

1. Navigate to the H999 Management screen under Agency/Billing.
2. Select "Download" from the Action column to download the 999.
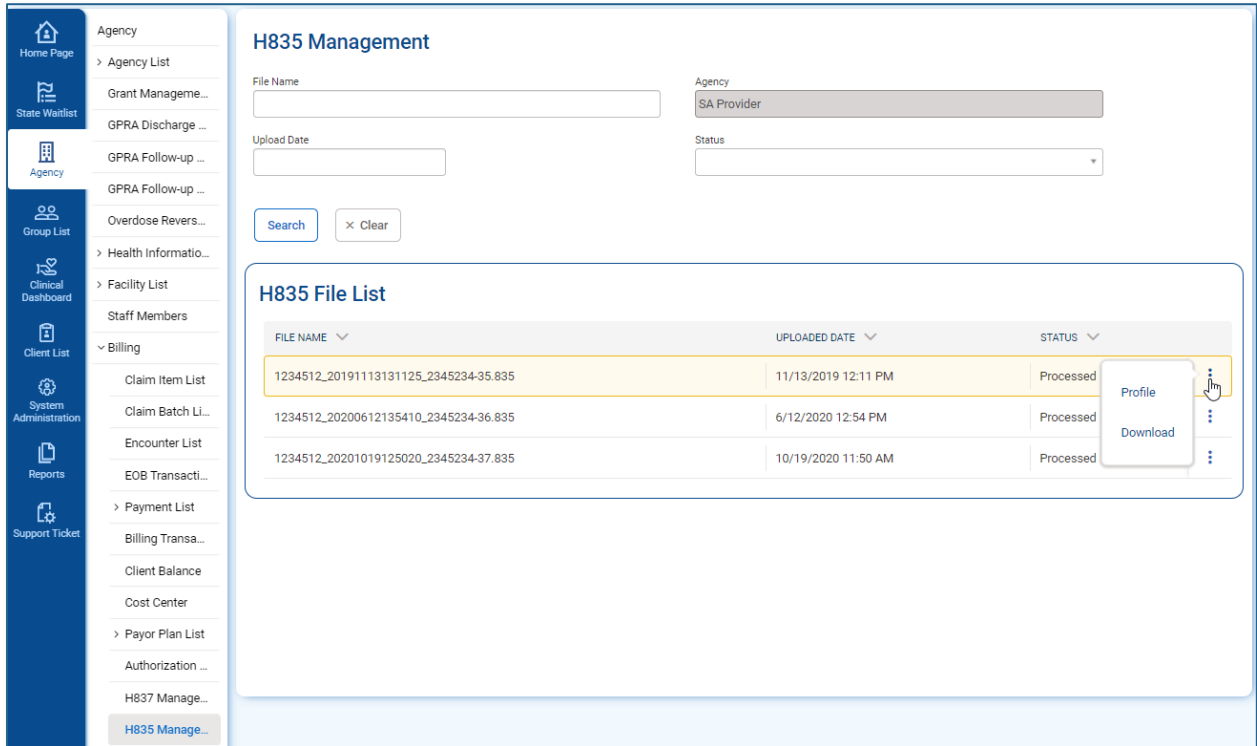
Figure 9: H999 Management Screen

4.3. Download 835

The 835 is available for download once claims are adjudicated by ADMH. Contact ADMH if an 835 is not available for download within the expected timeframe.

1. Navigate to the H835 Management screen under Agency/Billing.
2. Select "Download" from the Action column to download the 835.

Figure 10: H835 Management Screen

5. SFTP INSTRUCTIONS

SFTP credentials are assigned to each agency. 837P files are dropped in the billing folder as described below. This can be a manual process, or it may be automated by the provider's vendor.

1. Login to the SFTP site: Wing FTP Server - Web Client (feisystems.com)

Figure 11: SFTP Login screen

2. Providers have access to two environment folders, Production and UAT (testing).
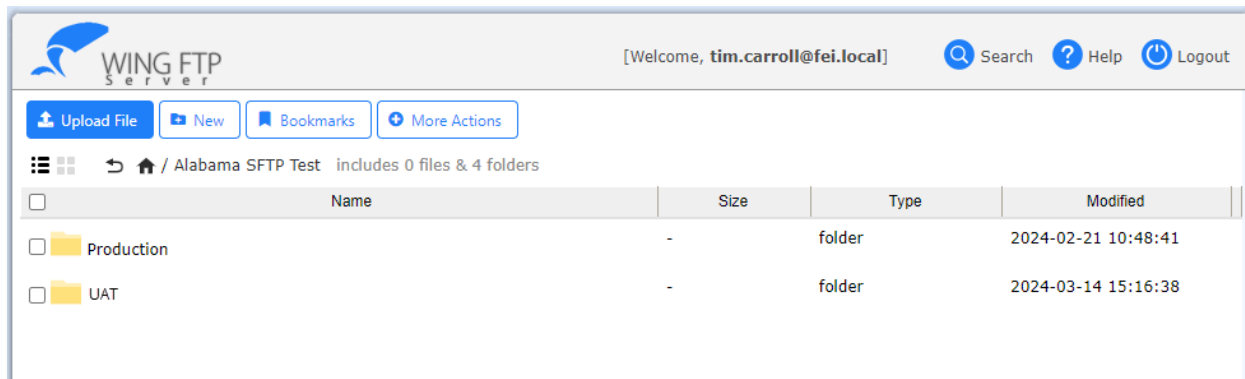Open the appropriate environment folder.

Figure 12: Environment folders: Production and UAT

3. Inside the environment folder, providers have access to their agency folder, designated by the AL WITS Agency ID. Providers cannot access other agency folders.
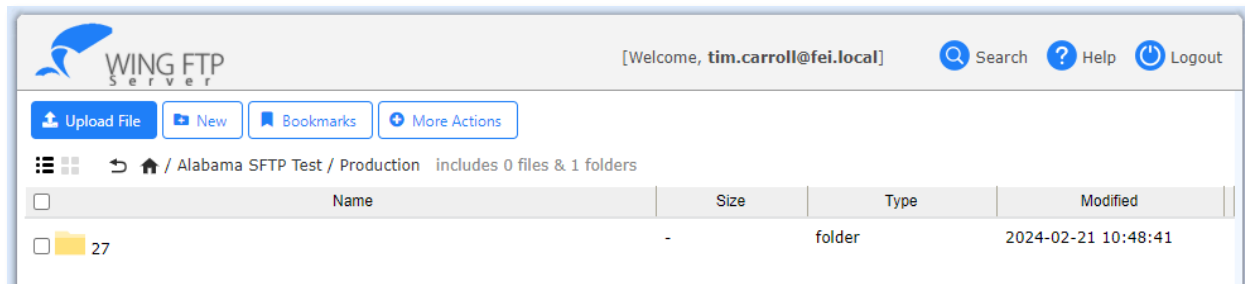Open the agency folder.

Figure 13: Agency folder

4. Inside the agency folder, providers have access to the Billing and/or Clinical Folder.
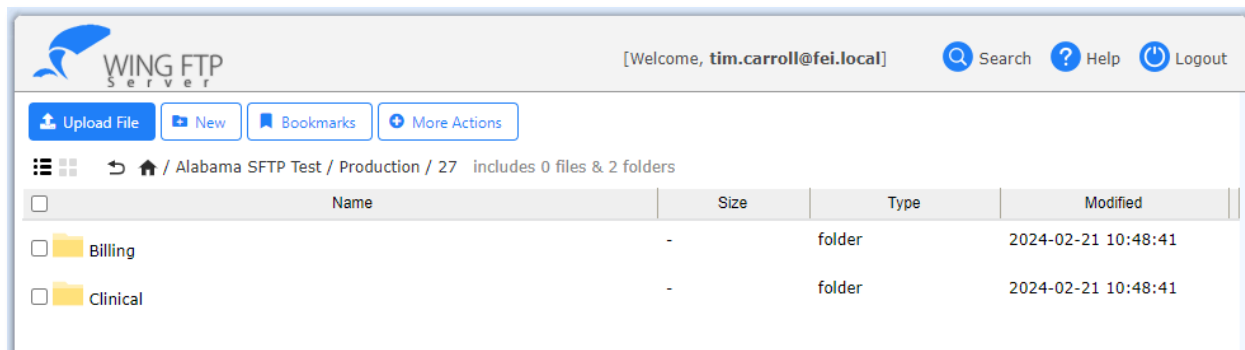Open the Billing folder.

Figure 14: Billing and Clinical folders

5. Inside the Billing folder, providers have access to the In, Out, and Archive folders.
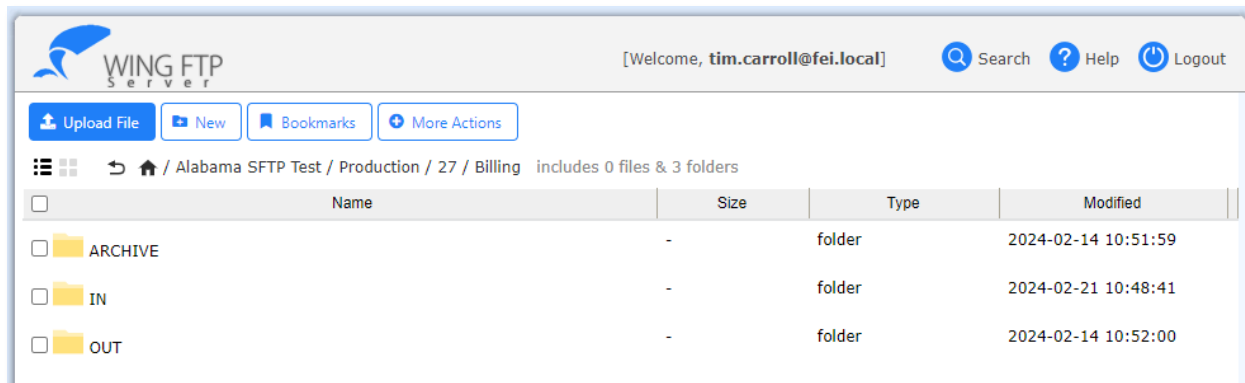

Figure 15: In, Out, and Archive folders

5.1. Upload 837P

1. Open the In folder to upload 837P files. Files uploaded to the Out or Archive folders will be ignored. Click the Upload File button, then Choose Files. Drag and drop files or select them manually by clicking the Choose Files button.
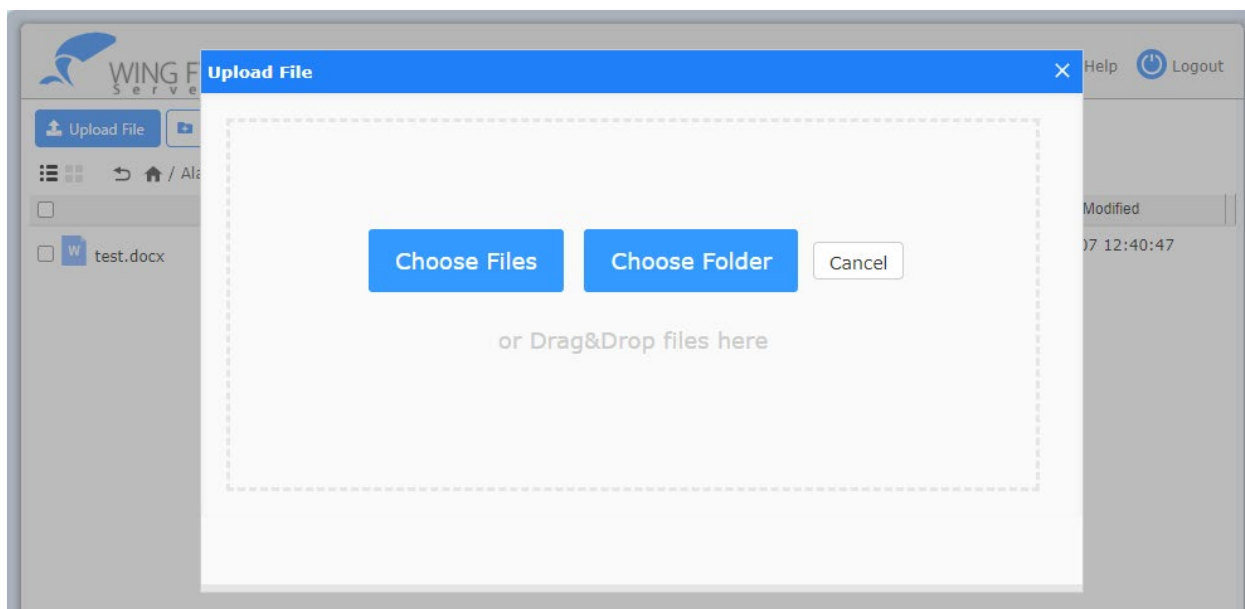

Figure 16: Upload files

Files that meet the naming convention are processed and moved to the Archive folder.

5.2. Download 999

The provider agency receives an email when the 837P file is accepted. The 999 files may be downloaded from the Out folder. The 999 is returned for all 837P transactions that were successfully processed. Contact ADMH if a 999 is not available for download within the expected timeframe.

Note that a 999 is not returned for failed submissions. Refer to the 837P File-Level Errors section for additional information.
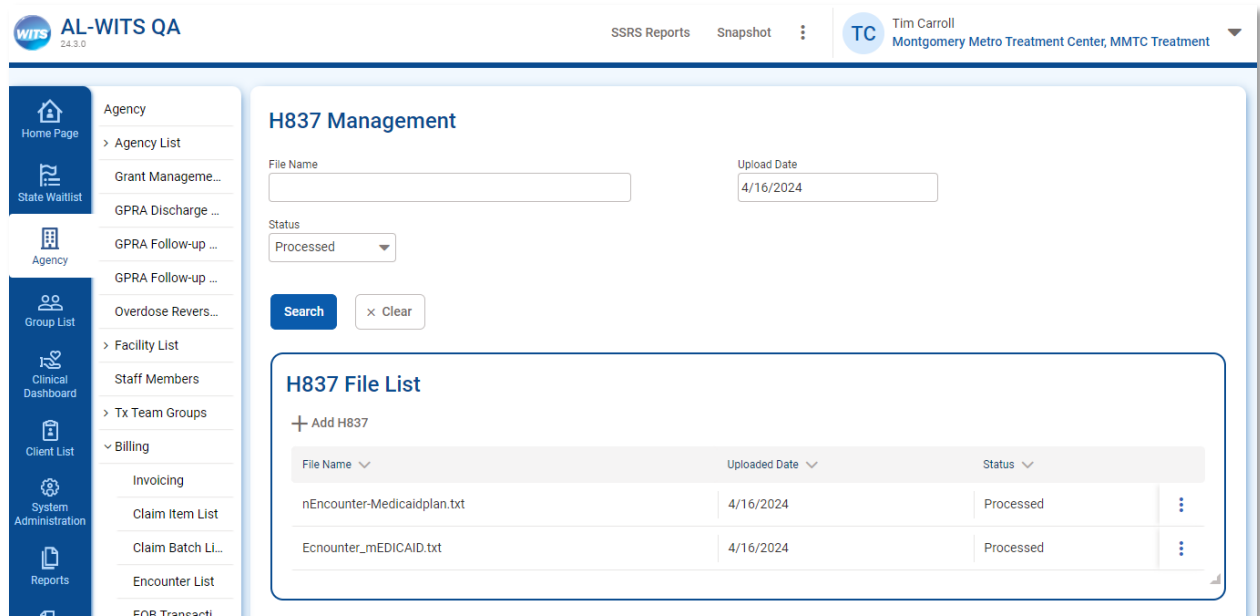
Additionally, 999 files may be viewed and downloaded in the application. Follow the instructions in Section 4.2 to download the 999 from AL WITS.

5.3. Download 835

Claims are adjudicated on a schedule defined by ADMH. The 835 is generated and made available in the Out folder. Contact ADMH if the expected 835 is not available for download within the expected timeframe.

Additionally, 835 files may be viewed and downloaded in the application. Follow the instructions in Section 4.3 to download the 835 from AL WITS.

Processed 837P files may be viewed on the H837 Management screen. Navigate to the H837 Management screen under Agency/Billing and search for the file by file name, upload date, and/or status:

Figure 17: H837 Management Screen, Processed Status

6. ERRORS
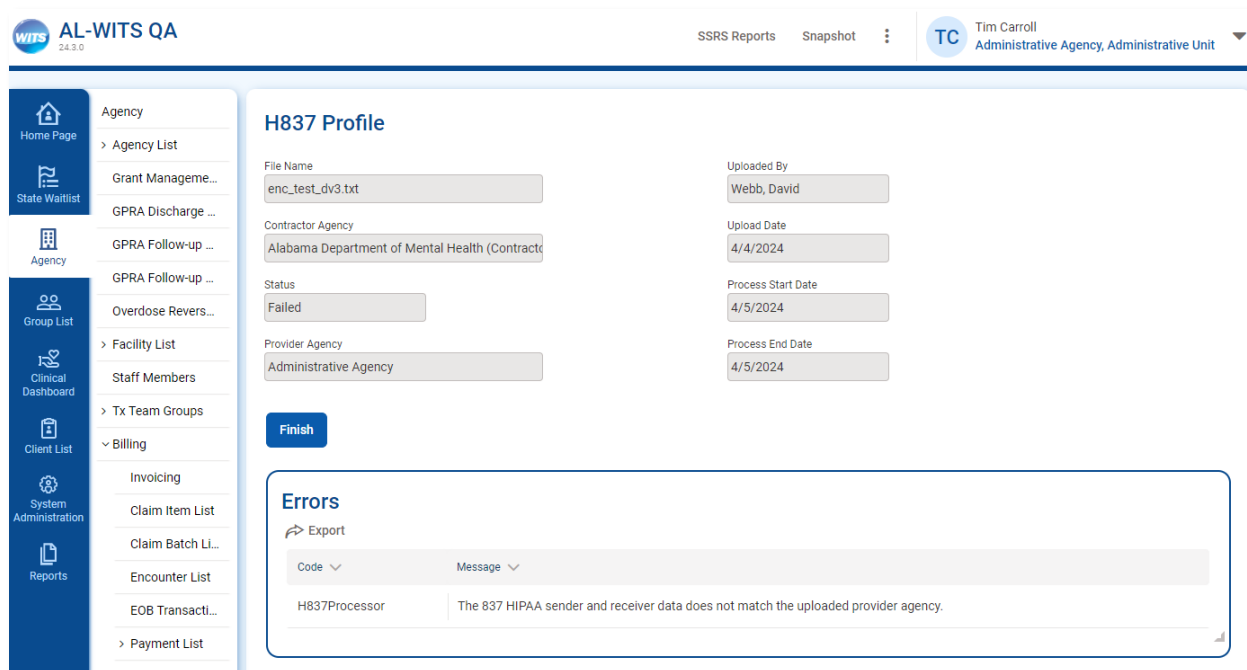
After processing the 837P file, AL WITS may return file-level or claim-level errors. Navigate to the H837 Management screen under Agency/Billing to review any errors.

6.1. 837P File-Level Errors

If the 837P contains invalid sender/receiver information or syntax errors, the entire file fails during processing. The 837P file status will be "Failed." The H837 Profile Error List displays the applicable file-level error messages.

All claims must be resubmitted when the submission fails. Provider agencies should notify ADMH if they continue to receive a file-level error after making necessary corrections.

See Appendix B for a full list of file-level error messages and resolutions.

Figure 18: Example file-level error on the H837 Management Profile

6.2. 837P Claim-Level Errors/Rejections

Once the 837P file passes file-level validation, each claim is validated. If a claim contains invalid information, the claim will fail during processing, and the 837P file status will be "Processed with Errors." 837P files may have multiple rejected claims, and the H837 Profile Error List displays all claim-level error messages.

AL WITS may reject claims when the client or other records are missing, or when codes are used that do not match valid codes. Errors are self-explanatory. Examples include:

- The client does not exist in the provider agency.
- The client does not have an Intake, Assessment, Outcome Measure, or Program Enrollment in the provider agency.
- The claim service line procedure/modifiers do not match a valid service in WITS.
- The claim diagnosis does not match a valid ICD-10 diagnosis in WITS.

The error code displayed on the H837 Profile Error List indicates the Loop, Segment, and Claim ID. The message indicates the type of error encountered.

Code ⌄	Message ⌄
H837Processor_2300CLM01_1001002	The Subscriber ID populated in 2010BA*NM109 is invalid or does not match a WITS UCN.

Figure 19: Example Claim Error Code and Message

The Code column in the figure above indicates the Loop, Segment/Element, and Claim ID. In this case, Loop 2300 CLM01 = 1001002.

Rejected claims must be resubmitted. Provider agencies should notify ADMH if they continue to receive a claim-level error after making necessary corrections.

See Appendix C for a full list of claim-level error messages and resolutions.

Figure 20: Example claim-level errors on the H837 Management Profile

FEI Systems

Appendix A: Example 837P

Note: Do not include line breaks in submitted 837P files. This example is shown with line breaks for legibility.

```
ISA*00*                 *00*                 *ZZ*99999999       *ZZ*300002373
*201231*1200*^*00501*201309197*0*T*:~
GS*HC*99999999*300002373*20210401*1200*201309197*X*005010X222A1~
ST*837*000013*005010X222A1~
BHT*0019*00*8899890*20210401*1200*CH~
NM1*41*2*Example Provider*****46*99999999~
PER*IC*Contact Name*TE*5551112222~
NM1*40*2*DMHMR*****46*300002373~
HL*1**20*1~
NM1*85*2*Example Provider*****XX*9999999999~
N3*123 45th St~
N4*Oxford*AL*362030000~
REF*EI*555555555~
HL*2*1*22*0~
SBR*P*18*******11~
NM1*IL*1*Client*Example****MI*01234567890123456789~
N3*1234 5th St~
N4*Oxford*IA*36203~
DMG*D8*19950905*F~
NM1*PR*2*ADMH*****PI*630506021~
N3*100 North Union St~
N4*Montgomery*AL*36130~
CLM*ABC1234*25***11:B:1*Y*A*Y*Y~
REF*EA*A1B2C3D~
HI*ABK:F111*ABF:F10151~
NM1*82*2*Example Provider*****XX*9999999999~
PRV*PE*PXC*251S00000X
NM1*77*2*Example Facility*****XX*9999999999~
N3*321 E 12th St~
N4*Oxford*AL*36203~
LX*1~
SV1*HC:H0007*25*UN*1***1:2~
DTP*472*RD8*20210301-20210301~
REF*6R*1234~
SE*31*000013~
GE*1*201309197~
IEA*1*201309197~
```

Appendix B: 837P File-Level Error Messages

Provider Note: 837P files that are rejected for the following reasons must be corrected and resubmitted. Contact ADMH if you continue to receive the error message after making corrections.

ADMH Note: Contact FEI Systems if the provider continues to receive the same error after resubmitting the corrected file. and the suggested steps in the ADMH Resolution column have been tried.

Error Message	Explanation	Provider Resolution	ADMH Resolution
A connection attempt failed because the connected party did not properly respond after a period of time, or established connection failed because connected host has failed to respond.	The 837P transaction could not be uploaded. The most common cause is a network issue.	Verify the network connection is stable and retry.	Notify FEI if the problem persists.
A Contract Auth Period for Contract ID = # effective on MM/DD/YYYY could not be found.	A claim was billed outside a contract period (state fiscal year). This means a contract authorization period does not exist for the provider for the claim service date. Note: The error message will contain the Contract ID instead of "#" and the reported date instead of "MM/DD/YYYY".	Verify the claim service date and update if necessary.	Verify a contract authorization period is applied to the provider contract that covers the claim service date.
ERROR: The Rendering Provider Loop and/or Service Facility Location Loop are missing at both the claim level and service level for claim #.	The Rendering Provider was not reported in Loops 2310B or 2420A OR The Service Facility was not reported in Loops 2310C or 2420C.	Include the rendering provider and service facility loops on the 837 and resubmit.	
Failed to find segment 'ABC' before end of file.	A required segment "ABC" was not found in the 837P. Note: The error message	Update the 837P to include the specified segment and resubmit.	

Error Message	Explanation	Provider Resolution	ADMH Resolution
	will contain the expected segment instead of "ABC".		
Illegal value encountered ('#') in segment 'CLM' at element position '5', composite position '3'. Legal value(s): , '1', '7', '8'.	A Claim Frequency Code "#" was reported in Loop 2300 CLM05-3. Accepted values are 1, 7, and 8. Note: The error message will contain the reported value instead of "#".	Update the 837P and resubmit.	
Illegal value in segment 'GS' at element position '3'. Only legal value is '§' but encountered '#'.	An Application Receiver's Code "#" was reported in GS03. Only code "§" is accepted. Note: The error message will contain the reported value instead of "#" and the accepted value instead of "§".	Update the 837P and resubmit.	
Illegal/unexpected value encountered ('#') in segment 'ISA' at element position '7'. Legal value(s): , 'ZZ'.	An Interchange ID Qualifier "#" was reported in ISA07. Only "ZZ" is accepted. Note: The error message will contain the reported value instead of "#".	Update the 837P and resubmit.	
Illegal/unexpected value encountered ('#') in segment 'NM1' at element position '1'. Legal value(s): , '82'.	An Entity Identifier Code "#" was reported in Loop 2310B NM101 or Loop 2420A NM101. Only "82" is accepted.	Update the 837P and resubmit.	
Illegal/unexpected value encountered ('|') in segment 'ISA' at element position '16'. Legal	A Component Element Separator "|" was reported in ISA16. Only ":" is accepted.	Update the 837P and resubmit.	

Error Message	Explanation	Provider Resolution	ADMH Resolution
value(s): , ':'.	Note: The error will contain the delimiter reported in ISA16.		
Illegal/unexpected value encountered ('1') in segment 'NM1' at element position '2'. Legal value(s): , '2'.	An Entity Type Qualifier "#" was reported in one of the following segments: Loop 2010AA NM102, Loop 2310C NM102, or Loop 2420C NM102. Only "2" is accepted. Note: The error message will contain the reported value instead of "#".	Update the 837P and resubmit.	
Illegal/unexpected value encountered ('82') in segment 'NM1' at element position '1'. Legal value(s): , '77'.	An Entity Identifier Code "#" was reported in Loop 2310C NM101 or Loop 2420C NM101. Only "77" is accepted.	Update the 837P and resubmit.	
Illegal/unexpected value encountered (''X'') in segment 'NM1' at element position '8'. Legal value(s): , 'XX'.	An Identification Code Qualifier "A" was reported in Loop 2010AA NM108, Loop 2310B NM108, Loop 2310C NM108, Loop 2420A NM108, or Loop 2420C NM108. Only "XX" is accepted. Note: The error message will contain the reported value instead of "X".	Update the 837P and resubmit.	
Illegal/unexpected value encountered ('X') in segment 'SBR' at element position '9'. Legal value(s): , '11'.	A Claim Filing Indicator Code "X" was reported in Loop 2320 SBR09. Only "11" is accepted. Note: The error message will contain the reported value instead of "X".	Update the 837P and resubmit.	

Error Message	Explanation	Provider Resolution	ADMH Resolution
Index was outside the bounds of the array.	This error message typically occurs when an incorrect element delimiter is used.	Update the 837P and resubmit.	Notify FEI if the problem persists.
ISA08 does not match the contractor agency's Interchange Receiver ID.	This error message occurs when there is no match between ISA08 and the Interchange Receiver Number on the contractor agency profile.	Verify the 837 Interchange Receiver Number matches the number on the Contract EDI screen on the Agency/Contract Management menu. Update the 837P and resubmit.	
Invalid zipcode ##### in segment N4 at element position 3.	The indicated zip code has the wrong number of digits. Typically, this happens when 9 digits are expected and only 5 are reported. Check all occurrences of N403.	Update the 837P and resubmit.	
Length cannot be less than zero. Parameter name: length	This error message typically occurs when an incorrect element delimiter is used. The error may occur when the ISA segment delimiter is * rather than the expected|. It may also occur when the 837P contains manual line breaks.	Update the 837P and resubmit.	
Neither the Service Start Date nor Service End Date can be greater than the transaction set created date.	The reported service date is after the 837P date.	Update the 837P and resubmit.	
Object reference not set to an instance of an object.	This error requires investigation.		Notify FEI if the problem persists.

Error Message	Explanation	Provider Resolution	ADMH Resolution
The 837 HIPAA sender and/or receiver data does not find any valid record in uploaded contractor agency.	The sender and/or receiver data cannot be matched to a WITS contract. Verify the following segments match what is shown on the Agreement EDI screen: ISA06, Interchange Sender ID ISA08, Interchange Receiver ID GS02, Application Sender's Code GS03, Application Receiver's Code Loop 1000A NM109, Submitter ETIN Loop 1000B NM109, Receiver ETIN	Update the 837P and resubmit.	
The DateTime represented by the string is not supported in calendar System.Globalization.GregorianCalendar.	An invalid date was reported.	Verify that valid dates are submitted in all date fields. Update the 837P and resubmit.	
The given key was not present in the dictionary.	This message indicates a code table value is missing or expired.	Once updates are made, the provider agency should resubmit the 837P transaction.	ADMH should update code tables. Notify FEI if the problem persists.
The 'Other Payor' ID code (#) identified in a service line adjudication info does not correspond to any specified 'Other	The Other Payer Identification Code reported in Loop 2430 SVD01 does not match the Identification Code in	Update the 837P and resubmit.	

Error Message	Explanation	Provider Resolution	ADMH Resolution
Payor'.	Loop 2330B NM109. Note: The error message will contain the reported value instead of "#".		
The Patient Detail loop is Not Supported. Claim Information must fall under the Subscriber.	Loop 2010CA should not be reported.	Update the 837P and resubmit.	
The Service Start Date cannot be greater than the transaction set created date.	This message should be self-explanatory.	Update the 837P and resubmit.	
The Total Claim Charge Amount for claim #1, indicated at segment 'CLM' position '2' of $### does not match the total of all service line charges, $###.	The sum of service line charges does not match the claim line monetary amount.	Update the 837P and resubmit.	
This 837 file is not valid. Multiple Provider loops are present but a valid file may contain only one.	Only one Billing Provider Hierarchical Level, Loop 2000A is accepted.	Update the 837P and resubmit.	
Timeout expired. The timeout period elapsed prior to completion of the operation or the server is not responding.	The 837P transaction could not be uploaded. The most common cause is a network issue.	Verify the network connection is stable and retry.	
Unexpected segment 'ABC'. Was expecting 'XYZ'.	This type of error message occurs when segments are reported out of order or an unexpected segment is reported. Note: The error message will contain the reported segments instead of "ABC" and the expected segment instead of "XYZ". Example: Unexpected	Update the 837P and resubmit.	

Error Message	Explanation	Provider Resolution	ADMH Resolution
	segment 'NM1'. Was expecting 'N3'.		
A connection attempt failed because the connected party did not properly respond after a period of time, or established connection failed because connected host has failed to respond	The 837P transaction could not be uploaded. The most common cause is a network issue.	Verify the network connection is stable and retry.	
A Contract Auth Period for Contract ID=# effective on MM/DD/YYYY could not be found.	An agreement authorization period does not exist in WITS for MM/DD/YYYY. Note: The error message will contain the Contract ID instead of "#" and the reported date instead of "MM/DD/YYYY".		Verify a provider contract and authorization period exists for the specified date.

Appendix C: Claim-Level Error Messages

Provider Note: Claims rejected for the following reasons must be corrected and resubmitted on a new 837P. Contact ADMH if you continue to receive the error message after making corrections.

ADMH Note: Contact FEI Systems if the provider continues to receive the same error after resubmitting the claim and the suggested steps in the ADMH Resolution column have been tried.

ADMH Error Message	Provider Resolution	ADMH Resolution
Gender code is invalid; must be 'F' or 'M'.	Resubmit the claim with 'F' or 'M' in Loop 2010BA DMG03.	
Multiple service lines for a single claim are not supported by WITS.	Each claim may have only one service line, Loop 2400. Resubmit as multiple claims with a single service line.	
The claim diagnosis does not match a valid ICD-10 diagnosis in WITS.	Verify each diagnosis in Loop 2300 HI must be an approved by ADMH for reimbursement.	If the provider continues to receive the error, verify the billed diagnosis is included in the diagnosis code table.
The claim service does not contain an approved service for the Program Enrollment.	Verify the procedure and modifiers in Loop 2400 SV101-2, SV101-3, SV101-4, SV101-5, and SV101-6 are valid for the client's LOC.	If the provider continues to receive the error, verify the service (both procedure and modifiers) is included in the modality approved services table for the client's LOC.
The client does not exist in the Provider Agency or does not have a Program Enrollment for the services billed.	Verify: • The subscriber number in Loop 2010BA NM109 matches a valid AL WITS UCN. • The client has a program enrollment record in AL WITS. • The procedure and modifiers in Loop 2400 SV101-2, SV101-3, SV101-4, SV101-5, and SV101-6 are valid for the client's LOC.	If the provider continues to receive the error, verify the service (both procedure and modifiers) is included in the modality approved services table for the client's LOC.
The client does not exist in the Provider Agency or does not have an Intake for the services billed.	Verify: • The subscriber number in Loop 2010BA NM109 matches a valid AL WITS UCN. • The client has an Intake record in AL WITS. • The client has a program enrollment record in AL WITS.	

ADMH Error Message	Provider Resolution	ADMH Resolution
The client does not exist in the Provider Agency or does not have an Assessment for the services billed.	Verify: • The subscriber number in Loop 2010BA NM109 matches a valid AL WITS UCN. • The client has an Intake record in AL WITS. • The client has a program enrollment record in AL WITS.	
The client does not exist in the Provider Agency or does not have an Outcome Measure for the services billed.	Verify: • The subscriber number in Loop 2010BA NM109 matches a valid AL WITS UCN. • The client has an Intake record in AL WITS. • The client has a program enrollment record in AL WITS.	
The client does not exist in the Provider Agency or does not have a Program Enrollment for the services billed.	Verify: • The subscriber number in Loop 2010BA NM109 matches a valid AL WITS UCN. • The client has an Intake record in AL WITS. • The client has a program enrollment record in AL WITS.	
The service billed does not match an active WITS service.	Verify the procedure and modifiers in Loop 2400 SV101-2, SV101-3, SV101-4, SV101-5, and SV101-6 are valid for the client's LOC.	
The Subscriber ID populated in 2010BA*NM109 is invalid or does not match a WITS UCN.	Verify the subscriber number in Loop 2010BA NM109 matches a valid AL WITS UCN.	