Nevada MMIS 837I Transaction Companion Guide

Institutional Health Care Claims and Managed Care Organization Encounter Claims
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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Change history

The following Change History log contains a record of changes made to this document:

Published / revised	Section /Nature of change
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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 submitting institutional claims (837I, UB-04) electronically to Magellan Medicaid Administration (MMA).

1.2. 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. Response files

- Functional acknowledgement (999)
  The 999 will be returned for all files that have been successfully uploaded. This response is intended to convey HIPAA compliance errors.
- Acknowledgement (TA1)
  The TA1 will be returned for all files that fail the Interchange Envelope content. This response is intended to report the status of processing on a received interchange header and trailer.

2.2.5. 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."

2.2.6. 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.

2.2.7. 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.

2.2.8. 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

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.

2.2.8.1. 835 testing

If an 835 response is desired for claims submitted the trading partner submitting the test files needs to contact the EDI Helpdesk and provide a list of the provider IDs to be tested as a link between the trading partner ID and provider IDs must be established for the return of this transaction.

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

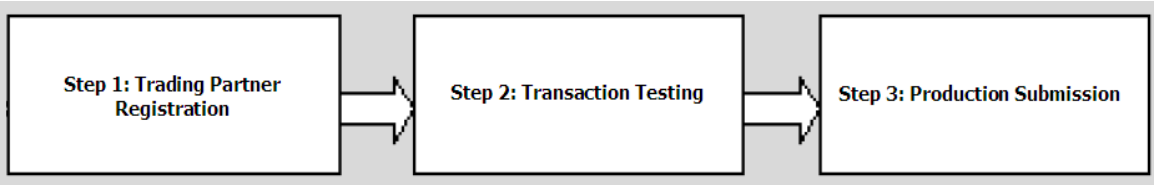
2.4. Testing contact information

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

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

Fax: 1-804-290-4805
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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 837I 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	Empty if ISA01 = 00
ISA03	Security Information Qualifier	C.4	00 = No Security Information Present
ISA04	Security Information	C.4	Empty if ISA03 = 00
ISA05	Interchange ID Qualifier	C.4	ZZ = Mutually Defined
ISA06	Interchange Sender ID	C.4	Use the 4-digit Service Center Code assigned by Magellan Medicaid Administration.
ISA07	Interchange ID Qualifier	C.5	ZZ = Mutually Defined
ISA08	Interchange Receiver ID	C.5	NVM FHSC FA
ISA09	Interchange Date	C.5	Format is YYMMDD
ISA10	Interchange Time	C.5	Format is HHMM
ISA11	Repetition Separator	C.5	^

Segment	Name	Page in IG	Comments
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 NOTE: A TA1 will be generated regardless of the value used.
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	1
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	HC
GS02	Application Sender's Code	C.7	Use the 4-digit Service Center Code assigned by Magellan Medicaid Administration.
GS03	Application Receiver's Code	C.7	NVM FHSC FA
GS04	Date	C.7	Format is CCYYMMDD
GS05	Time	C.8	Format is 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	005010X223A2

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	1
GE02	Group Control Number	C.9	Use the 4-digit Service Center Code assigned by Magellan Medicaid Administration.

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	67	837
ST02	Transaction Set Control Number	67	Increment by 1 when multiple transaction sets are included; must be identical to SE02.
ST03	Implementation Convention Reference	67	005010X223A2

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	488	Number of segments included within the ST/SE segments
SE02	Transaction Set Control Number	488	Must be identical to ST02

6. Instruction tables

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

6.1. 005010X223A2 Institutional health care claims and MCO encounter claims (837I)

Loop	Segment	Name	Page in IG	Comments
1000A	NM1	Submitter Name		
	NM109	Submitter Identifier	72	Use the 4-digit Service Center Code assigned by Magellan Medicaid Administration. For MCO encounter claims, enter the MCO's Southern or Northern Medicaid Submitter ID.
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.
	PER01	Contact Function Code	74	IC – Information Contact
	PER02	Name	74	Submitter Name
	PER03	Communication Number Qualifier	74	EM – Electronic Mail FX – Facsimile TE - Telephone
	PER04	Communication Number	74	Email Address, Fax Number or Telephone Number (including the area code)
1000B	NM1	Receiver Name		
	NM109	Receiver Primary Identifier	77	DHCFP

Loop	Segment	Name	Page in IG	Comments
2000A	PRV	Billing Provider Specialty Information		
	PRV03	Provider Taxonomy Code	80	A taxonomy code is recommended when using a National Provider Identifier (NPI).
2010AA	N4	Billing Provider City/ State/ ZIP Code		
	N403	Billing Provider Postal Zone or ZIP Code	89	The billing provider's 9-digit ZIP code (along with the other address information in the 2010AA N3 segment) is required.
2010BA	NM1	Subscriber Name		
	NM108	Identification Code Qualifier	113	MI - Member Identification Number
	NM109	Identification Code Qualifier	113	Nevada Medicaid Recipient ID
2300	CLM	Claim Information		
	CLM01	Patient Control Number	144	For MCO encounter claims, enter the MCO's claim number.
	CLM05-3	Claim Frequency Code	145	1 = Original Claim 7 = Adjustment 8 = Void
2300	CN1	Contract Information		
	CN101	Contract Type Code	158	This segment is required on MCO encounter claims.
	CN102	Contract Amount	158	On MCO encounter claims, enter the paid amount.
2300	REF	Prior Authorization		
	REF01	Reference Identification Qualifier	128	G1 = 11-digit Authorization Number
	REF02	Prior Authorization Number	129	Enter the 11-digit Authorization Number assigned by Magellan Medicaid Administration.

Loop	Segment	Name	Page in IG	Comments
2300	REF	Payer Claim Control Number		
	REF01	Reference Identification Qualifier	166	F8 = Original Reference Number Adjust or void a claim (as indicated by CLM05-3).
	REF02	Payer Claim Control Number	166	On Fee For Service (FFS) claims, enter the last paid Internal Control Number (ICN) that Magellan Medicaid Administration assigned to the claim. On MCO encounter claims, enter the MCO's claim number (CLM01 from last claim).
2300	NTE	Claim Note		
	NTE02	Claim Note Text	179	Provide free-text remarks, if needed. Magellan Medicaid Administration will use the first occurrence of this segment.
2300	NTE	Billing Note		
	NTE02	Billing Note Text	180	Provide free-text remarks if necessary.
2300	HI	Principal Procedure Information	184	Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.
2300	HI	Admitting Diagnosis		Although ICD10 values will be accepted in all diagnosis and ICD procedure code fields, only ICD9 values will be paid until ICD10 is implemented.

Loop	Segment	Name	Page in IG	Comments
2300	HI	Other Procedure Information		
	HI01-1, HI02-1, HI03-1, etc. through HI12-1	Code List Qualifier Code data elements only	243	BBQ = ICD-10-PCS BQ = ICD-9-CM If this field is submitted, use only ICD-9-CM diagnosis codes.
2310A	REF	Attending Provider Secondary Identification		
	REF01	Reference Identification Qualifier	324	0B = State License Number 1G = Provider UPIN G2 = Provider Commercial Number LU = Location Number
	REF02	Attending Provider Secondary Identifier	325	If qualifier G2 was used in data element REF01, enter the billing provider's Atypical Provider Identifier.
2310B	REF	Operating Physician Secondary Identification		
	REF01	Reference Identification Qualifier	329	0B = State License Number 1G = Provider UPIN G2 = Provider Commercial Number LU = Location Number
	REF02	Operating Physician Secondary ID	330	If qualifier G2 was used in data element REF01, enter the billing provider's Atypical Provider Identifier.

Loop	Segment	Name	Page in IG	Comments
2310C	REF	Other Operating Physician Secondary Identification		
	REF01	Reference Identification Qualifier	334	0B = State License Number 1G = Provider UPIN G2 = Provider Commercial Number LU = Location Number
	REF02	Other Provider Secondary Identifier	335	If qualifier G2 was used in data element REF01, enter the billing provider's Atypical Provider Identifier.
2310E	N4	Service Facility Location City, State, ZIP Code		The City, State and ZIP Code where the services were performed.
	N403	Postal Code		When reporting the ZIP code for U.S. addresses submit the ZIP + 4.
2320	SBR	Other Subscriber Information: TPL, Medicare or MCO	354	If the recipient has Medicare or other coverage, repeat this loop for each other payer. Omit Nevada Medicaid coverage information. For MCO encounter claims, if CAS reason codes are submitted, then use one iteration of this loop to represent the MCO.
	SBR09	Claim Filing Indicator Code	356	Use MA or MB to indicate a Medicare payer on claims for Medicare coinsurance and/or deductible.

Loop	Segment	Name	Page in IG	Comments
2320	CAS	Claim Level Adjustments: Adjustment Reason Code	358	Adjustment amounts may be reported at both the claim line and the service line, but they may not duplicate each other. For MCO encounter claims, use Claim Adjustment Reason Code (code source 139) to indicate the denial or cutback reason. Use the following qualifiers on claims for Medicare coinsurance and deductible: 01 = Deductible Amount 02 = Coinsurance Amount 66 = Blood Deductible Amount
2320	AMT	COB Payer Paid Amount		
	AMT01	Amount Qualifier Code	364	D = Payor Amount Paid
	AMT02	Payer Paid Amount	364	D = Non-Medicare TPL Payment Use this segment, for the appropriate payer, to report all prior payments you have received for this claim. Omit Nevada Medicaid payment information.
2330A	NM1	Other Subscriber Name		
	NM109	Other Insured Identifier	379	On claims for Medicare coinsurance and/or deductible, enter the recipient's Medicare ID.

Loop	Segment	Name	Page in IG	Comments
2330B	NM1	Other Payer Name		
	NM109	Other Payer Primary Identifier	385	On MCO encounter claims, enter the 4-digit Service Center Code that Magellan Medicaid Administration assigned to the electronic submitter (clearinghouse, trading partner or direct submitter).
2400	SV2	Institutional Service Line	424	Magellan Medicaid Administration recommends submitting fewer than 240 claim lines per institutional claim. Claims submitted with more than 240 claim lines may be subject to processing delays. NDC codes will not be captured in this segment, however an NDC must be sent in the LIN segment to supplement a J procedure code.
2410	LIN	Drug Identification		
	LIN02	Product or Service ID Qualifier	451	N4 = NDC
	LIN03	National Drug Code	451	An NDC code is required when a J procedure code is billed in Loop 2400, Segment SV1, Data Element SV101-2.

Loop	Segment	Name	Page in IG	Comments
2410	CTP	Drug Quantity		
	CTP04	National Drug Unit Count	452	Enter the actual NDC quantity dispensed.
	CTP05-1	Unit or Basis for Measurement Code	453	Enter the appropriate unit of measure: F2 = International Unit GR = Gram ME = Milligram ML = Milliliter UN = Unit
2410	REF	Prescription or Compound Drug Association Number		
	REF01	Prescription or Compound Drug Association Number	454	XZ - Pharmacy Prescription Number
2430	CAS	Line Adjustment	481	Adjustment amounts may be reported at both the claim line and the service line, but they may not duplicate each other. For MCO encounter claims, use Claim Adjustment Reason Code (code source 139) to indicate the denial or cutback reason. Use the following qualifiers on claims for Medicare coinsurance and deductible: 01 = Deductible Amount 02 = Coinsurance Amount 66 = Blood Deductible Amount
	CAS02	Adjustment Reason Code	482	For denied MCO encounter claims, use CAS02 Claim Adjustment Reason Code (code source 139) to indicate the denial reason.

7. Payer specific business rules and limitations

The information when applicable under this section is intended to help the trading partner understand the business context of the EDI transaction.

7.1. Use separate envelopes

Submit MCO encounter claims and non-encounter claims in separate ISA-IEA envelopes.

7.2. Submissions

You may submit electronic 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.

Claims must be submitted before 1:00 p.m. PT on Fridays to be included in the following Friday's electronic remittance advice (835 transaction).

8. Acknowledgements and reports

8.1. Inquiry requirements

Inquiries require the provider's NPI or Atypical Provider Identifier.

- The NPI will be accepted in the NM109 segment, Loop 2100B with qualifier XX.
- The Atypical Provider Identifier will be accepted in the NM109 segment, Loop 2100B with qualifier SV.

8.2. Error messages

The 837I response returns an error message if there is a problem with the request or response.

This may occur for any of the following reasons:

- Syntax error
- Unknown requester
- Incorrect file format
- Incorrect/incomplete request
- Transmission-related problem
- Requested entity was not found
- Magellan Medicaid Administration system error