HP Enterprise Services

837I Companion Guide For Nevada Medicaid and Nevada Check Up

Institutional Health Care Claims and Managed Care Organization (MCO) Encounter Claims

Nevada Medicaid Management Information System (NV MMIS)

State of Nevada
Division of Health Care Financing and Policy (DHCFP)
Medicaid Management Information System (MMIS)

In Support of the:
Nevada MMIS Takeover Project
Version 2.2
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Revision history

Date (mm/dd/yyyy)	Description of Changes	Pages Impacted
12/2006	Updates were made to several pages	Pages 83, 84, 158, 176, 177, 178, 191, 192, 365, 372, 373, 376, 403, 411 and 496
04/2007	Updates were made to accommodate NPI	Highlighted cells in the table that begins on page 3
10/2007	Added National Drug code (NDC) specifications; changes are effective for claims received January 1, 2008 and later.	Highlighted table rows beginning on page 3
04/09/2009	Inserted additional comments for MCO encounter claims	Highlighted rows in the "837I Institutional Health Care Claims and MCO Encounter Claims" table.
03/02/2010	Added specifications for the CTP segment (data elements CTP03, CTP04 and CTP05). This segment must be completed when billing for physician/outpatient-facility administered drugs.	
8/22/2011	Updated Table of Contents, removed yellow highlighting from email address and phone numbers, and corrected wording/spelling error in response to specific deliverable review comments.	All
08/31/2011	Removed Confidentiality and Trademarks section for consistency with similar documentation.	ii
12/05/2011	Takeover HPES	All

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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://www.wpc-edi.com/HealthCareFinal.asp.

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

Purpose

HP Enterprise Services has prepared this Companion Guide and website, http://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 HP Enterprise Services.

It supplements but does not contradict the X12N Health Care Implementation Guides and should be used solely for the purpose of clarification.

Availability and Requirements

You may submit electronic claims 24 hours a day, 7 days a week. Transactions submitted after 4 PM Pacific Standard Time (PST) are processed in the following day's cycle.

Claims must be submitted before 1 PM PST on Fridays to be included in the following Friday's electronic remittance advice (835 transaction).

The Functional Acknowledgement (997 transaction) is normally available for retrieval one hour after submission.

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

Questions

For technical questions regarding claim submission or testing; call the Electronic Commerce Customer Support Help Desk at (800) 924-6741.

For enrollment or setup questions, or for questions regarding content in this manual, please contact the EDI Coordinator at nvmmis.EDIsupport@hp.com or (877) 638-3472.

837I Institutional Health Care Claims and MCO Encounter Claims

Page	Loop	Seg-ment	Data Element	Comments
B.3	N/A	ISA	ISA01: Authorization Information Qualifier	"00" = No Authorization Information Present
B.3	N/A	ISA	ISA03: Security Information Qualifier	"00" = No Security Information Present
B.3	N/A	ISA	ISA05: Interchange ID Qualifier	"ZZ" = Mutually Defined
B.3	N/A	ISA	ISA06: Interchange Sender ID	Use the 4-digit Service Center Code assigned by HP Enterprise Services.
B.3	N/A	ISA	ISA08: Interchange Receiver ID	"NVM FHSC FA"
B.3	N/A	ISA	ISA14: Acknowledgement Requested	"0" = No Acknowledgement Requested
B.3	N/A	GS	GS02: Application Sender's Code	Use the 4-digit Service Center Code assigned by HP Enterprise Services.
B.3	N/A	GS	GS03: Application Receiver's Code	"NVM FHSC FA"
B.3	N/A	GS	GS08: Version/Release Industry ID Code	"004010X096A1"
60	N/A	REF	REF02: Transmission Type Code	"004010X096A1"
68	1000A: Submitter Name	NM1	NM109: Submitter Primary ID	Use the 4-digit Service Center Code assigned by HP Enterprise Services. For MCO encounter claims, enter the MCO's "Southern or Northern Medicaid Submitter ID."
68	1000B: Receiver	NM1	NM109: Receiver Primary ID	"DHCFP"
73	2000A: Billing/Pay-To Provider	PRV	PRV03: Provider Taxonomy Code	A taxonomy code is recommended when using a National Provider Identifier (NPI).

Page	Loop	Seg-ment	Data Element	Comments
77	2010AA: Billing Provider Name	NM1	NM108: ID Code Qualifier	"24" = Employer's Identification Number "34" = Social Security Number "XX" = NPI When "XX," is used, the Employer's Identification Number or the provider's SSN must be sent in the REF segment in this loop.
81	2010AA: Billing Provider Name	N4	N403: Billing Provider's Zip Code	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.
83	2010AA: Billing Provider Secondary ID	REF	REF01: Reference ID Qualifier	Medicaid issues payment to the "billing" provider– not the "pay to" provider (Loop 2010AB). "1D" = API "1C" = Medicare "EI" = Employer's Identification Number "SY" = Social Security Number "EI" or "SY" must be used when a NPI is sent in the Billing Provider Name segment of this loop.
84	2010AA: Billing Provider Secondary ID	REF	REF02: Billing Provider Secondary ID	If qualifier "1D" was used in data element REF01, enter the billing provider's API.
110	2010BA: Subscriber Name	NM1	NM108: ID Code Qualifier	"MI" = Member Identification Number
110	2010BA	NM1	NM109: Subscriber Primary ID	Use the recipient's 11-digit Recipient ID.
158	2300: Claim Information	CLM	CLM01: Claim Submitter's ID	For MCO encounter claims, enter the MCO's claim number.
159	2300: Claim Information	CLM	CLM05-3: Claim Frequency Code	"1" = Original Claim "7" = Adjustment "8" = Void
176	2300: Claim Information	CN1	CN101: Contract Type Code	This segment is required on MCO encounter claims.

Page	Loop	Seg-ment	Data Element	Comments
177	2300: Claim Information	CN1	CN102: Amount	On MCO encounter claims, enter the paid amount.
178	2300: Claim Information	AMT	AMT02: Payer Estimated Amount Due	Use "C5" on COB claims to report the amount owed from Medicaid. This amount is reported at the claim level only.
191	2300: Claim Information	REF	REF01: Reference ID Qualifier	"F8" = Adjust or void a claim (as indicated by CLM05-3).
192	2300: Claim Information	REF	REF02: Claim Original Reference Number	On Fee For Service (FFS) claims, enter the last paid Internal Control Number (ICN) that HP Enterprise Services assigned to the claim. On MCO encounter claims, enter the MCO's claim number (CLM01 from last claim).
198	2300: Claim Information	REF	REF01: Reference ID Qualifier	"9F" = Referral Number "G1" = 11-digit Authorization Number
199	2300: Claim Information	REF	REF02: Prior Authorization Number	Enter the 11-digit Authorization Number assigned by HP Enterprise Services.
206	2300: Claim Information	NTE	NTE02: Claim Note Text	Provide free-text remarks, if needed. HP Enterprise Services will use the first occurrence of this segment.
209	2300: Claim Information	NTE	NTE02: Billing Note Text	Provide free-text remarks if necessary.
228	2300: Claim Information	HI	HI02-1: Diagnosis Code List Qualifier	"BJ" = Admitting Diagnosis "ZZ" = Patient Reason for Visit If this field is submitted, use only ICD-9-CM diagnosis codes.
242	2300: Claim Information	HI	HI01-1: Principal Procedure Information	"BR" = ICD-9-CM If this field is submitted, use only ICD-9-CM diagnosis codes.
244 - 255	2300: Claim Information	HI	HI01-1 through HI12-1: Code List Qualifier Code	"BQ" = ICD-9-CM If this field is submitted, use only ICD-9-CM diagnosis codes.
323	2310A: Attending Physician Name	NM1	NM108: ID Code Qualifier	"24" = Employer's Identification Number "34" = Social Security Number "XX" = NPI

Page	Loop	Seg-ment	Data Element	Comments
326	2310A: Attending Physician Name	REF	REF01: Reference ID Qualifier	"1D" = API
327	2310A: Attending Physician Name	REF	REF02: Attending Physician Secondary ID	If qualifier "1D" was used in data element REF01, enter the billing provider's API.
329	2310B: Operating Physician Name	NM1	NM108: ID Code Qualifier	"24" = Employer's Identification Number "34" = Social Security Number "XX" = NPI
333	2310B: Operating Physician Name	REF	REF01: Reference ID Qualifier	"1D" = API
334	2310B: Operating Physician Name	REF	REF02: Operating Physician Secondary ID	If qualifier "1D" was used in data element REF01, enter the billing provider's API.
340	2310C: Other Provider Name	REF	REF01: Reference ID Qualifier	"1D" = API
341	2310C: Other Provider Name	REF	REF02: Other Physician Secondary ID	If qualifier "1D" was used in data element REF01, enter the billing provider's API.
359	2320: Other Subscriber Information	SBR	TPL, Medicare or MCO	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.

Page	Loop	Seg-ment	Data Element	Comments
363	2320: Other Subscriber Information	SBR	SBR09: Claim Filing Indicator	Use "MA" or "MB" to indicate a Medicare payer on claims for Medicare coinsurance and/or deductible.
365	2320: Other Subscriber Information	CAS	CAS: Claim Adjustment Reason Code	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
371	2320: Other Subscriber Information	AMT	AMT01: Amount Qualifier	"C4" = Prior Payment Actual
371	2320: Other Subscriber Information	AMT	AMT02: Payer Prior Payment	"C4" = 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.
372	2320: Other Subscriber Information	AMT	AMT02: COB Total Allowed Amount	"B6" = Total Allowed Amount from Medicare
373	2320: Other Subscriber Information	AMT	AMT02: COB Total Submitted Charges	"T3" = Total Billed Charges Submitted to Medicare
376	2320: Other Subscriber Information	AMT	AMT02: COB Total Medicare Paid Amount	"N1" = Total Medicare Paid Amount

Page	Loop	Seg-ment	Data Element	Comments
403	2330A: Other Subscriber Name	NM1	NM109: Other Insured ID	On claims for Medicare coinsurance and/or deductible, enter the recipient's Medicare ID.
411	2330B: Other Payer Name	NM1	NM109: Other Payer Primary ID#	On MCO encounter claims, enter the 4-digit Service Center Code that HP Enterprise Services assigned to the electronic submitter (clearinghouse, trading partner or direct submitter).
446	2400: Service Line	SV2	Recommendation	HP Enterprise Services 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 (see instructions for "Loop 2410: Drug Identification" on Addenda page 36).
495	2430	CAS	CAS02: Claim Adjustment Reason Code	For denied MCO encounter claims, use CAS02 Claim Adjustment Reason Code (code source 139)
496	2430: Line Adjudication Information	CAS	CAS: Claim Adjustment Reason Code	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

Page	Loop	Seg-ment	Data Element	Comments
36 Addenda	2410: Drug Identification	LIN	LIN02: Product or Service ID Qualifier	"N4" = NDC code
36 Addenda	2410: Drug Identification	LIN	LIN03: National Drug Code	An NDC code is required when a "J" procedure code is billed in Loop 2400, Segment SV1, Data Element SV101-2.
75: Addenda	2410: Drug Identification	CTP	CTP03: Drug Unit Price	This value is required for this segment to be complete, but Nevada Medicaid will not use this value in pricing. A zero dollar amount is acceptable.
75: Addenda	2410: Drug Identification	CTP	CTP04: Quantity	Enter the actual NDC quantity dispensed.
75: Addenda	2410: Drug Identification	CTP	CTP05: Composite Unit of Measure	Enter the appropriate unit of measure: F2 = International Unit GR = Gram ML = Milliliter UN = Unit