Nevada Medicaid

HIPAA Transaction
Standard Companion Guide

837 Health Care Claim/Encounter:

Professional Encounter (837P)

The information in this Companion Guide is valid to use for the certification/testing to transition to the modernized MMIS and upon implementation of the MMIS Modernization Project

February 6, 2025

Medicaid Management Information System (MMIS)

Department of Health and Human Services (DHHS)

Division of Health Care Financing and Policy (DHCFP)

Disclosure Statement

The following Nevada Medicaid companion guide is intended to serve as a companion document to the corresponding Accredited Standards Committee (ASC) X12N/005010X222 Health Care Claim Professional (837P), its related Addenda (005010X222A1), and its related Errata (005010X222E1). The companion guide further specifies the requirements to be used when preparing, submitting, receiving, and processing electronic health care administrative data. The companion guide supplements, but does not contradict, disagree, oppose, or otherwise modify the 005010X222 in a manner that will make its implementation by users to be out of compliance.

NOTE: Type 1 Technical Report Type 3 (TR3) Errata are substantive modifications, necessary to correct impediments to implementation and are identified with a letter "A" in the errata document identifier. Type 1 TR3 Errata were formerly known as Implementation Guide Addenda.

Type 2 TR3 Errata are typographical modifications and are identified with a letter "E" in the errata document identifier.

The information contained in this companion guide is subject to change. Electronic Data Interchange (EDI) submitters are advised to check the Nevada Medicaid EDI website at https://www.medicaid.nv.gov/providers/edi.aspx regularly for the latest updates.

Gainwell Technologies is the fiscal agent for Nevada Medicaid and is referred to as Nevada Medicaid throughout this document.

About DHCFP

The Nevada Department of Health and Human Services' Division of Health Care Financing and Policy (DHCFP) works in partnership with the Centers for Medicare & Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources. The medical programs are known as Medicaid and Nevada Check Up.

DHCFP website: Medicaid Services Manual, rates, policy updates, public notices: http://dhcfp.nv.gov.

Preface

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that Medicaid and all other health insurance payers in the United States comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services.

This companion guide to the 5010 ASC X12N TR3 documents and associated errata and addenda adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with Nevada Medicaid. Transmissions based on this companion guide, used in tandem with 005010 ASC X12 TR3 documents, are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 documents adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3 documents.

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1 Introduction

This section describes how TR3 Implementation Guides, also called 837P ASC X12N (version 005010X222), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that Nevada Medicaid has information additional to the TR3 Implementation Guide. That information can:

- Limit the repeat of loops, or segments
- Limit the length of a simple data element
- Specify a sub-set of the implementation guide's internal code listings
- Clarify the use of loops, segments, composite and simple data elements
- Provide any other information tied directly to a loop, segment, and composite, or simple data element pertinent to trading electronically with Nevada Medicaid

In addition to the row for each segment (highlighted in blue in the tables), one or more additional rows are used to describe Nevada Medicaid's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column to provide additional information from Nevada Medicaid for specific segments provided by the TR3 Implementation Guide. The following is just an example of the type of information that would be spelled out or elaborated on in the Section 10: Transaction Specific Information.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10 percent and notes or comments about the segment itself go in this cell.
193	2100C	NM109	Subscriber Primary Identifier	00	15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Nevada Medicaid Management Information System (NVMMIS).
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						may say that value N6 is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
241	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 Scope

This section specifies the appropriate and recommended use of the companion guide.

This companion guide is intended for Trading Partner use in conjunction with the TR3 HIPAA 5010 837 Professional Implementation Guide for the purpose of submitting professional encounter claims electronically. This companion guide is not intended to replace the TR3 Implementation Guide. The TR3 defines the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of this companion guide is to provide Trading Partners with a companion guide to communicate Nevada Medicaid-specific information required to successfully exchange transactions electronically with Nevada Medicaid. The instructions in this companion guide are not intended to be stand-alone requirements. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

Nevada Medicaid will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain Nevada Medicaid encounter specific information, though processed, may be rejected. For example, a compliant 837 professional encounter claim (837P) created with an invalid Nevada Medicaid recipient identification number will be rejected by the Encounter Engine for recipient ID number not on file.

Refer to this companion guide first if there is a question about how Nevada Medicaid processes a HIPAA transaction.

1.2 Overview

This section specifies how to use the various sections of the document in combination with each other.

Nevada Medicaid created this companion guide for Nevada Trading Partners to supplement the X12N Implementation Guide. This guide contains Nevada Medicaid specific instructions related to the following:

- Data formats, content, codes, business rules and characteristics of the electronic transaction

- Technical requirements and transmission options
- Information on testing procedures that each Trading Partner must complete before transmitting electronic transactions

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist Trading Partners in implementing electronic 837 professional encounter claim (837P) transactions that meet Nevada Medicaid processing standards by identifying pertinent structural and data-related requirements and recommendations. Updates to this companion guide will occur periodically and new documents will be posted on the Nevada Medicaid EDI webpage at https://www.medicaid.nv.gov/providers/edi.aspx.

1.3 References

This section specifies additional useful reference documents, for example, the X12N Implementation Guides adopted under HIPAA to which this document is a companion.

The TR3 implementation guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The TR3 implementation guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their Trading Partners. It is critical that your IT staff or software vendor review this document in its entirety and follow the stated requirements to exchange HIPAA-compliant files with Nevada Medicaid.

The TR3 implementation guides for X12N and all other HIPAA standard transactions are available electronically at https://www.wpc-edi.com/.

1.4 Additional Information

The intended audience for this document is the technical and operational staff responsible for generating, receiving, and reviewing electronic health care transactions.

2 Getting Started

This section describes how to interact with Nevada Medicaid's EDI Help Desk.

The Nevada Medicaid EDI Help Desk can be contacted at (877) 638-3472 options 2, 0, and then 3, Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific Time, with the exception of Nevada State holidays. You can also send an email to nvmmis.edisupport@gainwelltechnologies.com.

2.1 Trading Partner Enrollment

This section describes how to enroll as an encounter Trading Partner with Nevada Medicaid.

In order to submit and/or receive transactions with Nevada Medicaid, Trading Partners must complete a Trading Partner Profile (TPP) agreement, establish connectivity and certify transactions.

- A Trading Partner is any entity (provider, billing service, clearinghouse, software vendor, etc.) that transmits electronic data to and receives electronic data from another entity. Nevada Medicaid requires all Trading Partners to complete a TPP agreement regardless of the Trading Partner type listed below
- Vendor is an entity that provides hardware, software and/or ongoing technical support for covered entities. In EDI, a vendor can be classified as a software vendor, billing or network service vendor or clearinghouse.
    - Software vendor is an entity that creates software used by billing services, clearinghouses and providers/suppliers to conduct the exchange of electronic transactions.
    - Billing service is a third party that prepares and/or submits claims for a provider.
    - Clearinghouse is a third party that submits and/or exchanges electronic transactions on behalf of a provider.

Establishing a Trading Partner Profile (TPP) agreement is a simple process which the Trading Partner completes using the Nevada Medicaid Provider Web Portal. The Provider Web Portal is located at: https://www.medicaid.nv.gov/hcp/provider.

Trading Partners must agree to the Nevada Medicaid Trading Partner Agreement at the end of the Trading Partner Profile enrollment process. Once the TPP application is completed, an 8-digit Trading Partner ID will be assigned.

After the TPP Agreement has been completed, the Trading Partner must submit a Secure Shell (SSH) public key file to Nevada Medicaid to complete their enrollment. Once the SSH key is received, users will be contacted to initiate the process to exchange the directory structure and authorization access on the Nevada Medicaid external SFTP servers.

Failure to provide the SSH key file to Nevada Medicaid will result in your TPP application request being rejected and you will be unable to submit transactions electronically to Nevada Medicaid. Please submit the SSH public key via email within five business days of completing the TPP application. Should you require additional assistance with information on SSH keys, please contact the Nevada EDI Help Desk at (877) 638-3472 options 2, 0, and then 3.

2.2 Certification and Testing Overview

This section provides a general overview of what to expect during certification and testing phases.

All Trading Partners who submit electronic transactions with Nevada Medicaid will be certified through the completion of Trading Partner testing. This includes Clearinghouses, Software Vendors, Provider Groups and Managed Care Organizations (MCOs).

Providers who use a billing agent, clearinghouse or software vendor will not need to test for those electronic transactions that their entity submits on their behalf.

3 Testing with Nevada Medicaid

This section contains a detailed description of the testing phase.

Testing is conducted to ensure compliance with HIPAA guidelines. Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. Refer to Appendix B for a list of SNIP Level 4 edits.

Testing data such as provider IDs and recipient IDs will not be provided. Users should submit recipient information and provider information as done for production as the test environment is continually updated with production information.

There is no limit to the number of files that may be submitted. Results of the system's processing of your transactions are reviewed and communicated back via email. Once the test file(s) passes EDI compliance, a production URL and Production Authorization letter will be sent confirming certification.

The following Encounter transactions are available for testing:

- 837D Encounter Dental Claim
- 837P Encounter Professional (CMS-1500) Claim
- 837P NET Encounter Professional (CMS-1500) Claim
- 837I Encounter Institutional (UB-04) Claim
- NCPDP Batch Transaction Standard Version 1.2 and Telecommunication Standard Version D.0

3.1 Testing Process

The following points are actions that a Trading Partner will need to take before submitting production files to Nevada Medicaid:

- Enroll by using the Trading Partner Enrollment Application on the Nevada Medicaid Provider Web Portal to obtain a new Trading Partner ID
- Register on the Nevada Medicaid Provider Web Portal (optional unless submitting files via the Web Portal)
- Receive EDI Trading Partner Welcome Letter indicating Trading Partner Profile (TPP) has been approved for testing
- Submit test files using SFTP until transaction sets pass compliance testing
- Receive Production Authorization letter containing the list of approved transactions that could be submitted to the production environment along with the connection information
- Upon completion of the testing process, you may begin submitting production files for all approved transactions via the Nevada Medicaid Provider Web Portal or SFTP

To begin the testing process, please review the Nevada Medicaid Trading Partner User Guide located at: https://www.medicaid.nv.gov/providers/edi.aspx.

3.2 File Naming Standard

Use the following naming standards when submitting encounter files to Nevada Medicaid:

- Trading Partner ID_Encounters_filetype_Environment_DateTime.dat or .txt

Examples are as follows:

- 01234567_ENCOUNTERS_837P_PROD_201808301140512.dat
- 01234567_ENCOUNTERS_837P_PROD_201808301140512.txt

The preferred extension is .dat; however, .txt is also allowed. Zip files (.zip) may also be submitted, but each zip file can contain only one encounter file, either .dat or .txt. Both the zip file and the encounter file it contains must meet the file naming standards.

If the file does not meet the file naming standard, the file will not be processed. In this instance, the Nevada Medicaid EDI Help Desk will notify the submitter of the issue and request correct and resubmittal. You will need to correct the file name and resubmit the file in order for it to process.

4 Connectivity with Nevada Medicaid / Communications

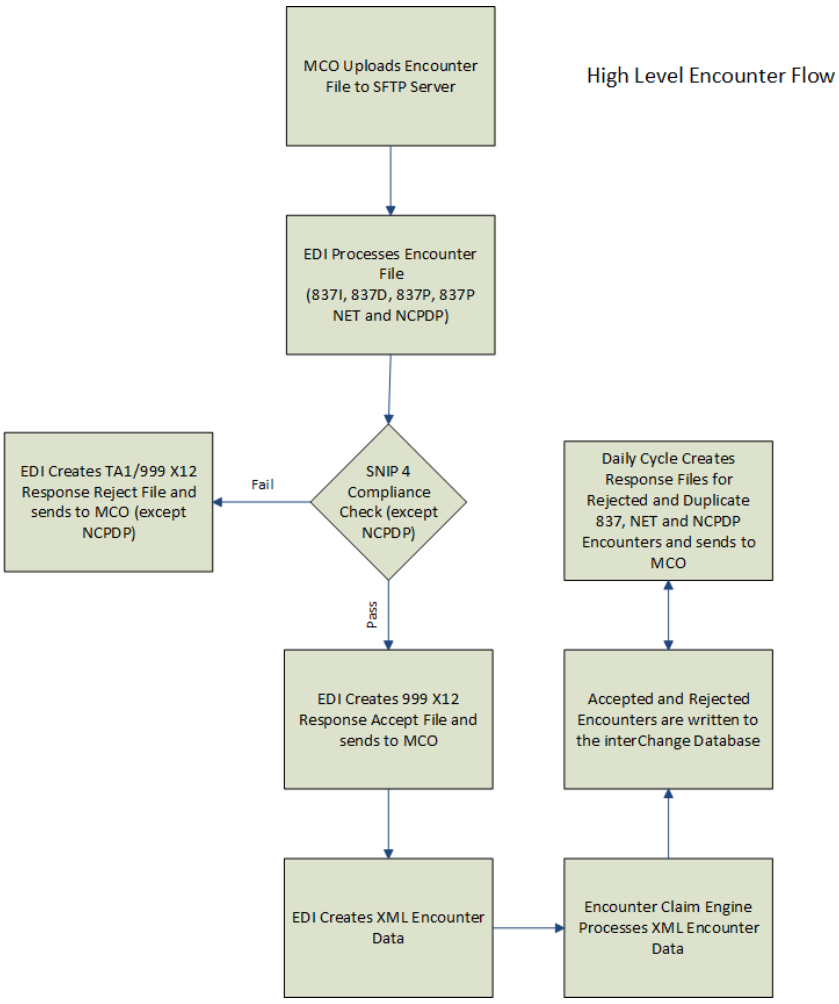
This section describes the process to submit HIPAA 837P Encounter transactions, along with submission methods, security requirements, and exception handling procedures.

Nevada Medicaid supports multiple methods for exchanging electronic healthcare transactions depending on the Trading Partner's needs. For HIPAA 837 Encounter transactions, the following can be used:

- Secure File Transfer Protocol (SFTP) (this only applies to batch transactions)
- The Nevada Medicaid Provider Web Portal (not recommended for Encounter claims due to the size limitations)

4.1 Process Flows

This section contains a process flow diagram and appropriate text.



4.2 Health Care Encounter Claim and Response

1. The Trading Partner submits a batch of encounter claims to the Nevada Medicaid SFTP server. The batch is then validated for EDI compliance.
2. EDI processes the batch which can result in a TA1 or 999.
    - A TA1 will be generated when errors occur within the outer envelope (no 999 will be generated).
    - A 999 will be generated if no errors occurred within the outer envelope.
3. When the batch successfully processes through EDI, the encounter claims are transformed into XML records and submitted to the interChange Encounter Claim engine for further validation and processing. At this stage, individual encounter claims are inspected and if necessary rejected and sent back to the submitter for correction. (When resubmitting a rejected encounter claim, the same MCO ICN/TCN must be used on the corrected encounter claim.) The submitter can expect two different response files as follows:
    - 837 Encounter Response File - Once the transaction is “Accepted” the transaction is translated and sent to the backend for processing. The encounter 837 response file will be generated once the translated file has processed. This response file will contain the status of each encounter claim within the file/batch. An encounter claim with no threshold edit errors will be accepted. Encounter claims can have both threshold and informational edits, but only the information pertaining to the threshold edit will need to be corrected and resubmitted for the encounter claim to be accepted. See the Acknowledgements and/or Reports section for further details on the 837 response file.
    - Encounter Claim Duplicate File - If an encounter claim within the batch is rejected due to a duplicate, then an Encounter Claim Duplicate file will also be generated. This file provides information on the current encounter claim that is being rejected and the related encounter claim in the Encounter Claim Engine. See the Acknowledgements and/or Reports section for further details on the Encounter Claim Duplicate file.

4.3 Transmission Administrative Procedures

This section provides Nevada Medicaid’s specific transmission administrative procedures.

For details about available Nevada Medicaid Access Methods, refer to the Communication Protocol Specifications section below.

Nevada Medicaid is only available to authorized users. The submitter/receiver must be a Nevada Medicaid Trading Partner. Each submitter/receiver is authenticated using the Username and private SSH key provided by the Trading Partner as part of the enrollment process.

4.4 System Availability

The system is typically available 24X7 with the exception of scheduled maintenance windows as noted on the Nevada Medicaid website at https://www.medicaid.nv.gov/.

4.5 Transmission File Size

The HIPAA TR3 Implementation Guide states on the CLM (Claim Information) segment it is recommended that Trading Partners limit the size of the transaction (ST/SE) envelope to be a maximum of 5,000 CLM segments. Nevada Medicaid follows the recommendation of the HIPAA TR3 Guide.

Transactions	Submission Method	File Size Limit	Other Conditions
837s	SFTP	300 MB	5,000 claims per transaction set
837s	Web Portal	4 MB	

4.6 Transmission Errors

When processing batch 837 transactions that have Interchange Header errors, a TA1 will be generated. If the Interchange Header is valid but the 837P Encounter transaction fails compliance a 999 will be generated. More information on each of these responses can be found in the Acknowledgements and/or Reports section below.

4.7 Re-transmission Procedure

Nevada Medicaid does not require any identification of a previous transmission of a file with the Note exception listed below. All files sent should be marked as original transmissions.

Nevada Medicaid does identify duplicate files based on content of the file before it reaches the MMIS system. The duplicate check algorithm only checks for file content. It does not check for filename or file size.

The submitter must correct and resubmit a disputed encounter file or claim within sixty (60) calendar days of receipt of rejection.

> Note: If the same file was resubmitted using SFTP and the data content is the same content of another file, this file will be detected as a duplicate file. The EDI Help Desk will contact the EDI contact listed on file to see if the file was meant to be reprocessed.

4.8 Communication Protocol Specifications

This section describes Nevada Medicaid's communication protocol(s).

- **Secure File Transfer Protocol (SFTP)**: Nevada Medicaid allows Trading Partners to connect to the Nevada Medicaid SFTP server using the SSH private key and assigned user name. There is no password for the connection.
- **Nevada Medicaid Provider Web Portal**: Nevada Medicaid allows Trading Partners to connect to the Nevada Medicaid Provider Web Portal. Refer to the Trading Partner User Guide for instructions.

4.9 Passwords

Trading Partners must adhere to Nevada Medicaid’s use of passwords. Trading Partners are responsible for managing their own data. Each Trading Partner must take all necessary precautions to ensure that they are safeguarding their information and sharing their data (e.g., granting access) only with users and entities who meet the required privacy standards. It is equally important that Trading Partners know who on their staff is linked to other providers or entities, in order to notify those entities whenever they remove access for that person in your organization(s).

5 Contact Information

Refer to this companion guide with questions and use the contact information below for questions not answered by this guide.

5.1 EDI Customer Service

This section contains detailed information concerning EDI Help Desk, especially contact numbers.

MCOs should send an email to nvmmis.edisupport@gainwelltechnologies.com with any encounter claims status inquiries or questions regarding how an encounter claim was processed. The email should contain enough information to research the question. The following is a list of information that would be helpful in answering most questions:

- Trading Partner ID
- Contact Name
- Contact Phone Number
- Question
- Encounter claim Identifying Information (TCN or Processor Control Number)
- Original File Name
- Response File Name
- Duplicate File Name

5.2 EDI Technical Assistance

This section contains detailed information concerning EDI Technical Assistance, especially contact numbers.

Nevada Medicaid EDI Help Desk can help with connectivity issues or transaction formatting issues at (877) 638-3472 options 2, 0, then 3, Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific Time, with the exception of Nevada State holidays.

The 8-digit Trading Partner ID is Nevada Medicaid's key to accessing Trading Partner information. Trading Partners should have this number available each time they contact the Nevada Medicaid EDI Help Desk.

For written correspondence:

Nevada Medicaid
PO Box 30042
Reno, Nevada 89520-3042

5.3 Customer Service/Provider Enrollment

This section contains information for contacting Customer Service and Provider Enrollment.

Customer Service should be contacted instead of the EDI Help Desk for questions regarding claim status information and provider enrollment.

Customer Service

- Phone: (877) 638-3472 (select option 2, option 0 and then option 2)
- Billing Manual can be found at: https://www.medicaid.nv.gov/Downloads/provider/NV_Billing_General.pdf

Provider Enrollment

- Phone: (877) 638-3472 (select option 2, option 0 and then option 5)
- E-mail: nv.providerapps@gainwelltechnologies.com (license updates and voluntary terminations only)
- Provider Enrollment Information Booklet can be found at: https://www.medicaid.nv.gov/Downloads/provider/NV_Provider_Enrollment_Information_Booklet.pdf

5.4 Applicable Websites/Email

This section contains detailed information about useful websites.

- Accredited Standards Committee (ASC X12): ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org.
- Accredited Standards Committee (ASC X12N): ASC X12N develops and maintains X12 EDI and XML standards, standards interpretations, and guidelines as they relate to all aspects of insurance and insurance-related business processes. www.x12.org.
- American Dental Association (ADA): Develops and maintains a standardized data set for use by dental organizations to transmit claims and encounter information. www.ada.org.
- American Hospital Association Central Office on ICD-10-CM/ICD-10-PCS (AHA): This site is a resource for the International Classifications of Diseases, 10th edition, Clinical Modification (ICD-10-CM) codes, used for reporting patient diagnoses and (ICD-10-PCS) for reporting hospital inpatient procedures. www.ahacentraloffice.org.
- American Medical Association (AMA): This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org.
- Centers for Medicare & Medicaid Services (CMS): CMS is the unit within HHS that administers the Medicare and Medicaid programs. Information related to the Medicaid HIPAA Administrative Simplification provision, along with the Electronic Health-Care Transactions and Code Sets, can be found at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA.

  This site is the resource for information related to the Health-Care Common Procedure Coding System (HCPCS). https://www.cms.gov/search/cms?keys=HCPCS+Release+Code+Sets.
- Committee on Operating Rules for Information Exchange (CORE): A multi-phase initiative of Council for Affordable Quality Healthcare, CORE is a committee of more than 100 industry leaders who help create and promulgate a set of voluntary business rules focused on improving physician and hospital access to electronic patient insurance information at or before the time of care. www.caqh.org/CORE_overview.php.
- Council for Affordable Quality Healthcare (CAQH): A nonprofit alliance of health plans and trade

associations, working to simplify healthcare administration through industry collaboration on public-private initiatives. Through two initiatives – the Committee on Operating Rules for Information Exchange and Universal Provider Datasource, CAQH aims to reduce administrative burden for providers and health plans. www.caqh.org.

- Designated Standard Maintenance Organizations (DSMO): This site is a resource for information about the standard-setting organizations and transaction change request system. https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/hipaa/standard-setting-related-organizations#:~:text=Designated%20Standards%20Maintenance%20Organizations%20(DSMOs,standards%20or%20modify%20existing%20standards.
- Health Level Seven (HL7): HL7 is one of several ANSI-accredited Standards Development Organizations (SDOs), and is responsible for clinical and administrative data standards. www.hl7.org.
- Healthcare Information and Management Systems (HIMSS): An organization exclusively focused on providing global leadership for the optimal use of IT and management systems for the betterment of health care. www.himss.org.
- National Committee on Vital and Health Statistics (NCVHS): The National Committee on Vital and Health Statistics was established by Congress to serve as an advisory body to the Department of Health and Human Services on health data, statistics, and national health information policy. www.ncvhs.hhs.gov.
- National Council of Prescription Drug Programs (NCPDP): The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org.
- National Uniform Billing Committee (NUBC): NUBC is affiliated with the American Hospital Association. It develops and maintains a national uniform billing instrument for use by the institutional health-care community to transmit claims and encounter information. www.nubc.org.
- National Uniform Claim Committee (NUCC): NUCC is affiliated with the American Medical Association. It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org.
- Nevada Department of Health and Human Services (DHHS) Division of Health Care Financing and Policy (DHCFP): The DHCFP website assists with policy questions: dhcfp.nv.gov and this website assists providers with billing and enrollment support: www.medicaid.nv.gov.
- Office for Civil Rights (OCR): OCR is the office within the Department of Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa.
- United States Department of Health and Human Services (HHS): The DHHS website is a resource for the Notice of Proposed Rule Making, rules, and their information about HIPAA. www.aspe.hhs.gov/admnsimp.
- Washington Publishing Company (WPC): WPC is a resource for HIPAA-required transaction technical report type 3 documents and code sets. www.wpc-edi.com.
- Workgroup for Electronic Data Interchange (WEDI): WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org.

6 Control Segments/Envelopes

The page numbers listed below in each of the tables represent the corresponding page number in the X12N 837P HIPAA Implementation Guide.

X12N EDI Control Segments
ISA – Interchange Control Header Segment
IEA – Interchange Control Trailer Segment
GS – Functional Group Header Segment
GE – Functional Group Trailer Segment
ST – Transaction Set Header
SE – Transaction Set Trailer
TA1 – Interchange Acknowledgement

6.1 ISA-IEA

This section describes Nevada Medicaid's use of the interchange control segments.

It includes a description of expected sender and receiver codes, authorization information, and delimiters.

To promote efficient, accurate electronic transaction processing, please note the following Nevada Medicaid specifications:

- Nevada Medicaid requires Trading Partners to use the ASC X12 Extended Character Set.
- Each Trading Partner is assigned a unique Trading Partner ID.
- All dates are in the CCYYMMDD format with the exception of the ISA09, which is YYMMDD.
- All date/times are in the CCYYMMDDHHMM format.
- Nevada Medicaid Payer ID is NVMED for Encounter transactions.
- Batch responses are not returned until all inquiries are processed.
- Only one ISA/IEA is allowed per logical file.

Transactions transmitted during a session or as a batch are identified by an ISA header segment and IEA trailer segment, which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The tables below represent the interchange envelope information.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.3		ISA	Interchange Control Header			
C.4		ISA01	Authorization Information Qualifier	00, 03		
			No Authorization Information Present	00	2	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.4		ISA02	Authorization Information		10	Space fill
C.4		ISA03	Security Information Qualifier	00, 01		
			No Security Information Present	00	2	
C.4		ISA04	Security Information		10	Space fill
C.4		ISA05	Interchange ID Qualifier	01, 14, 20, 27-30, 33, ZZ		
			Mutually Defined	ZZ	2	
C.4		ISA06	Interchange Sender ID		15	The 8-digit Trading Partner ID assigned by Nevada Medicaid, left justified and space filled.
C.4		ISA07	Interchange ID Qualifier	01, 14, 20, 27-30, 33, ZZ		
			Mutually Defined	ZZ	2	
C.4		ISA08	Interchange Receiver ID	NVMED	15	NV Medicaid receiver ID, left justified and space filled.
C.5		ISA09	Interchange Date		6	Format is YYMMDD
C.5		ISA10	Interchange Time		4	Format is HHMM
C.5		ISA11	Repetition Separator	^	1	The repetition separator is a delimiter and not a data element. It is used to separate repeated occurrences of a simple data element or a composite data structure. This value must be different from the data element separator, component element separator, and the segment terminator.
C.5		ISA12	Interchange Control Version Number	00501	5	
C.5		ISA13	Interchange Control Number		9	Must be identical to the associated interchange control trailer IEA02.
C.6		ISA14	Acknowledgment Requested	0, 1		

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			No interchange acknowledgment requested	0	1	A TA1 will be generated if the file fails the 'Interchange Envelope' content regardless of the value used.
			Interchange acknowledgement requested	1	1	
C.6		ISA15	Usage Indicator	T, P		
			Test data	T	1	
			Production data	P	1	
C.6		ISA16	Component Element Separator	:	1	The component element separator is a delimiter and not a data element. It is used to separate component data elements within a composite data structure. This value must be different from the data element separator and the segment terminator.
C.10		IEA	Interchange Control Trailer			
C.10		IEA01	Number of Included Functional Groups		1/5	Number of included Functional Groups.
C.10		IEA02	Interchange Control Number		9	The control number assigned by the interchange sender. Must be identical to the value in ISA13.

6.2 GS-GE

This section describes Nevada Medicaid's use of the functional group control segments.

It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how Nevada Medicaid expects functional groups to be sent and how Nevada Medicaid will send functional groups. These discussions will describe how similar transaction sets will be packaged and Nevada Medicaid's use of functional group control numbers. The tables below represent the functional group information.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.7		GS	Functional Group Header			
C.7		GS01	Functional ID Code	HC	2	
C.7		GS02	Application Sender's Code		8	Trading Partner ID supplied by NV Medicaid. This will be the same value in the ISA06.
C.7		GS03	Application Receiver's Code	NVMED	5	
C.7		GS04	Date		8	Format is CCYYMMDD
C.8		GS05	Time		4/8	Format is HHMM
C.8		GS06	Group Control Number		1/9	Must be identical to GE02.
C.8		GS07	Responsible Agency Code	X	1	
C.8		GS08	Version/Release/Industry ID Code		12	005010X222A1

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.9		GE	Functional Group Trailer			
C.9		GE01	Number of Transaction Sets Included		1/6	Total number of transaction sets included in the functional group.
C.9		GE02	Group Control Number		1/9	This is the same value as the GS06.

6.3 ST-SE

This section describes Nevada Medicaid's use of transaction set control numbers.

Nevada Medicaid recommends that Trading Partners follow the guidelines set forth in the TR3 Implementation Guide – start the first ST02 in the first file with 000000001 and increment from there. The TR3 Implementation Guide should be reviewed for how to create compliant transactions set control segments.

The 837 Encounter Professional files may contain multiple ST-SE segments.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
70		ST	Transaction Set Header			
70		ST01	Transaction Set Identifier Code	837	3	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
70		ST02	Transaction Set Control Number		4/9	Increment by 1 when multiple transaction sets are included; must be identical to SE02.
70		ST03	Implementation Convention Reference		12	005010X222A1

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
496		SE	Transaction Set Trailer			
496		SE01	Number of Included Segments		1/10	Total number of segments included in a transaction set including ST and SE segments.
496		SE02	Transaction Set Control Number		4/9	Transaction set control number. Identical to the value in ST02.

6.4 Control Segment Notes

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.

6.5 File Delimiters

Nevada Medicaid requests that submitters use the following delimiters on your 837 file. If used as delimiters, these characters (* : ~ ^) must not be submitted within the data content of the transaction sets.

- **Data Element**: Byte 4 in the ISA segment defines the data element separator to be used throughout the entire transaction. The recommend data element delimiter is an asterisk (*).
- **Repetition Separator**: ISA11 defines the repetition separator to be used throughout the entire transaction. The recommend repetition separator is a caret (^).
- **Component-Element**: ISA16 defines the component element delimiter to be used throughout the entire transaction. The recommended component-element delimiter is a colon (:).
- **Data Segment**: Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The recommended segment delimiter is a tilde (~).

7 Nevada Medicaid Specific Business Rules and Limitations

This section describes Nevada Medicaid's specific business rules and limitations for the 837 Encounter transaction.

Before submitting electronic encounter claims to Nevada Medicaid, please review the appropriate HIPAA Technical Report Type 3 (TR3) Implementation Guide and Nevada Medicaid companion guide.

7.1 Encounter Claim Submissions

You may submit electronic encounter claims 24 hours a day, 7 days a week. Transactions submitted after 4:00 p.m. Pacific Time (PT) are processed in the following day's cycle. The Functional Acknowledgement (999 transaction) is normally available for retrieval one hour after submission; however it could take up to 24 hours. Encounter claims will be processed through the Encounter Engine and an Encounter 837 Response file will be available one business day after the file was received.

The Nevada Medicaid program has the following requirements for encounter claims submission:

- Encounters files must, at a minimum, be sent monthly.
- All encounters must be submitted for proper and accurate reporting and must be submitted within ninety (90) calendar days of receipt of encounter.
- Correct and resubmit a disputed encounter file within sixty (60) calendar days of receipt.
- Submit response file listing resubmitted encounters, specifying if encounter was corrected or explanation of why encounter could not be corrected.
- All encounters will be adjusted or voided within sixty (60) calendar days following the identification of the overpayments.

7.2 Adjustments and Voids

Encounter claims that have been accepted and received a Nevada Medicaid ICN can be Adjusted or Voided. Adjustments are only allowed on accepted encounters that have an encounter claim status of Paid (CLM01-2).

To submit an Adjustment/Void users need to submit an encounter claim frequency (CLM05-3) of 7 (Adjustment/Replace) or 8 (Void/Credit). The Nevada Medicaid ICN to Adjust/Void should be placed in the 2300 REF02, where REF01=F8. Providers must use the most recently paid Nevada Medicaid ICN when voiding or adjusting an encounter claim.

7.3 Logical File Structure

There can only be one interchange (ISA/IEA) per logical file. The interchange can contain multiple functional groups (GS/GE); however, the functional groups must be the same type.

7.4 Compliance Checking

Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. Refer to Appendix B for a list of SNIP Level 4 edits.

7.5 Document Level Rejection

Files for encounters are processed at the transaction set level (ST/SE). This means if one compliance error is received at the transaction set level (ST/SE), that transaction set will be rejected, and the error reported on the 999 transaction. This may create a partially accepted file if the file contains multiple transaction sets.

The claim(s) that caused the rejection need to be corrected and the entire transaction set (ST/SE) needs to be resubmitted for processing.

7.6 Encounter Claim Detail Status

No status is sent in directly. If the units allowed = 0 and the amount paid = 0 on the detail, then the detail is denied.

7.7 Contract Information

The CN1 segment in the 2300 and 2400 loop is to be excluded. If submitted, transaction set will reject. The replacement of the CN1 segment will now be sent in either the 2300 REF or the 2400 REF (Prior Authorization) segment. MCOs could use either of these to populate Prior Authorization and/or capitation/flat/value additions instead of CN1 segment. There are two parts under REF02 in the below example. The part that precedes "-CN1" is the Prior Authorization number (ABCD12345). The part that succeeds "-CN1" is the value/capitation amount addition fields. The second part is where the MCOs would populate as if they are populating the CN1 segment and use hyphen ("-") instead of asterisk ("*").

Example:

REF*G1*ABCDEFGHIJ12345-CN1-05-4.45--M

"-CN1" is the discriminator.

Pattern of REF02 is *(Prior Authorization Number)-CN1-(Value of CN101)-(Value of CN102)-(Value of CN103)-(Value of CN104).*

Here are some additional examples and the situations:

REF*G1*ABCDEFGHIJ12345~ - MCO sends only Prior Authorization number.

REF*G1*ABCDEFGHIJ12345-CN1-04-80.45~ - MCO sends both Prior Authorization and CN1(Flat) information. -(Value of CN103)-(Value of CN104) is not sent.

REF*G1*ABCDEFGHIJ12345-CN1-04~ - MCO sends both Prior Authorization and CN1(Flat) information. -(Value of CN102)-(Value of CN103)-(Value of CN104) is not sent.

REF*G1*-CN1-04-80.45~ - MCO sends only CN1(Flat) information without Prior Authorization. -(Value of CN103)-(Value of CN104) is not sent.

REF*G1*-CN1-04~ - MCO sends only CN1(Flat) information without Prior Authorization. -(Value of CN102)-(Value of CN103)-(Value of CN104) is not sent.

REF*G1*ABCDEFGHIJ12345-CN1-05-70.95~ - MCO sends both Prior Authorization and CN1(Capitated) information. -(Value of CN103)-(Value of CN104) is not sent.

REF*G1*ABCDEFGHIJ12345-CN1-05~ - MCO sends both Prior Authorization and CN1(Capitated) information. -(Value of CN102)-(Value of CN103)-(Value of CN104) is not sent. This should be sent for each detail when the there is a PA and units allowed on the detail are greater than 1, but the amount paid on the detail is 0.00

REF*G1*-CN1-05-70.95~ - MCO sends only CN1(Capitated) information without Prior Authorization. -(Value of CN103)-(Value of CN104) is not sent.

REF*G1*-CN1-05~ - MCO sends only CN1(Capitated) information without Prior Authorization. -(Value of CN102)-(Value of CN103)-(Value of CN104) is not sent. This should be sent for each detail when there is no PA and units allowed on the detail are greater than 1, but the amount paid on the detail is 0.00

7.8 Duplicate Encounter Professional Claim Logic

Professional claims

Logic will consider each detail in paid status on the incoming claim (current claim).

Logic will consider each paid detail on history claims.

If a detail is denied, do not use it for duplicate auditing.

If a detail has procedure codes: 87798, 87481, 86317 do not check it for duplicate.

If the incoming claim has more than one paid detail, check its paid details against each other for duplicates.

- Procedure code is equal
- Detail first date of service is equal
- Detail last date of services is equal
- Detail rendering provider is equal
- Modifiers are equal
- National Drug Code (NDC) is equal (if present on the detail)

Then set audit code 5302 - ENCOUNTER DUPLICATE – PROFESSIONAL.

Next, check the current claim's paid details against all history claim paid details.

If a paid Encounter claim detail is found in history where, compared to the current claim paid detail:

- Recipient is equal
- Trading partner ID is equal
- Claim type is equal
- Detail procedure code is equal
- Detail first DOS is equal
- Detail last DOS is equal
- Detail rendering provider is equal
- Modifiers are equal
- National Drug Code (NDC) is equal (if present on the detail)

Then set audit code 5302 - ENCOUNTER DUPLICATE – PROFESSIONAL.

8 Acknowledgements and/or Reports

8.1 The TA1 Interchange Acknowledgement

The TA1 allows the receiver of a file to notify the sender that an invalid interchange structure was received or that problems were encountered. The TA1 verifies only the interchange header (ISA/GS) and trailer (IEA/GE) segments of the file envelope.

If ISA or GS errors were encountered, then the generated TA1 report with the Interchange Header errors will be returned for pickup.

What to look for in the TA1

The TA1 segment indicates whether or not the submitted interchange control structure passed the HIPAA compliance check.

If TA104 is "R", then the transmitted interchange control structure header and trailer were rejected because of errors. The submitter will need to correct the errors and resubmit the corrected file to Nevada Medicaid.

Example:

TA1*000100049*130716*0935*R*020~

The data elements in the TA1 segment are defined as follows:

- TA101 contains the Interchange Control Number (ISA13) from the file to which this TA1 is responding ("000100049" in the example above).
- TA102 contains the Interchange Date ("130716" in the example above).
- TA103 contains the Interchange Time ("0935" in the example above).
- TA104 code indicates the status of the interchange control structure ("R" in the example above). The definition of the code is as follows: "R" – The transmitted interchange control structure header and trailer are rejected because of errors.
- TA105 code indicates the error found while processing the interchange control structure ("020" in the example above). The definitions of the codes are as follows:

Code	Description
000	No Error
001	The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.
002	This Standard as Noted in the Control Standards Identifier is Not Supported
003	This Version of the Controls is Not Supported
004	The Segment Terminator is Invalid
005	Invalid Interchange ID Qualifier for Sender
006	Invalid Interchange Sender ID
007	Invalid Interchange ID Qualifier for Receiver

Code	Description
008	Invalid Interchange Receiver ID
009	Unknown Interchange Receiver ID
010	Invalid Authorization Information Qualifier Value
011	Invalid Authorization Information Value
012	Invalid Security Information Qualifier Value
013	Invalid Security Information Value
014	Invalid Interchange Date Value
015	Invalid Interchange Time Value
016	Invalid Interchange Standards Identifier Value
017	Invalid Interchange Version ID Value
018	Invalid Interchange Control Number Value
019	Invalid Acknowledgment Requested Value
020	Invalid Test Indicator Value
021	Invalid Number of Included Groups Value
022	Invalid Control Structure
023	Improper (Premature) End-of-File (Transmission)
024	Invalid Interchange Content (e.g., Invalid GS Segment)
025	Duplicate Interchange Control Number
026	Invalid Data Element Separator
027	Invalid Component Element Separator
028	Invalid Delivery Date in Deferred Delivery Request
029	Invalid Delivery Time in Deferred Delivery Request
030	Invalid Delivery Time Code in Deferred Delivery Request
031	Invalid Grade of Service Code

The TA1 segment will be sent within its own interchange (i.e., ISA-TA1-IEA)

Example of a TA1 within its own interchange:

ISA*00* *00* *ZZ*NVMED *ZZ*TPID1234
*171222*0106*^*00501*000000001*0*P*:~TA1*000100049*130716*0935*R*020~IEA*0*000000001~

For additional information, consult the Interchange Control Structures, X12.5 Guide. TR3 documents may be obtained by logging on to www.wpc-edi.com and following the links to ”EDI Publications” and ”5010 Technical Reports.”

8.2 The 999 Implementation Acknowledgement

If a 5010 X12 file is submitted to Nevada Medicaid, a 999 acknowledgement is sent to the submitter normally within one hour, however, it could take as long as 24 hours. A 999 does not guarantee processing of the transaction. It only signifies that Nevada Medicaid received the Functional Group.

The following sections explain how to read the 999 to find out whether a file is Accepted, Rejected, Partially Accepted or Accepted, But Errors Were Noted. If a Functional Group is Accepted or Accepted, But Errors Were Noted, no action is required by the submitter. If the Functional Group is Partially Accepted or Rejected, the submitter must correct the errors and re-submit the corrected file or transaction set(s) to Nevada Medicaid.

What to look for in the 999

Locate the AK9 segment. These segments indicate whether or not the submitted Functional Group passed the HIPAA compliance check.

If the AK9 segment appears as AK9*A (Accepted), the entire file was accepted for processing.

If the AK9 segment appears as AK9*R (Rejected), the entire file was rejected.

If the AK9 segment appears as AK9*P (Partially Accepted), the transaction set(s) was rejected.

If the AK9 segment appears as AK9*E (Accepted, But Errors Were Noted), the entire file was accepted for processing, but warning or informational edits were found.

Example of the 999 Acknowledgment:

ST*999*0001*005010X222~

AK1*HC*284*005010X222A1~

AK2*837*284001*005010X222A1~

IK5*A~

AK2*837*284002*005010X222A1~

IK3*NM1*8*2010*8~

CTX*CLM01:123456789~

IK4*2*782*1~

IK5*R*5~

AK9*P*2*2*1~

SE*8*0001~

AK1

This segment refers to the (GS) Group Set level of the original file sent to Nevada Medicaid.

- AK101 is equal to GS01 from the original file (e.g., the AK101 of an 837 claims file would be “HC”).
- AK102 is equal to GS06 from the original file (Group Control Number).
- AK103 is equal to GS08 from the original file (EDI Implementation Version).

AK2

This segment refers to the (ST) Transaction Set level of the original file sent to Nevada Medicaid.

- AK201 is equal to ST01 from the original file (e.g., the AK201 of an 837 claims file would be “837”).
- AK202 is equal to ST02 from the original file (Transaction Set Control Number).
- AK203 is equal to ST03 from the original file (EDI Implementation Version).

IK3

This segment reports errors in a data segment.

Example:

IK3*CLM*22**8~

- IK301 contains the segment name that has the error. In the example above, the segment name is “CLM”.
- IK302 contains the numerical count position of this data segment from the start of the transaction set (a “line count”). The erroneous “CLM” segment in the example above is the 22nd segment line in the Transaction Set. Transaction Sets start with the “ST” segment. Therefore, the erroneous segment in the example is the 24th line from the beginning of the file because the first two segments in the file, ISA and GS, are not part of the transaction set.
- IK303 may contain the loop ID where the error occurred.
- IK304 contains the error code and states the specific error. In the example above, the code ”8” states “Segment Has Data Element Errors.”

Code	Description
1	Unrecognized segment ID
2	Unexpected segment
3	Required segment missing
4	Loop occurs over maximum times
5	Segment Exceeds Maximum Use
6	Segment not in defined transaction set
7	Segment not in proper sequence
8	Segment has data element errors
I4	Implementation “Not Used” segment present
I6	Implementation Dependent segment missing
I7	Implementation loop occurs under minimum times
I8	Implementation segment below minimum use
I9	Implementation Dependent “Not Used” segment present

CTX

This segment describes the Context/Business Unit. The CTX segment is used to identify the data that triggered the situational requirement in the IK3.

Example:

IK3*CLM*22**8~

CTX*CLM01:123456789~

IK4

This segment reports errors in a data element.

Example:

IK4*2*782*1~

- IK401 contains the data element position in the segment that is in error. The “2” in the example above represents the second data element in the segment.
- IK402 contains the data element reference number as found in the appropriate TR3 document. The “782” in the example above represents the CLM02 data element from the 837P.
- IK403 contains the error code and states the specific error. The “1” in the example above represents “Required Data Element Missing.”

Code	Description
1	Required data element missing
2	Conditional required data element missing
3	Too many data elements
4	Data element too short
5	Data element too long
6	Invalid character in data element
7	Invalid code value
8	Invalid date
9	Invalid time
10	Exclusion condition violated
12	Too many repetitions
13	Too many components
I6	Code value not used in implementation
I9	Implementation dependent data element missing
I10	Implementation “Not Used” data element present
I11	Implementation too few repetitions

Code	Description
I12	Implementation pattern match failure
I13	Implementation Dependent “Not Used” element present

NOTE: IK404 may contain a copy of the bad data element.

IK5

This segment reports errors in a transaction set.

Example:

IK5*R*5~

- IK501 indicates whether the transaction set is:
  - A = Accepted
  - R = Rejected

  The “R” in the example above means the transaction set was rejected due to errors.
- IK502 indicates the implementation transaction set syntax error. The “5” in the example above indicates “One or More Segments in Error.”

Below is a sample of IK502 error codes. Please refer to the 999 TR3 document for a complete list of these error codes.

Code	Description
1	Transaction Set not supported
2	Transaction Set trailer missing
3	Transaction Set Control Number in Header/Trailer do not match
5	One or more segments in error

AK9

This segment reports the functional group compliance status.

Example:

AK9*P*2*2*1~

- AK901 indicates whether the entire functional group is:
  - A = Accepted
  - P = Partially Accepted. The transaction set(s) rejected and will NOT be forwarded for processing. The transaction set(s) will need to be corrected and resubmitted.
  - R = Rejected. The entire file rejected and will NOT be forwarded for processing. The file will need to be corrected and resubmitted.
  - E = Accepted, But Errors Were Noted. No action is needed as this means the entire file was accepted for processing, but warning or informational edits were found.

The “P” in the example above means the functional group was partially accepted and at least one transaction set was rejected.

- AK902 contains the total number of transaction sets. In the example above, two transaction sets were submitted.
- AK903 contains the number of received transaction sets. In the example above, two transaction sets were received.
- AK904 contains the number of accepted transaction sets in a Functional Group. In the example above, one transaction set was accepted.
- AK905 contains the Functional Group Syntax Error Code.

Below is a sample of AK905 error codes. Please refer to the 999 TR3 document for a complete list of error codes.

Code	Description
1	Functional group not supported
2	Functional group version not supported
3	Functional group trailer missing
4	Group Control Number in the functional group Header and Trailer do not agree
5	Number of included transaction sets does not match actual count
6	Group Control Number violates syntax
17	Incorrect message length (Encryption only)
18	Message authentication code failed
19	Functional Group Control Number not unique within interchange

For additional information, consult the Implementation Acknowledgment for Health Care Insurance (999) Guide. TR3 documents may be obtained by logging onto www.wpc-edi.com and following the links to “HIPAA” and “HIPAA Guides”.

8.3 The 837 Encounter Response File

If all encounter claims within the file pass SNIP Level 4 compliance, then the encounter claims will be processed by the backend Encounter Claim Engine and the 837 Encounter Response File will be sent to the submitter. The response file will be available one business day after the file was received.

The response file contains the status of each encounter claim that was processed. One response file will be sent for each batch file received. Each edit/audit on an encounter claim is a record in the response file. If there are multiple edits/audits on the encounter claim, then an encounter claim will be in the file more than once. The Encounter Engine contains informational and threshold edits. Both types of edits are reported on the response file; however, only threshold edits will reject an encounter claim. An encounter claim with no edits or only informational edits will be accepted. Encounter claims can have both threshold and informational edits, but only the information pertaining to the threshold edits will need to be corrected and resubmitted for the encounter claim to be accepted. DHCFP reserves the right to change the edit type (informational and threshold) at any time.

Below is the file layout of the 837 Encounter Response file.

Field Name	Format	Length	Information
FILE_NUMBER	Char	9	This is the file number of the file submitted to Nevada Medicaid.
FILE_TYPE	Char	4	This field will contain 837I, 837D, or 837P depending on the type of transaction file it came in on.
FILE_STATUS	Char	1	A = Accepted, R = Rejected. If the file/batch is rejected, all of the encounter claims in that file will be rejected.
Nevada Medicaid ICN	Char	13	ICN will be in the record if the encounter claim was accepted, "REJECTED" if not accepted
MCO_TCN	Char	20	MCO TCN submitted
NUM_PAT_ACCT	Char	38	MCO Submitted Patient Account Number (CLM01).
ID_MEDICAID	Char	12	Recipient Medicaid ID
MCO_PROVIDER_NUMBER	Char	15	MCO Provider Number submitted
PROVIDER_ID	Char	15	The Primary Provider on the encounter claim.
TXN_TYPE	Char	1	Transaction type will have either of the following values: 'O' - Original, 'A' - Adjustments or 'V' - Void
INTERCHANGE_EDIT	Char	4	Interchange Edit on this encounter claim submitted (blank if no edit)
INTERCHANGE_EDIT_DESC	Char	50	Interchange Edit description (blank if no edit)
EDIT_SVC_LINE	Char	3	This is the detail number of the encounter the failed the edit. Zero indicates that header of the encounter. This field is only valid when there is an edit present.
Filler - line feed	Char	1	This is one character of filler - for Nevada Medicaid use. It will contain a line feed character.

NOTE: There will be a possibility of more than one record for each encounter claim since Nevada Medicaid is reporting back all the edits set on the encounter claim.

8.4 Encounter Claim Duplicate File

The duplicate file contains information about the encounter claim rejected as a duplicate and the related encounter claim within the Encounter Claim Engine.

Field Name	Format	Length	Information
NUM_PAT_ACCT	Char	38	MCO Submitted Patient Account Number with the MCO TCN
ID_MEDICAID	Char	12	Recipient Medicaid ID
DUPE_CLAIM_TYPE	Char	1	Encounter claim Type of the duplicate encounter claim

Field Name	Format	Length	Information
DUPE_SVC_LINE	Char	3	This is the detail number of the encounter the failed as a duplicate. Zero indicates that header of the encounter.
INTERCHANGE_AUDIT_NBR	Char	4	Interchange Audit Duplicate Error number
RELATED_MMIS_ICN	Char	13	This is the encounter claim Nevada Medicaid ICN on file.
RELATED_NUM_PAT_ACCT	Char	38	MCO Submitted Patient Account Number
RELATED_CLAIM_TYPE	Char	1	Encounter claim Type of the duplicate encounter claim
RELATED_SVC_LINE	Char	3	This is the detail number of the encounter the failed as a duplicate. Zero indicates that header of the encounter.
Filler - line feed	Char	1	This is one character of filler - for Nevada Medicaid use. It will contain a line feed character.

NOTE: There will be a possibility of more than one record for each encounter claim since there are multiple reasons for duplicates and all reasons are reported to support resolution.

9 Trading Partner Agreements

Trading Partners who intend to conduct electronic transactions with Nevada Medicaid must agree to the terms of the Nevada Medicaid Trading Partner Agreement.

An EDI Trading Partner is defined as any entity (provider, billing service, software vendor, employer group, financial institution, etc.) that conducts electronic transactions with Nevada Medicaid. The Trading Partner and Nevada Medicaid acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Each party agrees to take all steps reasonably necessary to ensure that all electronic transactions between them conform to all HIPAA regulations.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

A copy of the agreement is available on the Nevada Medicaid EDI webpage at https://www.medicaid.nv.gov/providers/edi.aspx.

10 Transaction Specific Information

This section describes how ASC X12N TR3 Implementation Guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Nevada Medicaid has something additional, over and above, the information in the TR3s. That information can:

- Limit the repeat of loops or segments
- Limit the length of a simple data element
- Specify a sub-set of the TR3 internal code listings
- Clarify the use of loops, segments, composite and simple data elements
- Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Nevada Medicaid

In addition to the row for each segment, one or more additional rows are used to describe Nevada Medicaid's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

10.1 837P Encounter (Inbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
71		BHT	Beginning of Hierarchical Transaction			
71		BHT02	Transaction Set Purpose Code	00, 18		
			Original	00	2	
72-73		BHT06	Transaction Type Code	31, CH, RP		
			Reporting	RP	2	
74	1000A	NM1	Submitter Name			
75	1000A	NM109	Identification Code		10	Use the MCO Regional Medicaid Provider ID.
76	1000A	PER	Submitter EDI Contact Information			The contact information in this segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
77	1000A	PER02	Name		1/60	Required if different than the name contained in the Submitter Name (Loop 1000A-NM1 segment).
77	1000A	PER03	Communication Number Qualifier	EM, FX, TE	2	
77	1000A	PER04	Communication Number			
79	1000B	NM1	Receiver Name			
80	1000B	NM103	Name Last or Organization Name			Division of Health Care Financing and Policy
80	1000B	NM109	Identification Code	NVMED	5	
83	2000A	PRV	Billing Provider Specialty Information			
83	2000A	PRV03	Reference Identification		10	Enter a taxonomy code when using a National Provider Identifier (NPI).
88	2010AA	NM1	Billing Provider Name			
90	2010AA	NM109	Identification Code		10	Billing Provider NPI
91	2010AA	N3	Billing Provider Address			
91	2010AA	N301	Address Information		1/55	
92	2010AA	N4	Billing Provider City/ State/ ZIP Code			
93	2010AA	N403	Billing Provider Postal Zone or ZIP Code		9	The billing provider's 9-digit ZIP code (along with the other address information in the 2010AA N3 segment) is required.
94	2010AA	REF	Billing Provider Tax Identification			
94	2010AA	REF01	Reference Identification Qualifier	EI, SY	2	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
94	2010AA	REF02	Reference Identification		9	If, REF01=EI value equals Tax ID. If, REF01=SY value equals SSN.
114	2000B	HL	Subscriber Hierarchical Level			For Nevada Medicaid, the insured and the patient are always the same person. Use this HL segment to identify the member and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C).
115	2000B	HL04	Hierarchical Child Code	0, 1		
			No Subordinate HL Segment in This Hierarchical Structure	0	1	For Nevada Medicaid the Member is the Subscriber so there should never be a Dependent Level.
116	2000B	SBR	Subscriber Information			
116	2000B	SBR01	Payer Responsibility Sequence Number Code	A-H, P, S, T, U		
			Secondary (Primary COB)	S	1	
			Tertiary (Secondary COB)	T	1	
118	2000B	SBR09	Claim Filing Indicator Code	11-17, AM, BL, CH, CI, DS, FI, HM, LM, MA, MB, MC, OF, TV, VA, WC, ZZ		
			Medicaid	MC	2	The value sent at this level should always be 'MC'.
121	2010BA	NM1	Subscriber Name			
122	2010BA	NM102	Entity Type Qualifier	1, 2		
			Person	1	1	
122-123	2010BA	NM108	Identification Code Qualifier	II, MI		

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Member Identification Number	MI	2	
123	2010BA	NM109	Identification Code		11	11-digit Nevada Medicaid Recipient ID.
133	2010BB	NM1	Payer Name			
134	2010BB	NM103	Name last or Organization Name			
134	2010BB	NM108	Identification Code Qualifier	PI, XV		
			Payer Identification	PI	2	
134	2010BB	NM109	Identification Code	NVMED	5	
140	2010BB	REF	Billing Provider Secondary Identification			This loop is used when billing with an Atypical Provider (API) number.
140	2010BB	REF01	Reference Identification Qualifier	G2, LU		
			Provider Commercial Number	G2	2	
141	2010BB	REF02	Billing Provider Secondary Identifier			If REF01 = G2, enter the billing provider's Atypical Provider Identifier. Note: "G2" or "LU" must be absent if 2010AA NM109 is present.
157	2300	CLM	Claim Information			

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
157	2300	CLM01	Patient Control Number		1/38	Enter the MCO's encounter claim number. Nevada is requiring a concatenated field for the CLM01 element. This will allow maximum usage of this element to carry multiple information segments inside the single element. These sub-elements will not be separated by the ":", but merely concatenated together. Although this format is not required by the TR3 Guide, it will be required by Nevada Medicaid for correct processing and evaluation of the encounter. Refer to tables below.
			Media Type (Position 1)		1	The Media Type will be the first byte of the CLM01 element in the X12 837 transaction. P – Paper E – Electronic W – Web I – IVR R – Portal
			Claim Status (Position 2)		1	The Claim Status will be the second byte of the CLM01 element in the X12 837 transaction. P – Paid D – Denied When CLM05-3, Claim Frequency Code, is '8' (void) the Claim Status must be 'D'
			CMO Claim Number/Patient Control Number (Positions 3-38)		1/36	The CMO Claim number combined with the Providers Patient Control Number will be in positions 3-38.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
159	2300	CLM05-3	Claim Frequency Code	1, 7, 8	1	Value indicates whether the current encounter claim is an original encounter claim, a void, or an adjustment. '1' = Original Encounter claim '7' = Adjustment (Replacement of Paid Encounter claim) '8' = Void (Credit only) The ICN to Credit should be placed in the REF02, where REF01=F8. Providers must use the most recently paid Nevada Medicaid ICN when voiding or adjusting an encounter claim.
162	2300	CN1	Contract Information			This segment must be excluded. If submitted, the transaction set will reject with "CN1 must be excluded". See additional guidance for sending CN1 information in section 7.7 Contract Information
193	2300	REF	Referral Number			
193	2300	REF01	Reference Identification Qualifier	9F	2	
193	2300	REF02	Reference Identification		1/50	MCO Referral Number
194	2300	REF	Prior Authorization			The 2300 REF segment is used to supply Prior Authorization and/or capitation/flat/value additions. It replaces the values from the CN1 segment.
194	2300	REF01	Reference Identification Qualifier	G1	2	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
195	2300	REF02	Prior Authorization Number		1/50	Value of REF02 is (Prior Authorization Number)-CN1-(Value of CN101)-(Value of CN102)-(Value of CN103)-(Value of CN104). Refer to section 7.7 – Contract Information for detailed information and examples.
196	2300	REF	Payer Claim Control Number			
196	2300	REF01	Reference Identification Qualifier	F8	2	Adjust or void an encounter claim (as indicated by CLM05-3).
196	2300	REF02	Payer Claim Control Number			Enter the last paid Internal Control Number (ICN) that Nevada Medicaid assigned to the encounter claim.
202	2300	REF	Claim Identifier for Transmission Intermediaries			
202	2300	REF01	Reference Identification Qualifier	D9	2	
202	2300	REF02	Reference Identification		1/20	Value Added Network Trace Number (Maximum Length Allowed = 20).
226	2300	HI	Health Care Diagnosis Code			
226-227	2300	HI01-1	Code List Qualifier Code	ABK, BK	2/3	Principal Diagnosis 'ABK' – ICD-10
227	2300	HI01-2	Industry Code		3/7	For ICD-10, length allowed is 3-7.
227-238	2300	HI02-1 to HI12-1	Code List Qualifier Code	ABF, BF	2/3	Other Diagnosis 'ABF' – ICD-10
227-238	2300	HI02-2 to HI12-2	Industry Code		3/7	For ICD-10, length allowed is 3-7.
258	2310A	NM1	Referring Provider Name			
259	2310A	NM109	Identification Code		10	Referring Provider NPI ID

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
260	2310A	REF	Referring Provider Secondary Identification			Used for non-healthcare providers who are unable to obtain an NPI ID.
260	2310A	REF01	Reference Identification Qualifier	0B, 1G, G2, LU	2	
260	2310A	REF02	Reference Identification		10	If REF01 = G2, enter the billing provider's Atypical Provider Identifier.
262	2310B	NM1	Rendering Provider Name			
264	2310B	NM109	Identification Code		10	Rendering Provider NPI ID
265	2310B	PRV	Rendering Provider Specialty Information			
265	2310B	PRV02	Reference Identification Qualifier	PXC	3	
265	2310B	PRV03	Reference Identification		10	Rendering Provider Taxonomy Code Used for encounter claims submitted with NPI ID.
267	2310B	REF	Rendering Provider Secondary Identification			
267-268	2310B	REF01	Reference Identification Qualifier	0B, 1G, G2, LU	2	
268	2310B	REF02	Rendering Provider Secondary Identifier			If REF01= G2, enter the billing provider's Atypical Provider Identifier.
295	2320	SBR	Other Subscriber Information			

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
296	2320	SBR01	Payer Responsibility Sequence Number Code	P, S, T	1	MCO COB information will always be Primary and required. This is also true for the corresponding segment occurrences associated with the Primary COB/MCO iteration. P = Primary (Always MCO) S = Secondary (Primary COB) T = Tertiary (Secondary COB)
296-297	2320	SBR02	Relationship Code	18	2	
298	2320	SBR09	Claim Filing Indicator Code		2	Use 'MC' for MCO encounter claims. Use MA or MB to indicate a Medicare payer on encounter claims for Medicare coinsurance and/or deductible. For all other relationships use one of the other listed values.
299	2320	CAS	Claim Level Adjustments			Adjustment amounts may be reported at both the encounter claim line and at the service line, but they cannot duplicate each other.
301-304	2320	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17	Adjustment Reason Code		1/3	
305	2320	AMT	COB Payer Paid Amount			
305	2320	AMT01	Amount Qualifier Code	D	1	Payer Amount Paid
305	2320	AMT02	Payer Paid Amount		10	Use the MCO Amount Paid when Primary, otherwise Amount paid per COB. It is acceptable to show "0" amount paid.
307	2320	AMT	Remaining Patient Liability			
307	2320	AMT01	Amount Qualifier Code	EAF	3	Payer Amount Paid

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
307	2320	AMT02	Remaining Patient Liability		10	Enter the amount that is owed from the recipient (patient responsibility amount). On encounter claims for Medicare coinsurance and/or deductible, submit the Medicare allowed amount for the total encounter claim.
313	2330A	NM1	Other Subscriber Name			
315	2330A	NM108	Identification Code Qualifier	II, MI		
			Member Identification	MI	2	
315	2330A	NM109	Other Insured Identifier		11	Nevada Medicaid Recipient ID On encounter claims for Medicare coinsurance and/or deductible, enter the recipient's Medicare ID.
320	2330B	NM1	Other Payer Name			
321	2330B	NM109	Other Payer Primary Identifier			This number must be identical to at least once occurrence of the 2430-SVD01 to identify the other payer if the 2430 loop is present. Nevada Medicaid captures third party payment amount(s) from the service line(s) in 2430-SVD02. NOTE: The 2320/2330 Loop(s) can repeat up to 10 times for a single encounter claim and the 2430 Loop can repeat up to 15 times for a single detail.
325	2330B	DTP	Claim Check or Remittance Date			
325	2330B	DTP01	Date Claim Paid	573	3	
325	2330B	DTP02	Date Time Period Format Qualifier	D8	2	
325	2330B	DTP03	Date Time Period		8	Date encounter claim was received by MCO. (CCYYMMDD)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
331	2330B	REF	Other Payer Claim Control Number			
331	2330B	REF01	Reference Identification Qualifier	F8	2	
331	2330B	REF02	Reference Identification			MCO Internal Control Number (ICN) or Transaction Control Number (TCN) WHEN RE-SUBMITTING A REJECTED ENCOUNTER CLAIM, THIS FIELD NEEDS TO CONTAIN THE SAME ICN/TCN AS ON THE ORIGINAL ENCOUNTER CLAIM
350	2400	LX	Service Line Number			
350	2400	LX01	Line Counter		2	Nevada Medicaid will accept up to the HIPAA allowed 50 detail lines per claim.
351	2400	SV1	Professional Service			
352-353	2400	SV101-1	Product/Service ID Qualifier		2	HC = HCPCS Codes
353	2400	SV101-2	Procedure Code			
353	2400	SV101-3 to SV101-6	Procedure Modifier			TB or UD must be submitted if the drug or biological was acquired with the 340B drug pricing program discount.
354	2400	SV102	Line Item Charge Amount			On encounter claims for Medicare coinsurance and/or deductible, enter the line charge amount billed to Medicare.
380	2400	DTP	Date-Service Date			
380-381	2400	DTP02	Date Time Period Format Qualifier	D8, RD8		

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
381	2400	DTP03	Date Time Period			D8=Date Expressed in Format CCYYMMDD RD8=Range of Dates Expressed in Format CCYYMMDDCCYYMMDD
395	2400	CN1	Contract Information			This segment must be excluded. If submitted, the transaction set will reject with "CN1 must be excluded". See additional guidance for sending CN1 information in section 7.7 Contract Information
399	2400	REF	Prior Authorization			This segment is used to supply Prior Authorization and/or capitation/flat/value additions which replaces the values from the CN1 segment.
399	2400	REF01	Reference Identification Qualifier	G1	2	
399	2400	REF02	Reference Identification		1/50	Value of REF02 is (Prior Authorization Number)-CN1-(Value of CN101)-(Value of CN102)-(Value of CN103)-(Value of CN104). Refer to section 7.7 – Contract Information for detailed information and examples.
423-424	2410	LIN	Drug Identification			
425	2410	LIN02	Product or Service ID Qualifier	N4	2	
425	2410	LIN03	National Drug Code			The NDC is required for each claim line with a physician-administered drug. The associated HCPCS procedure code should be billed in Loop 2400, Segment SV1, Data Element SV101-2.
426	2410	CTP	Drug Quantity			
426	2410	CTP04	National Drug Unit Count			Enter the actual NDC quantity dispensed.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
427	2410	CTP05-1	Unit or Basis for Measurement Code	F2, GR, ME, ML, UN	2	
428	2410	REF	Prescription or Compound Drug Association Number			
428	2410	REF01	Prescription or Compound Drug Association Number	XZ	2	
433	2420A	PRV	Rendering Provider Specialty Information			
433	2420A	PRV03	Reference Identification			A taxonomy code is recommended when using a National Provider Identifier (NPI).
434	2420A	REF	Rendering Provider Secondary Identification			
434	2420A	REF01	Reference Identification Qualifier	0B, 1G, G2, LU	2	
434	2420A	REF02	Billing Provider Secondary Identifier			If qualifier G2 was used in data element REF01, enter the billing provider's Atypical Provider Identifier.
480	2430	SVD	Line Adjudication Information			
480	2430	SVD01	Other Payer Primary Identifier		2/80	This Data Element is required if the payer identified in Loop 2330B adjudicated the encounter claim previously and the service line has adjustments applied to it. This number should match one occurrence of the 2330B-NM109 identifying Other Payer.
481	2430	SVD02	Service Line Paid Amount		1/10	Service Line Paid Amount.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
483	2430	SVD05	Quantity		8	This data element should be filled with paid unit quantity. When reporting the paid amount for a claim detail, the paid quantity is also required to determine the cost per service paid.
484-485	2430	CAS	Line Adjustment			This Data Element is required if the payer identified in Loop 2330B has adjudicated the encounter claim previously and the service line has adjustments applied to it. Use Claim Adjustment Reason Code (code source 139) to indicate the denial or cutback reason.
490	2430	DTP	Claim Check or Remittance Date			
490	2430	DTP01	Date Claim Paid	573	3	
490	2430	DTP02	Date Time Period Format Qualifier	D8	2	
490	2430	DTP03	Date Time Period			Adjudication Date or MCO Paid Date. (CCYYMMDD)

Appendix A: Implementation Checklist

This appendix contains all necessary steps for submitting transactions with Nevada Medicaid.

1. Call the Nevada Medicaid EDI Help Desk with any questions at (877) 638-3472 options 2, 0, and then 3 or send an email to: nvmmis.edisupport@gainwelltechnologies.com.
2. Check the Nevada Medicaid webpage at: www.medicaid.nv.gov regularly for the latest updates.
3. Review the Trading Partner User Guide which includes enrollment and testing information. This can be found on the EDI webpage at: https://www.medicaid.nv.gov/providers/edi.aspx.
4. Confirm you have completed your Trading Partner Agreement and been assigned a Trading Partner ID.
5. Make the appropriate changes to your systems/business processes to support the updated companion guides. If using a third party software, work with your software vendor to have the appropriate software installed.
6. Identify the Encounter transactions you will be testing:
    - Health Care Claim: Encounter Dental (837D)
    - Health Care Claim: Encounter Institutional (837I)
    - Health Care Claim: Encounter Professional (837P)
    - Health Care Claim: Encounter Professional NET (837P)
    - NCPDP Batch Transaction Standard Version 1.2 and Telecommunication Standard Version D.0.
7. If the entity testing is a billing intermediary or software vendor, use the provider's identifiers on the test transaction.
8. When submitting test files, make sure the recipients/encounter claims you submit are representative of the type of service(s) you provide to Nevada Medicaid providers.
9. Schedule a week for the initial test.

Appendix B: SNIP Edit (Compliance)

The Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) recommends seven types of testing to determine compliance with HIPAA. Nevada Medicaid has adopted this through SNIP Level 4 edits. At this level a claim's inter-segment relationships are validated. For example, if element A exists, then element B should be populated.

The following SNIP Level 4 edits are applied for Encounter 837P transactions:

LOOP	MESSAGE
2010AA	2010AA REF_0B;1G must be absent if 2010AA NM109 present
2010AA	2310B NM1 must be different from 2010AA NM1
2010AA	2310C NM1 must be different from 2010AA NM1
2010AA	2310C N3/N4 must be different from 2010AA N3/N4
2010AA	2010AA PER02 must be present for first iteration of PER
2010AA	2420C N3/N4 must be different from 2010AA N3/N4
2010AC	2010AC can only be present when BHT06 = 31
2010AC	2320 AMT01 = "D" is required when 2010AC is used
2010AC	2010AC NM108 = "XV" when 2010AC REF_2U present
2000B	2300 CLM loop req'd in 2000B when 2000B SBR02 = "18"
2000B	2010BA N3 must be present when 2000B SBR02 = "18"
2000B	2010BA DMG must be present when 2000B SBR02 = "18"
2000B	2000C HL must be absent when 2000B SBR02 = "18"
2000B	2010BA N4 must be present when 2000B SBR02 = "18"
2000B	2000C required when 2000 SBR02 = "18" is absent
2000B	2320 SBR must be present when 2000B SBR01 = "P"
2000B	2300 CLM loop not allowed in 2000B when 2000B SBR02 absent
2010BA	2000B SBR02 = "18" must be present when 2010BA N3 is present
2010BA	2000B SBR02 = "18" must be present when 2010BA N4 is present
2010BA	2000B SBR02 = "18" must be present when 2010BA DMG is present
2010BB	2010BB NM108 = "XV" when 2010BB REF_2U present
2010BB	2010BB REF01 = "G2";"LU" must be absent if 2010AA NM109 present
2300	2300 CLM11 must be present when 2300 DTP01 = "439" is used
2300	2300 CR1 must be present when 2300 CRC_01 = "07" is used
2300	2300 DTP01 = "439" must be present when CLM11-01= "AA";"OA"
2300	2300 DTP01 = "439" must be present when CLM11-02 = "AA";"OA"
2300	2310A NM1 must be present when 2300 REF_9F present
2310A	2310A REF_0B;1G;G2 must be absent if 2310A NM109 present
2310B	2310B REF_0B;1G;G2;LU must be absent if 2310B NM109 present

LOOP	MESSAGE
2310C	2310C REF_0B;G2;LU must be absent if 2310C NM109 present
2310C	2420C N3/N4 must be different from 2310C N3/N4
2310D	2420D NM1 must be different from 2310D NM1
2310E	2420G N3/N4 must be different from 2310E N3/N4
2310F	2420H N3/N4 must be different from 2310F N3/N4
2320	2320 SBR01 (except U) must not equal 2000B SBR01
2320	Within 2300 loop 2320 SBR01 (except U) must be unique
2320	When present ((2320 AMT_D) & ABSENT (2430 FOR PAYER) present (2330B DTP_573))
2320	When present ((2430 SVD FOR 2320 PAYER) present (2320 AMT_D))
2400	2400 SV501-02 = 2400 SV101-02
2400	2400 DTP01 = "607" must be present when CR301 = "R" or "S"
2400	2300 CR1 must be present when 2400 CR1 used
2420A	2420A REF_0B;1G;G2;LU must be absent if 2420A NM109 present
2420B	2420B REF_0B;1G;G2 must be absent if 2420B NM109 present
2420D	2420D REF_0B;1G;G2;LU must be absent if 2420D NM109 present
2420D	2310D NM1 must be present when 2420D NM1 present
2420E	2420E REF_0B;1G;G2 must be absent if 2420E NM109 present
2420F	2420F REF_0B;1G;G2 must be absent if 2420F NM109 present
2430	2430 SVD01 must = 2330B NM109

Appendix C: Transmission Examples

This is an example of a batch file containing one claim. For Nevada Medicaid batch files have the ability to loop at the functional group, transaction and hierarchical levels. Each functional group within an interchange has to be the same transaction type.

ISA*00* *00* *ZZ*TPID1234 *ZZ*NVMED *180304*1259*^*00501*000001601*0*T*:~

GS*HC*TPID1234*NVMED*20180304*125946*284*X*005010X222A1~

ST*837*284001*005010X222A1~

BHT*0019*00*4438713*20180304*125946*RP~

NM1*41*2*SUBMITTER INC*****46*1234567890~

PER*IC*CONTACT NAME*TE*8001231234~

NM1*40*2*DIVISION OF HEALTH CARE FINANCING AND POLICY*****46*NVMED~

HL*1**20*1~

NM1*85*2*BILLING PROVIDER*****XX*BILLPNPI123~

N3*BILL PROV STREET~

N4*RENO*NV*895209998~

REF*EI*BILLTAXID~

HL*2*1*22*0~

SBR*S*18*******MC~

NM1*IL*1*RECLNAME*RECFNAME****MI*00000123456~

N3*123 RECIPIENT STREET~

N4*RENO*NV*89503~

DMG*D8*19531207*M~

NM1*PR*2*DHCFP*****PI*NVMED~

REF*G2*MEDICAIDID

CLM*EPPATACT1*139.8***12:B:1*Y*A*Y*Y~

HI*ABK:M6281~

SBR*P*18*******MC~

AMT*D*130.47~

OI***Y***Y~

NM1*IL*1*RECLNAME*RECFNAME****MI*RECID123456~

N3*123 RECIPIENT STREET~

N4*RENO*NV*89520~

NM1*PR*2*MCO NAME*****PI*TPID1234

DTP*573*D8*20180101

REF*F8*MCOICN~

LX*1~

SV1*HC:E0570*139.8*UN*1***1:2**Y~

DTP*472*D8*20180111~

REF*G1*-CN1-05~

REF*6R*108134~

SVD*OTHERPAYERID*139.8*HC:E0570:NU**1~

DTP*573*D8*20180118~

SE*36*000000001~

GE*1*284~

IEA*1*000001601~

Appendix D: Frequently Asked Questions

This appendix contains a compilation of questions and answers relative to encounter claims submitted to Nevada Medicaid.

Q: As a Trading Partner or clearinghouse, who should I contact if I have questions about testing, specifications, Trading Partner enrollment or if I need technical assistance with electronic submission?

A: After visiting the EDI webpage located at: https://www.medicaid.nv.gov/providers/edi.aspx if you still have questions regarding EDI testing and Trading Partner enrollment, support is available Monday through Friday 8 a.m.-5 p.m. Pacific Time by calling toll-free at (877) 638-3472 option 2, 0, and then 3. You can also send an email to nvmmis.edisupport@gainwelltechnologies.com.

Q: Is the same Trading Partner ID used for all encounter file types?

A: Yes, the same Trading Partner ID will be used for all encounter file types, unless the Trading Partner has requested multiple Trading Partner IDs to use for different locations.

Q: Who should I contact if I have questions regarding how an encounter claim was processed or to check on the status of a submitted encounter claim?

A: MCOs should send an email to nvmmis.edisupport@gainwelltechnologies.com with any encounter claims status inquiries or questions regarding how an encounter claim was processed. The email should contain enough information to research the question. The following is a list of information that would be helpful in answering most questions:

- Trading Partner ID
- Contact Name
- Contact Phone Number
- Question
- Encounter claim Identifying Information (TCN or Processor Control Number)
- Original File Name
- Response File Name
- Duplicate File Name

Q: How do I request and submit EDI files through the secure Nevada Medicaid SFTP server in production?

A: Once you have satisfied testing, you will receive an approval letter via email, which will contain the URL to connect to production.

Q: What types of acknowledgment reports will Nevada Medicaid return following EDI submission?

A: Several acknowledgements are provided back to the submitter:

- A TA1 will be generated when errors occur within the interchange envelope ISA/IEA.
- A 999 acknowledgement will be returned on batch 837 transactions.
- An 837 Encounter response file will be returned for all encounter claims stating each encounter claims' errors and disposition.
- An encounter claim duplicate file will be returned if duplicate encounter claims rejected within the Encounter Claims Engine.

Q: Is there a limit on the number of files which can be submitted per day or per week?

A: There is no limit to the number of files sent per day or week.

Q: Where can I find a copy of the HIPAA ANSI TR3 documents?

A: The TR3 documents must be purchased from x12.org at https://x12.org/products

Q: Since there is only one 1000A submitter loop allowed per batch file, do you expect separate files for encounters for each of the MCOs Northern and Southern Medicaid Provider ID?

A: A MCO that has a separate provider ID for Northern and Southern Nevada must submit encounters for each provider ID separately. The provider ID is required in Loop 1000A.

Q: Is there a certain ICN numbering convention depending on type of transaction (i.e. all originals begin with 11, replacements begin with 99)?

A: The ICNs assigned in Encounters are 13 bytes. They have a two-byte prefix that is the 'Region Code':

- 70 – Original
- 71 – Original non-emergency transportation
- 74 – Adjustment
- 75 – Void

The breakdown of the full 13 characters of the ICN is as follows:

- Position 1-2: Region code
- Position 3-7: Julian date
- Position 8-10: A sequential batch number from 1-999
- Position 11-13: A sequence number from 1-999

Q: What data elements must match on a void?

A: The most recently paid Nevada Medicaid ICN, which was assigned to the original claim being voided, must be sent. The original ICN number was sent back on the Response file from when the original claim was first accepted.

Q: When correctable rejects are received, by when do they have to be corrected and resubmitted? Are there timeliness measures or edits in place?

A: A disputed encounter file or claim must be corrected and resubmitted within sixty (60) calendar days of receipt of rejection.

Q: When a multiple line claim is submitted, some lines paid, some denied - what 2nd digit is expected in the patient account number of a partially denied encounter?

A: We determine paid and denied at the detail level based on the units allowed and the amount paid of service. When the units allowed = 0 and the amount paid = 0 the detail is considered denied. However, if there are other details that are paid, the patient account number 2nd digit should contain a P.

Q: When resubmitting a rejected encounter, is it submitted as an original or as a replacement with the ICN in the 2300/REF02, where 2300/REF01=F8?

A: A rejected claim needs to be resubmitted as an original. If the claim rejected because it was a duplicate of a previously accepted claim, then you would submit the Nevada Medicaid ICN of the previously accepted claim in 2300/REF02, where 2300/REF01=F8 and a claim frequency of 7 if you need to replace the original claim with the adjusted claim.

Q: When a void is submitted, is a response returned indicating the submitted void was accepted?

A: Yes, a response will be returned indicating the void was accepted.

Q: Where is Aid Category value code to be submitted in the encounter file? Is Aid Category required for all members or just those within the Nevada Check Up Program?

A: The Aid Category is not a required field.

Appendix E: Change Summary

This section describes the differences between the current Companion Guide and previous versions of the guide.

Published / Revised	Section / Nature of change
06/18/2018	Initial version published.
09/11/2018	Added additional information in section 7.7 Contact Information. Removed Claim Check or Remittance Date in section 7. Added additional notes to the 2300 REF (Prior Authorization) segment. Added the 2400 REF (Prior Authorization) segment. Removed notes in 2330B DTP segment. Updated notes in 2430 DTP03 segment. Removed SNIP edit "2330B DTP must be absent if 2430 DTP present" from section Appendix B. Added 2330B DTP segment in the Transmission Example in section Appendix C.
04/23/2019	Updated section 2.1 to Trading Partner Enrollment. Updated provider website link in section 2.1. Updated contact information in section 5.3.
01/31/2020	Updated Snip Edit (Compliance) table in Appendix B.
04/19/2021	Updated paid quantity instructions in section 10.1, Loop ID 2430.
07/01/2022	Added instructions for TR3 Page# 353 Loop ID 2400 Procedure Code and Procedure Modifier; updated instructions for TR3 Page# 425 Loop ID 2410 National Drug Code.
05/29/2024	Updates related to "units allowed > 0 and the paid amount = 0" in sections 7.6, 7.7, 7.8, and updated Appendix C: Transmission Examples with REF*G1*-CN1-05~
12/17/2024	Updated Section 7.8 Duplicate Encounter Professional Claim Logic
02/06/2025	Updated verbiage in 2300 CLM01 for void submissions and FAQ