Nevada MMIS 837P Transaction Companion Guide

Professional 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
2/03/2012	Initial version.

Table of contents

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 professional claims (837P, CMS-1500) 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. PST

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 failed 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
- 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.

2.2.8.1. 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

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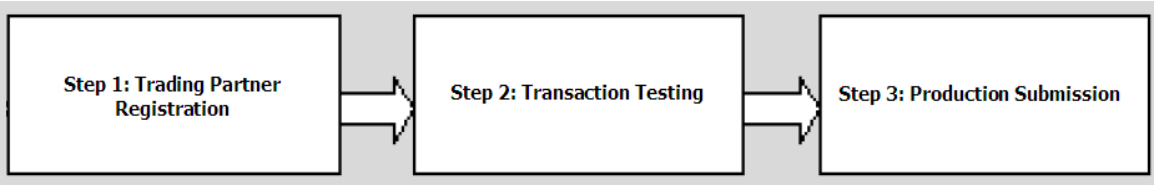
3. Connectivity/communications

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. PST

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

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

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Fax: 1-775-784-7932
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 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

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	The 4-digit Service Center Code assigned by Magellan Medicaid Administration

Segment	Name	Page in IG	Comments
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	^
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	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	The 4-digit Service Center Code assigned by Magellan Medicaid Administration
GS03	Application Receiver's Code	C.7	NVM FHSC FA
GS04	Functional Group Creation Date	C.7	Format is CCYYMMDD
GS05	Functional Group Creation Time	C.8	Format is HHMM

Segment	Name	Page in IG	Comments
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	005010X222A1

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	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	61	837
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	005010X222A1

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. 005010X222A1 Professional health care claims and MCO encounter claims (837P)

Loop	Segment	Name	Page in IG	Comments
1000A	NM1	Submitter Name		
	NM109	Submitter ID	75	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.
	PER	Submitter EDI Contact Information	76	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's organization.
	PER01	Contact Function Code	77	IC = Information Contact
	PER02	Submitter Contact Name	77	Submitter Name
	PER03	Communication Number Qualifier	77	EM = Email FX = Fax TE = Telephone
	PER04	Communication Number	77	Email address, fax number or telephone number (including the area code)

Loop	Segment	Name	Page in IG	Comments
1000B	NM1	Receiver Name		
	NM109	Receiver Primary Identifier	80	DHCFP
2000A	PRV	Billing Provider Specialty Information		
	PRV03	Provider Taxonomy Code	83	A taxonomy code is recommended when using a National Provider Identifier (NPI).
2010AA	N4	Billing Provider City/ Sate/ ZIP Code		
	N403	Billing Provider Postal Zone or ZIP Code	93	The billing provider's 9-digit ZIP code (along with the other address information in the 2010AA N3 segment) is required. The ZIP code may be used to determine claim pricing.
2010BA	NM1	Subscriber Name		
	NM108	Identification Code Qualifier	122-123	MI = Member Identification Number
	NM109	Subscriber Primary Identifier	123	Required when NM102 = 1
2300	CLM	Claim Information		
	CLM01	Patient Control Number	158	For MCO encounter claims, enter the MCO's claim number.
	CLM05-3	Claim Frequency Code	159	1 = Original Claim 7 = Adjustment 8 = Void

Loop	Segment	Name	Page in IG	Comments
2300	REF	Referral Number		
	REF01	Reference Identification Qualifier	193	9F = Referral Number
2300	REF	Prior Authorization		
	REF01	Reference Identification Qualifier	194	G1 = 11-digit Prior Authorization Number
	REF02	Prior Authorization Number	195	If G1 was entered in Data Element REF01, enter the 11-digit Authorization Number assigned by Magellan Medicaid Administration.
2300	REF	Payer Claim Control Number		
	REF01	Reference Identification Qualifier	196	F8 = Adjust or void a claim (as specified in Data Element CLM05-3).
	REF02	Payer Claim Control Number	196	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).

Loop	Segment	Name	Page in IG	Comments
2300	CR1	Ambulance Transport Information		
	CR106	Transport Distance	213	Required on all claims involving ambulance services. Report the base rate at the line level (2400, CR106); put the number of miles traveled in this segment.
2310A	REF	Referring Provider Secondary Identification		
	REF01	Reference Identification Qualifier	260	0B = State License Number 1G = Provider UPIN G2 = Provider Commercial Number
	REF02	Referring Provider Secondary Identifier	261	If qualifier G2 was used in data element REF01, enter the billing provider's Atypical Provider Identifier.
2310B	PRV	Rendering Provider Specialty Information		
	PRV03	Provider Taxonomy Code	265	A taxonomy code is recommended when using a National Provider Identifier (NPI).

Loop	Segment	Name	Page in IG	Comments
2310B	REF	Rendering Provider Secondary Identification		
	REF01	Reference Identification Qualifier	267	0B = State License Number 1G = Provider UPIN G2 = Provider Commercial Number LU = Location Number
	REF02	Rendering Provider Secondary Identifier	268	If qualifier G2 was used in data element REF01, enter the billing provider's Atypical Provider Identifier.
2310C	N4	Service Facility Location City/ State/ ZIP		
	N403	Laboratory or Facility Postal Zone or ZIP Code	274	The facility's 9-digit ZIP code is required (along with the address in Loop 2310C, Segment N3). The ZIP code may be used to determine claim pricing.

Loop	Segment	Name	Page in IG	Comments
2320	SBR	Other Subscriber Information	295-298	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	298	Use MB to indicate a Medicare payer on claims for Medicare coinsurance and/or deductible.
2320	CAS	Claim Level Adjustments: Claim Adjustment Reason Code	299-304	Adjustment amounts may be reported at both the claim line and at the service line, but they cannot duplicate each other. For MCO encounter claims, use Claim Adjustment Reason Code (code source 139) to indicate the denial or cutback reason.
2320	AMT	COB Payer Paid Amount		
	AMT02	Payer Paid Amount	305	Use this segment, for the appropriate payer, to report all prior payments you have received for this claim. Omit Nevada Medicaid payment information.

Loop	Segment	Name	Page in IG	Comments
2320	AMT	Remaining Patient Liability		
	AMT02	Remaining Patient Liability	307	Enter the amount that is owed from the recipient (patient responsibility amount). On claims for Medicare coinsurance and/or deductible, submit the Medicare allowed amount for the total claim.
2330A	NM1	Other Subscriber Name		
	NM109	Other Insured Identifier	315	On claims for Medicare coinsurance and/or deductible, enter the recipient's Medicare ID number.
2330B	NM1	Other Payer Name		
	NM109	Other Payer Primary Identifier	321	For 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).

Loop	Segment	Name	Page in IG	Comments
2400	SV1	Professional Service		
	SV101-1	Product or Service ID Qualifier	352-353	HC = HCPCS Codes NDCs will not be captured in this segment; however an NDC must be submitted in the LIN segment to supplement a J or Q procedure code.
	SV102	Line Item Charge Amount	354	On claims for Medicare coinsurance and/or deductible, enter the line charge amount billed to Medicare.
	SV103	Unit or Basis for Measurement Code	355	For anesthesia claims, enter UN when sending anesthesia units in Data Element SV104.
2400	CR1	Ambulance Transport Information		
	CR106	Transport Distance	370	When billing with a base rate code that does not require mileage, enter a 1 for quantity.
2400	CN1	Contract Information		
	CN101	Contract Type Code	395	This segment is required on MCO encounter claims.
	CN102	Contract Amount	395	Enter the MCO paid amount.
2400	NTE	Line Note		
	NTE01	Note Reference Code	413	On transportation claims, enter ADD.
	NTE02	Line Note Text	413	Enter line level free-text remarks as needed (enter claim level remarks in Loop 2300).

Loop	Segment	Name	Page in IG	Comments
2410	LIN	Drug Identification		
	LIN02	Product or Service ID Qualifier	425	N4 = NDC
	LIN03	National Drug Code	425	An NDC is required when a J or Q procedure code is billed in Loop 2400, Segment SV1, Data Element SV101-2.
2410	CTP	Drug Quantity		
	CTP04	Quantity	426	Enter the actual NDC quantity dispensed.
	CTP05-1	Unit or Basis for Measurement Code	427	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	XZ	XZ = Pharmacy Prescription Number

Loop	Segment	Name	Page in IG	Comments
2420A	PRV	Rendering Provider Specialty Information		
	PRV03	Provider Taxonomy Code	433	A taxonomy code is recommended when using a National Provider Identifier (NPI).
2420A	REF	Rendering Provider Secondary Identification		
	REF01	Reference Identification Qualifier	434-435	0B = State License Number 1G = Provider UPIN G2 = Provider Commercial Number LU = Location Number
	REF02	Billing Provider Secondary Identifier	435	If qualifier G2 was used in data element REF01, enter the billing provider's Atypical Provider Identifier.
2420C	N4	Service Facility Location City/ State/ ZIP		
	N403	Laboratory or Facility Postal Zone or ZIP code	446	The Service Facility ZIP code (along with the address information in Loop 2420C, Segment N3) is required when the place of service is different than the billing ZIP code in Loop 2310C, Segment N3. The facility's 9-digit ZIP code is required.

Loop	Segment	Name	Page in IG	Comments
2420F	REF	Referring Provider Secondary Identification		
	REF01	Reference Identification Qualifier	468-469	0B = State License Number 1G = Provider UPIN G2 = Provider Commercial Number
	REF02	Referring Provider Secondary Identifier	469	If qualifier G2 was used in data element REF01, enter the billing provider's Atypical Provider Identifier.
2430	SVD	Line Adjudication Information		
	SVD01	Other Payer Primary Identifier	480	For MCO encounter claims, enter the 4-digit Service Center Code assigned by Magellan Medicaid Administration. This Data Element is required if the payer identified in Loop 2330B adjudicated the claim previously and the service line has adjustments applied to it.

Loop	Segment	Name	Page in IG	Comments
2430	CAS	Line Adjustment: Adjustment Reason Code	484-489	1 = Medicare deductible amount 2 = Medicare coinsurance amount For MCO encounter claims, use Claim Adjustment Reason Code (code source 139) to indicate the denial or cutback reason. This Data Element is required if the payer identified in Loop 2330B has adjudicated the claim previously and the service line has adjustments applied to it.
	CAS01	Claim Adjustment Group Code	485	PR = Patient Responsibility (Non-Medicare TPL claim) This Data Element is required if the payer identified in Loop 2330B has adjudicated the claim previously and the service line has adjustments applied to it. Use qualifier PR to report balance due.
	CAS02	Adjustment Reason Code	486	Use Claim Adjustment Reason Code A7 to report balance due.
	CAS03	Adjustment Amount	486	this data element is required if the payer identified in Loop 2330B has adjudicated the claim previously and the service line has adjustments applied to it.

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. Claims and attachments

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

Any professional claim that requires an attachment must be submitted on a paper CMS-1500 form.

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).

The Functional Acknowledgement (999 transaction) is normally available for retrieval one hour after submission.

8. Acknowledgements and reports

8.1. Inquiry requirements

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

- 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 837P 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