HP Enterprise Services

837P Companion Guide For Nevada Medicaid and Nevada Check Up

Professional Health Care Claims and Managed Care Organization (MCO) Encounters

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
December 5, 2011

Revision history

Date (mm/dd/yyyy)	Description of Changes	Pages Impacted
10/2006	Changed comment for MCO Encounter claims , added field information for the use of National Drug Codes (NDCs), and added descriptions for loops 2330A (Other Subscriber A) and 2330B (Other Payer Name).	Page 230
04/2007	Updates were made to accommodate the National Provider Identifier (NPI). Please see the highlighted table cells beginning on the next page	Table beginning on next page
10/2007	National Drug Code (NDC) specifications were added; Changes are effective for claims received January 1, 2008 and later.	Table beginning on next page
06/2008	Added instructions for ambulance providers.	Table beginning on next page
04/2009	Inserted additional comments for MCO encounter claims.	Table beginning on next page
06/2009	Inserted instructions to report balance due.	Table beginning on next page
03/2010	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.	Table beginning on next page
08/22/2011	Removed yellow highlighting from email address and phone numbers in response to specific deliverable review comments.	2
08/31/2011	Removed Confidentiality and Trademarks section for consistency with similar documentation.	ii
12/5/2011	Takeover HPES	All

Table of contents

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 at 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 professional claims (837P, CMS-1500) 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 Acknowledgement

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.

Claim Attachments

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

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, please contact HP Enterprise Services' EDI Coordinator at nvmmis.EDIsupport@hp.com or (877) 638-3472.

837P Professional Health Care Claims and MCO Encounter Claims

Page	Loop	Segment	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	"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	"004010X098A1"
66	N/A	REF	REF02: Transmission Type Code	"004010X098A1"
69	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."
75	1000B: Receiver Name	NM1	NM109: Receiver Primary ID	"DHCFP"

Page	Loop	Segment	Data Element	Comments
80	2000A: Billing/Pay To Provider	PRV	PRV03: Provider Taxonomy Code	A taxonomy code is recommended when using a National Provider Identifier (NPI).
86	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.
90	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.
92	2010AA: Billing Provider Name	REF	REF01: Reference ID Qualifier	Medicaid issues payment to the "billing" provider–not the "pay to" provider (Loop 2010AB). "1D" = Atypical Provider Identifier (API) "1C" = Medicare "EI" = Employer's Identification Number "SY" = Social Security Number "EI" or "SY" must be used when the 10-digit NPI is sent in the Billing Provider Name segment of this loop.
92	2010AA: Billing Provider Name	REF	REF02: Billing Provider Secondary ID	If qualifier "1D" was used in data element REF01, enter the billing provider's Atypical Provider Identifier
119	2010BA: Subscriber Name	NM1	NM108: ID Code Qualifier	"MI" = Member Identification Number
119	2010BA: Subscriber Name	NM1	NM109: Subscriber Primary ID	Required when NM102 = "1"

Page	Loop	Segment	Data Element	Comments
171	2300: Claim Information	CLM	CLM01: Claim Submitter's ID	For MCO encounter claims, enter the MCO's claim number.
173	2300: Claim Information	CLM	CLM05-3: Claim Frequency Code	"1" = Original Claim "7" = Adjustment "8" = Void
228	2300: Claim Information	REF	REF01: Reference ID Qualifier	"9F" = Referral Number "G1" = 11-digit Authorization Number
228	2300: Claim Information	REF	REF02: Prior Authorization or Referral Number	If "G1" was entered in Data Element REF01, enter the 11-digit Authorization Number assigned by HP Enterprise Services.
230	2300: Claim Information	REF	REF01: Reference ID Qualifier	"F8" = Adjust or void a claim (as specified in Data Element CLM05-3).
230	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).
250	2300 - Claim Information	CR1	CR106 – Transport Distance	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.
284	2310A: Referring Provider Name	NM1	NM108: ID Code Qualifier	"24" = Employer's Identification Number "34" = Social Security Number "XX" = NPI
288	2310A: Referring Provider Name	REF	REF01: Reference ID Qualifier	"1D" = Atypical Provider Identifier (API)
289	2310A: Referring Provider Name	REF	REF02: Referring Provider Secondary Identifier	If qualifier "1D" was used in data element REF01, enter the billing provider's Atypical Provider Identifier (API).

Page	Loop	Segment	Data Element	Comments
292	2310B: Rendering Provider Name	NM1	NM108: Identification Code Qualifier	"24" = Employer's Identification Number "34" = Social Security Number "XX" = NPI
294	2310B: Rendering Provider Name	PRV	PRV03: Provider Taxonomy Code	A taxonomy code is recommended when using a National Provider Identifier (NPI).
296	2310B: Rendering Provider Name	REF	REF01: Reference Identification Qualifier	"1D" = Atypical Provider Identifier (API)
297	2310B: Rendering Provider Name	REF	REF02: Rendering Provider Secondary Identifier	If qualifier "1D" was used in data element REF01, enter the billing provider's Atypical Provider Identifier (API).
309	2310D: Service Facility Location	N4	N403: Laboratory or Facility Zip Code	The facility's 9-digit zip code is required (along with the address in Loop 2310D, Segment N3). The zip code may be used to determine claim pricing.
318	2320: Other Subscriber Information	SBR		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.
321	2320: Other Subscriber Information	SBR	SBR09: Claim Filing Indicator Code	Use "MB" to indicate a Medicare payer on claims for Medicare coinsurance and/or deductible.

Page	Loop	Segment	Data Element	Comments
323	2320: Other Subscriber Information	CAS	CAS: Claim Adjustment Reason Code	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.
332	2320: Other Subscriber Information	AMT	AMT02: Payer Paid Amount	Use this segment, for the appropriate payer, to report all prior payments you have received for this claim. Omit Nevada Medicaid payment information.
335	2320: Other Subscriber Information	AMT	AMT02: Other Payer Patient Responsibility Amount	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.
352	2330A: Other Subscriber A	NM1	NM109: Other Insured Identifier	On claims for Medicare coinsurance and/or deductible, enter the recipient's Medicare ID number.
361	2330B: Other Payer Name	NM1	NM109: Other Payer Primary ID#	For 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).
401	2400: Service Line	SV1	SV101-1: Product or Service ID Qualifier	"HC" = HCPCS Codes NDC codes 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 (see instructions for "Loop 2410: Drug Identification" on Addenda page 73).
402	2400: Service Line	SV1	SV102: Line Item Charge Amount	On claims for Medicare coinsurance and/or deductible, enter the line charge amount billed to Medicare.

Page	Loop	Segment	Data Element	Comments
403	2400: Service Line	SV1	SV103	For anesthesia claims, enter "UN" when sending anesthesia units in Data Element SV104.
414	2400: Service Line	CR1	CR106 – Transport Distance	When billing with a base rate code that does not require mileage, enter a "1" for quantity.
466	2400: Service Line	CN1	CN101: Contract Type Code	This segment is required on MCO encounter claims.
467	2400: Service Line	CN1	CN102: Contract Amount	Enter the MCO paid amount.
485	2400: Service Line	AMT	AMT02: Approved Amount	On claims for Medicare coinsurance and/or deductible, enter the line item amount allowed by Medicare.
488	2400: Service Line	NTE	NTE01: Note Reference Code	On transportation claims, enter "ADD."
488	2400: Service Line	NTE	NTE02: Line Note Text	Enter line level free-text remarks as needed (enter claim level remarks in Loop 2300).
503	2420A: Rendering Provider	NM1	NM108: ID Code Qualifier	"24" = Employer's Identification Number "34" = Social Security Number "XX" = NPI
505	2420A: Rendering Provider Name	PRV	PRV03: Provider Taxonomy Code	A taxonomy code is recommended when using a National Provider Identifier (NPI).
507	2420A: Rendering Provider Name	REF	REF01: Reference Identification Qualifier	"1D" = Atypical Provider Identifier (API)
508	2420A: Rendering Provider Name	REF	REF02: Billing Provider Secondary Identifier	If qualifier "1D" was used in data element REF01, enter the billing provider's Atypical Provider Identifier (API).

Page	Loop	Segment	Data Element	Comments
520	2420C:	N4	N403 – Laboratory or Facility Zip code	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 2310D, Segment N3. The facility's 9-digit zip code is required. The zip code may be used to determine claim pricing.
543	2420F: Referring Provider Name	NM1	NM108: Identification Code Qualifier	"24" = Employer's Identification Number "34" = Social Security Number "XX" = NPI
547	2420F: Referring Provider Name	REF	REF01: Reference ID Qualifier	"1D" = Atypical Provider Identifier (API)
548	2420F: Referring Provider Name	REF	REF02: Referring Provider Secondary Identifier	If qualifier "1D" was used in data element REF01, enter the billing provider's Atypical Provider Identifier (API).
555	2430: Line Adjudication Information	SVD	SVD01: ID Code	For MCO encounter claims, enter the 4-digit Service Center Code assigned by HP Enterprise Services. 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.
560	2430: Line Adjudication Information	CAS	CAS01: Claim Adjustment Group Code	"PR" = 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.

Page	Loop	Segment	Data Element	Comments
560	2430: Line Adjudication Information	CAS	CAS02: Claim Adjustment Reason Code	Use Claim Adjustment Reason Code "A7" to report balance due.
560	2430: Line Adjudication Information	CAS	CAS: Claim Adjustment Reason Code	"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.
560	2430: Line Adjudication Information	CAS	CAS03: Monetary Amount	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.
73: Addend	2410: Drug Identification	LIN	LIN02: Product or Service ID Qualifier	"N4" = NDC code
73: Addend a	2410: Drug Identification	LIN	LIN03: National Drug Code	An NDC code is required when a "J" or "Q" procedure code is billed in Loop 2400, Segment SV1, Data Element SV101-2.
75: Addend a	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: Addend	2410: Drug Identification	CTP	CTP04: Quantity	Enter the actual NDC quantity dispensed.
75: Addend a	2410: Drug Identification	CTP	CTP05: Composite Unit of Measure	Enter the appropriate unit of measure: F2 = International Unit GR = Gram ML = Milliliter UN = Unit