Nevada MMIS 835 Transaction Companion Guide

Health Care Claim Payment/Advice
HIPAA Version 5010

Nevada Medicaid Management Services

Department of Health and Human Services (DHHS)

Division of Health Care Financing and Policy (DHCFP)

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1. Introduction

The Health Insurance Portability and Accountability Act (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.

The X12N Health Care Implementation Guides have been established as the standards of compliance and are online at:

http://store.x12.org/store/healthcare-5010-consolidated-guides.

Additional information is on the Department of Health and Human Services website at http://aspe.hhs.gov/admnsimp.

1.1. Purpose

The intended purpose of this document is to provide information such as registration, testing, support and specific transaction requirements to electronic data interchange (EDI) trading partners that exchange X12 information with the Nevada Medicaid Agency.

An EDI trading partner is defined by Nevada Medicaid as anybody such as a provider, software vendor and clearinghouse that exchanges transactions adopted under the Healthcare Portability and Accountability Act of 1996 (HIPAA).

HPES has prepared this companion guide and website, http://www.medicaid.nv.gov, to support Nevada Medicaid and Nevada Check Up billing. (Hereafter, Nevada Medicaid and Nevada Check Up are referred to as Medicaid unless otherwise specified.)

This companion guide provides specific requirements for receiving electronic claim data from HP. It supplements but does not contradict the X12N Health Care Implementation Guides and should be used solely for the purpose of clarification.

The 835 Health Care Claim Payment Advice transaction set (hereafter called the "835 transaction") communicates the results of claim adjudication. An 835 transaction is also called an electronic remittance advice (ERA).

The 835 transaction lists paid claims and denied claims (claims with a "pended" status are sent in a 277U transaction). Please work with your software vendor to ensure integration with your account management software.

The 835 transaction does not automatically issue an electronic funds transfer (EFT). A provider must register to receive EFT payments by submitting form FA-32 on HPES's website, http://www.medicaid.nv.gov.

Standard HIPAA claims adjustment codes and remarks codes will replace the edit and EOB codes on the 835 transaction.

1.2. 835 basic business flow

The basic business flow of the 835 transaction is from the payer to the health care provider that provided the service. Both the DHCFP and the provider may contract with other parties for the performance of various administrative services. A value added network (VAN) or a service center may perform value added services or simply act as a communications pipeline.

An 835 transaction may be sent from HP to:

- The provider
- The VAN to the provider
- The billing service to the provider
- The service center to the provider
- The independent practice association to the provider.

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1.3. Intended use

The following information is intended to serve only as a companion guide to the HIPAA ANSI Accredited Standards Committee (ASC) X12N Technical Report Type 3 (TR3) document. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the ASC X12 TR3 document. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

2. Working together

Nevada Medicaid in an effort to assist the community with their electronic data exchange needs have the following options available for either contacting a help desk or referencing a website for further assistance.

Nevada Medicaid Website: http://www.medicaid.nv.gov

EDI Helpdesk

Monday – Friday
8:00 a.m. – 5:00 p.m. PT

Technical questions (claim submission or testing): 1-800-924-6741

Fax: 1-804-290-4805
Email: dighelpdesk@magellanhealth.com

Enrollment or setup questions: 1-877 638-3472

Fax: 1-775-784-7932
Email: nvedi@magellanhealth.com

2.1. Trading partner registration

An EDI 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 EDI registration regardless of the trading partner type as defined below. Contact the EDI Helpdesk to register.

- Trading partner is an entity engaged in the exchange or transmission of electronic transactions.
- 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.

Vendors must fill out a data switch agreement. The Trading Partner Data Switch agreement form is located at:

http://www.medicaid.nv.gov

2.2. Trading partner testing and certification

Nevada Medicaid requires that all newly registered trading partners complete basic transaction submission testing. Successful transaction submission and receipt of both valid responses and error responses is an indication that all systems involved can properly submit and receive transactions.

2.2.1. Trading partner ID

Once registration is completed the following IDs will be created:

- Test trading partner ID
- Production trading partner ID

These IDs are exclusive to the environment submitted and will not be accepted if submitted incorrectly.

2.2.2. Web user ID

Each entity will be assigned a personal identification number (PIN) that allows access to a secure website. The secure website allows for the uploading and downloading of electronic transactions. Separate PINs will be produced for testing and production.

2.2.3. Usage indicator

ISA15 of the HIPAA X12 transaction allows for the submission of either a T, to indicate testing or a P, to indicate production. The following process is defined for these usage indicators:

T – May be submitted into the test and production environments. However, only a compliance check will be performed. The electronic files submitted with a T will not be translated for further processing.

P – May be submitted into the test and production environments. A compliance check will be performed and the files will be translated for further processing (edit, audit, adjudication and response).

2.2.4. Secure Web upload - tracking number

A tracking number will be assigned and returned online for each successful upload of an electronic file. This tracking number should be maintained if any questions should arise concerning the processing of the file. The following message will be returned:

> "File was uploaded successfully. File tracking number is 0123456.
> Please make note of this number for future reference."

2.2.5. Error messages

If an electronic file fails to upload, an error message will be returned online.

The following messages will be returned:

- Error occurred. Error uploading file:
- Error occurred. Error gathering information for upload:
- The session has been timed out. Please try login again.

2.2.6. Secure website download – file retention

All electronic files that have been made available for download will remain available online for download as follows:

7 Days	999, TA1, 271, 277
30 Days	277U
90 Days	835

After the allotted time frame has passed the files will be removed from the list and will no longer be available for download. This applies to testing and production.

2.2.7. Testing transactions

The following transaction types are available for testing:

- 270 Eligibility Request/271 Eligibility Response
- 276 Claim Status Request/277 Claim Status Response
- 837D Dental Claim
- 837P Professional (CMS-1500) Claim
- 837I Institutional (UB-04) Claim
- 835 Electronic Remittance Advice
- 277U Unsolicited Claim Status

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

There is not a limit to the number of files that may be submitted. Users will be allowed to move to production once a successfully compliant transaction is received and the appropriate responses returned.

2.3. Payer specific documentation

For additional information in regards to business processes related to eligibility, prior authorization and claims processing please review the Provider Manual located on the Nevada Medicaid website.

http://www.medicaid.nv.gov

For further information on specific payer prior authorization information please see the Nevada Medicaid website.

http://www.medicaid.nv.gov

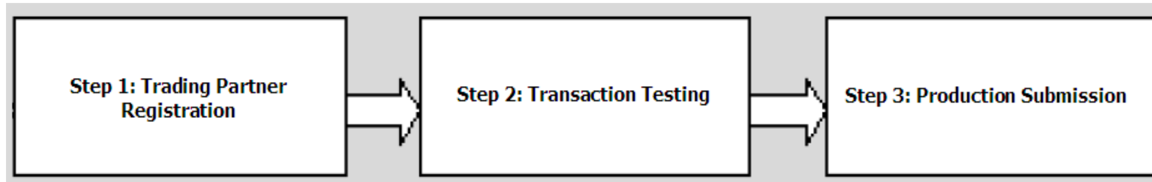
2.4. Testing contact information

All correspondence for assistance with testing should be submitted to the following email address:

nvedi@magellanhealth.com.

3. Connectivity/communications

3.1. Process flows



3.2. Transmission procedures

Availability

24 hours/7 days a week

Downtime notification

HPES will notify the trading partners in the case of any planned downtime or unexpected downtime using email distribution.

Re-Transmission procedures

Trading partners may call HPES for assistance in researching problems with submitted transactions. HPES will not edit trading partner data and/or resubmit transactions for processing on behalf of a trading partner. The trading partner must correct any errors found and resubmit.

3.3. Communication and security protocols

Vendors may find information regarding communication protocols in the Service Center User Manual.

https://www.medicaid.nv.gov/downloads/provider/MMIS_Service_center_user_manual.pdf

4. Contact information

4.1. EDI customer service/technical assistance

EDI Helpdesk

Monday – Friday
8:00 a.m. – 5:00 p.m. PT

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Email: nvedi@magellanhealth.com

4.2. Provider services

Provider Relations Department

The Provider Relations Department is composed of field representatives who are committed to assisting Nevada Medicaid providers in the submission of claims and the resolution of claims processing concerns.

Provider Relations Call Center

The Provider Relations Call Center communication specialists are available to respond to written and telephone inquiries from providers on billing questions and procedures, claim status, form orders, adjustments, use of the Automated Response System (ARS), electronic claims submission via electronic data interchange (EDI) and remittance advice (RAs).

Both departments can be reached by calling: 1-877-638-3472

5. Control segments/envelopes

NOTE: The page numbers listed below in each of the tables represent the corresponding page number in the X12N 835 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

5.1. ISA–Control header

Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

Segment	Name	Page in IG	Comments
ISA	Interchange Control Header		
ISA01	Authorization Information Qualifier	C.4	00 = No Authorization Information Present
ISA02	Authorization Information	C.4	Value is 10 spaces as field is fixed length
ISA03	Security Information Qualifier	C.4	00 = No Security Information Present
ISA04	Security Information	C.4	Value is 10 spaces as field is fixed length
ISA05	Interchange ID Qualifier	C.4	ZZ
ISA06	Interchange Sender ID	C.4	NVM FHSC FA
ISA07	Interchange ID Qualifier	C.5	ZZ

Segment	Name	Page in IG	Comments
ISA08	Interchange Receiver ID	C.5	Use the 4-digit Service Center Code assigned by Magellan Medicaid Administration.
ISA09	Interchange Date	C.5	Format is YYMMDD
ISA10	Interchange Time	C.5	Format is HHMM
ISA11	Interchange Control Standards Identifier	C.5	^
ISA12	Interchange Control Version Number	C.5	00501
ISA13	Interchange Control Number	C.5	Must be identical to Interchange Trailer IEA02
ISA14	Acknowledgement Requested	C.6	0 = No Acknowledgement Requested or 1 = Acknowledgement Requested
ISA15	Interchange Usage Indicator	C.6	P = Production Data T = Test Data
ISA16	Component Element Separator	C.6	:

5.2. IEA–Control trailer

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

Segment	Name	Page in IG	Notes/Comments
IEA	Interchange Control Trailer		
IEA01	Number of Included Functional Groups	C.10	Number of included Functional Groups
IEA02	Interchange Control Number	C.10	Must be identical to ISA13

5.3. GS–Functional group header

Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

Segment	Name	Page in IG	Comments
GS	Functional Group Header		
GS01	Functional Identifier code	C.7	HP – Health Care Claim Payment/Advice (835)
GS02	Application Sender's Code	C.7	NVM FHSC FA
GS03	Application Receiver's Code	C.7	Use the 4-digit Service Center Code assigned by Magellan Medicaid Administration.
GS04	Functional Group Creation Date	C.8	Format = CCYYMMDD
GS05	Functional Group Creation Time	C.8	Format = HHMM
GS06	Group Control Number	C.8	Must be identical to GE02
GS07	Responsible Agency Code	C.8	X = Accredited Standards Committee X12
GS08	Version/Release/Industry Identifier Code	C.8	005010X221A1

5.4. GE–Functional group trailer

Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

Segment	Name	Page in IG	Notes/Comments
GE	Functional Group Trailer		
GE01	Number of Transaction Sets Included	C.9	Number of included Transaction Sets
GE02	Group Control Number	C.9	Must be identical to the value in GS06.

5.5. ST–Transaction set header

Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

Segment	Name	Page in IG	Notes/Comments
ST	Transaction Set Header		
ST01	Transaction Set Identifier Code	61	835
ST02	Transaction Set Control Number	61	Increment by 1 when multiple transaction sets are included. Must be identical to SE02
ST03	Implementation Convention Reference	62	005010X221A1

5.6. SE–Transaction set trailer

Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

Segment	Name	Page in IG	Notes/Comments
SE	Transaction Set Trailer		
SE01	Transaction Segment Count	450	Number of segments included within the ST/SE segments
SE02	Transaction Set Control Number	450	Must be identical to ST02

6. Instruction tables

This table contains one or more rows for each segment for which supplemental instruction is needed.

6.1. 005010X221A1 Health care claim payment/advice (835)

Loop	Segment	Name	Page in IG	Comments
N/A	BPR	Financial Information		
N/A	BPR01	Transaction Handling Code	70	I = Remittance information only H = Notification only
N/A	BPR04	Payment Method Code	71	ACH = Automated Clearing House (if EFT is used) CHK = Paper check NON = No funds transmitted If BPR04 = CHK or NON, then BPR05 through BPR12 are blank.
N/A	BPR10	Payer Identifier	74	DHCFP Fed Tax ID (54-0849793) preceded by a 1
N/A	TRN	Reassociation Trace Number		
N/A	TRN01	Trace Type Code	77	1 = Current Transaction Trace Number
N/A	TRN02	Check or EFT Trace Number	77	Check or EFT trace number
N/A	TRN03	Payer Identifier	78	DHCFP Fed Tax ID (54-0849793) preceded by a 1
N/A	TRN04	Originating Company Supplemental Code	78	If BPR04 = ACH, the same value as BRP11 (Originating Company Supplemental Code) is used. If BPR04 = CHK or NON, the RA ADVICE NUMBER is used.

Loop	Segment	Name	Page in IG	Comments
N/A	REF	Receiver Identification		
N/A	REF01	Reference Identification Qualifier	82	EV = Receiver Identification Number
N/A	REF02	Receiver Identifier	82	Medicaid Service Center
N/A	DTM	Production Date		
N/A	DTM01	Date/Time Qualifier	85	405 = Production
N/A	DTM02	Production Date	86	Weekly End Date, CCYYMMDD
1000A	N1	Payer Identification		
	N101	Entity Identifier Code	87	PR = Payer
	N102	Payer Name	87	Division of Health Care Financing and Policy
1000A	N3	Payer Address		
	N301	Payer Address Line	89	1100 East William Street
1000A	N4	Payer City, State, Zip Code		
	N401	Payer City Name	90	Carson City
	N402	Payer State Code	91	Nevada
	N403	Payer Postal Zone or ZIP Code	91	89701
1000B	N1	Payee Identification		
	N103	ID Code Qualifier	103	XX = NPI FI = Federal Tax ID or SSN
	N104	Payee ID Code	103	NPI or Federal Tax ID (depends on qualifier sent in N103)

Loop	Segment	Name	Page in IG	Comments
1000B	REF	Payee Additional Information		
	REF01	Reference Identification Qualifier	107	TJ = Federal Tax ID PQ = 10-digit Atypical Provider Identifier
	REF02	Additional Payee Identifier	108	The Federal Tax ID will be returned in this segment if the NPI is returned in N104. The Atypical Provider Identifier will be returned in this segment if a NPI is not used.
2000	LX	Header Number		
	LX01	Assigned Number	111	01 = Nevada Medicaid 02 = Nevada Check Up 03 = Unmatched ZZ = Other
2000	TS	Provider Summary Information		
	TS301	Provider Identifier	113	NPI or Atypical Provider Identifier of the servicing provider
	TS302	Facility Type Code	113	For institutional claims, this data element reflects the bill type. For professional claims, this data element reflects the place of service. The default value is 99.

Loop	Segment	Name	Page in IG	Comments
2100	CLP	Claim Payment Information		
	CLP01	Patient Control Number	123	Claim Patient Account or Rx Number returned from 837 CLM01 If a Patient Account Number or Rx number was not provided on the claim, this field will display 0.
	CLP06	Claim Filing Indicator Code	126	MC = Medicaid
	CLP07	Payer Claim Control Number	127	The 16-digit Internal Control Number assigned by HP is formatted as follows: 2-digit century, 2-digit year, 3-digit Julian date, 1-digit media type, 6-digit document number, 2-digit claim line number
	CLP08	Facility Type Code (1st and 2nd position of TOB)	127	Type of Bill or Place of Service returned from 837 CLM05-1; Default value is 99.
	CLP09	Claim Frequency Code (3rd position of TOB)	127	On 837I transactions only, this is returned from the CLM05-2 data element.
2100	CAS	Claim Adjustment	131	If multiple errors are found with a claim, or when additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.

Loop	Segment	Name	Page in IG	Comments
2100	NM1	Patient Name		
2100	NM101	Entity Identifier Code	137	QC = Patient
	NM108	Identification Code Qualifier	139	MR = Medicaid Recipient Identification Number MI = Member Identification Number
2100	NM1	Service Provider Name		
	NM101	Entity Identifier Code	147	82 = Rendering Provider
	NM108	Identification Code Qualifier	148	MC = Medicaid XX = NPI
	NM109	Rendering Provider Identifier	149	This identification code will be the servicing provider's NPI.
2100	MIA	Inpatient Adjudication Information		
	MIA20 - MIA24	Reference Identification - Remark Codes (Inpatient Adjudication Information)	164	If multiple errors are found with a claim, or when additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.

Loop	Segment	Name	Page in IG	Comments
2100	MOA	Outpatient Adjudication Information		
	MOA03 - MOA09	Reference Identification - Remark Codes (Outpatient Adjudication Information)	167	If multiple errors are found with a claim, or when additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.
2100	REF	Other Claim Related Identification		
	REF01	Reference Identification Qualifier	169	G1 = Prior Authorization Number F8 = Original Reference Number (This refers to the Internal Control Number or ICN.)
	REF02	Other Claim Related Identifier	170	If data element REF01 = G1, the 11-digit Authorization Number and the prior authorization line number are displayed. If data element REF01 = F8, the ICN is displayed.
2110	SVC	Service Payment Information		The service line loop will occur once for professional or pharmacy claims. For outpatient or home health services, this loop may occur once per revenue line.
	SVC01-3 -- SVC01-6	Procedure Modifier	188	Up to four procedure modifiers can be displayed as reported on the claim.

Loop	Segment	Name	Page in IG	Comments
2110	CAS	Service Adjustment	196	For outpatient services, home health services, professional claims or pharmacy claims, this segment will appear at the line level. If multiple errors are found with a claim line, or when additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.
2110	REF	Line Item Control Number		
	REF01	Reference Identification Qualifier	206	6R = Provider Control Number
	REF02	Line Item Control Number	206	Line item control from 837
2110	LQ	Health Care Remark Codes		
	LQ02	Remark Code	216	If multiple errors are found with a claim, or when additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.
N/A	PLB	Provider Adjustment		
	PLB03	Adjustment Identifier	165	The value in this field will be the NPI or the Atypical Provider Identifier.

7. Payer specific business rules and limitations

Financial adjustment reason codes – A composite reference identifier in the PLB03-02 segment describes a provider level financial adjustment transaction. A component of this identifier is referred to as the DHCFP financial adjustment reason codes. These reason codes and their descriptions are available on the DHCFP website at http://dhcfp.nv.gov.