Nevada Medicaid

HIPAA Transaction

Standard Companion Guide

Refers to the Technical Report Type 3 Document

Based on ASC X12N version: 005010X223A2

Institutional Health Care Claim:

Fee-for-Service (837I)

The information in this Companion Guide is valid to use for the certification/testing to transition to the modernized MMIS and upon implementation of the MMIS Modernization Project

March 13, 2020

Medicaid Management Information System (MMIS)

Department of Health and Human Services (DHHS)

Division of Health Care Financing and Policy (DHCFP)

Disclosure Statement

The following Nevada Medicaid companion guide is intended to serve as a companion document to the corresponding Accredited Standards Committee (ASC) X12N/005010X223 Health Care Claim Institutional (837I), its related Addenda (005010X223A2), and its related Errata (005010X223E1). The companion guide further specifies the requirements to be used when preparing, submitting, receiving, and processing electronic health care administrative data. The companion guide supplements, but does not contradict, disagree, oppose, or otherwise modify the 005010X223 in a manner that will make its implementation by users to be out of compliance.

NOTE: Type 1 Technical Report Type 3 (TR3) Errata are substantive modifications, necessary to correct impediments to implementation and are identified with a letter "A" in the errata document identifier. Type 1 TR3 Errata were formerly known as Implementation Guide Addenda.

Type 2 TR3 Errata are typographical modifications and are identified with a letter "E" in the errata document identifier.

The information contained in this companion guide is subject to change. Electronic Data Interchange (EDI) submitters are advised to check the Nevada Medicaid EDI webpage at https://www.medicaid.nv.gov/providers/edi.aspx regularly for the latest updates.

DXC Technology is the fiscal agent for Nevada Medicaid and is referred to as Nevada Medicaid throughout this document.

About DHCFP

The Nevada Department of Health and Human Services' Division of Health Care Financing and Policy (DHCFP) works in partnership with the Centers for Medicare & Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources. The medical programs are known as Medicaid and Nevada Check Up.

DHCFP website: Medicaid Services Manual, rates, policy updates, public notices: http://dhcfp.nv.gov.

Preface

The Health Insurance Portability and Accountability Act of 1996 (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.

This companion guide to the 5010 ASC X12N TR3 documents and associated errata and addenda adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with Nevada Medicaid. Transmissions based on this companion guide, used in tandem with 005010 ASC X12 TR3 documents, are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 documents adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3 documents.

Table of Contents

1 Introduction

This section describes how TR3 Implementation Guides, also called 837I ASC X12N (version 005010X223), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that Nevada Medicaid has information additional to the TR3 Implementation Guide. That information can:

- Limit the repeat of loops, or segments.
- Limit the length of a simple data element.
- Specify a sub-set of the implementation guide's internal code listings.
- Clarify the use of loops, segments, composite and simple data elements.
- Provide any other information tied directly to a loop, segment, and composite, or simple data element pertinent to trading electronically with Nevada Medicaid.

In addition to the row for each segment (highlighted in blue in the tables), one or more additional rows are used to describe Nevada Medicaid's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column to provide additional information from Nevada Medicaid for specific segments provided by the TR3 Implementation Guide. The following is just an example of the type of information that would be spelled out or elaborated on in the Section 10: Transaction Specific Information.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10 percent and notes or comments about the segment itself go in this cell.
193	2100C	NM109	Subscriber Primary Identifier	00	15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Nevada Medicaid Management Information System (NVMMIS).
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first three columns makes it clear that

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
241	2110C	EB13-1	Product/ Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 Scope

This section specifies the appropriate and recommended use of the companion guide.

This companion guide is intended for Trading Partner use in conjunction with the TR3 HIPAA 5010 837 Institutional Implementation Guide for the purpose of submitting institutional claims electronically. This companion guide is not intended to replace the TR3 Implementation Guide. The TR3 defines the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of this companion guide is to provide Trading Partners with a companion guide to communicate Nevada Medicaid-specific information required to successfully exchange transactions electronically with Nevada Medicaid. The instructions in this companion guide are not intended to be stand-alone requirements. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

The intended purpose of this document is to provide information such as registration, testing, support and specific transaction requirements to EDI Trading Partners that exchange X12 information with the Nevada Medicaid Agency.

This companion guide provides specific requirements for submitting institutional claims (837I) electronically to Nevada Medicaid.

1.2 Overview

This section specifies how to use the various sections of the document in combination with each other.

Nevada Medicaid created this companion guide for Nevada Trading Partners to supplement the X12N Implementation Guide. This guide contains Nevada Medicaid specific instructions related to the following:

- Data formats, content, codes, business rules and characteristics of the electronic transaction
- Technical requirements and transmission options
- Information on testing procedures that each Trading Partner must complete before transmitting electronic transactions

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist Trading Partners in implementing electronic 837I transactions that meet Nevada Medicaid processing standards by identifying pertinent structural and data-related requirements and recommendations. Updates to this companion guide will occur periodically and new documents will be posted on the Nevada Medicaid EDI webpage at https://www.medicaid.nv.gov/providers/edi.aspx.

1.3 References

This section specifies additional useful reference documents, for example, the X12N Implementation Guides adopted under HIPAA to which this document is a companion.

The TR3 Implementation Guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer or government agency. The TR3 Implementation Guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their Trading Partners. It is critical that your IT staff or software vendor review this document in its entirety and follow the stated requirements to exchange HIPAA-compliant files with Nevada Medicaid.

The implementation guides for X12N and all other HIPAA standard transactions are available electronically at https://www.wpc-edi.com/.

1.4 Additional Information

The intended audience for this document is the technical and operational staff responsible for generating, receiving and reviewing electronic health care transactions.

2 Getting Started

This section describes how to interact with Nevada Medicaid's EDI Help Desk.

The Nevada Medicaid EDI Help Desk can be contacted at (877) 638-3472 options 2, 0, and then 3, Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific Time, with the exception of Nevada State holidays. You can also send an email to nvmmis.edisupport@dxc.com

2.1 Trading Partner Enrollment

This section describes how to enroll as a Trading Partner with Nevada Medicaid.

In order to submit and/or receive transactions with Nevada Medicaid, Trading Partners must complete a Trading Partner Profile (TPP) agreement, establish connectivity and certify transactions.

- A 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 a TPP agreement regardless of the Trading Partner type listed below
- 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.

Establishing a Trading Partner Profile (TPP) agreement is a simple process which the Trading Partner completes using the Nevada Medicaid Provider Web Portal. The Provider Web Portal is located at: https://www.medicaid.nv.gov/hcp/provider.

Trading Partners must agree to the Nevada Medicaid Trading Partner Agreement at the end of the Trading Partner Profile enrollment process. Once the TPP application is completed, an 8-digit Trading Partner ID will be assigned.

After the TPP Agreement has been completed, the Trading Partner must submit a Secure Shell (SSH) public key file to Nevada Medicaid to complete their enrollment. Once the SSH key is received, you will be contacted to initiate the process to exchange the directory structure and authorization access on the Nevada Medicaid external SFTP servers.

Failure to provide the SSH key file to Nevada Medicaid will result in your TPP application request being rejected and you will unable to submit transactions electronically to Nevada Medicaid. Please submit your SSH public key via email within five business days of completing the TPP application. Should you require additional assistance with information on SSH keys, please contact the Nevada EDI Help Desk at (877) 638-3472 options 2, 0, and then 3.

2.2 Certification and Testing Overview

This section provides a general overview of what to expect during certification and testing phases.

All Trading Partners who submit electronic transactions with Nevada Medicaid will be certified through the completion of Trading Partner testing. This includes Clearinghouses, Software Vendors, Provider Groups and Managed Care Organizations (MCOs).

Providers who use a billing agent, clearinghouse or software vendor will not need to test for those electronic transactions that their entity submits on their behalf.

3 Testing with Nevada Medicaid

This section contains a detailed description of the testing phase.

Testing is conducted to ensure compliance with HIPAA guidelines. Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. Refer to Appendix B for a list of SNIP Level 4 edits.

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

There is no limit to the number of files that may be submitted. Results of the system's processing of your transactions are reviewed and communicated back via email. Once the test file(s) passes EDI compliance, a production URL and Production Authorization letter will be sent confirming certification.

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

3.1 Testing Process

The following points are actions that a Trading Partner will need to take before submitting production files to Nevada Medicaid:

- Enroll by using the Trading Partner Enrollment Application on the Nevada Medicaid Web Provider Portal to obtain a new Trading Partner ID
- Register on the Nevada Medicaid Web Provider Portal (optional unless submitting files via the Web Portal)
- Receive EDI Trading Partner Welcome Letter indicating Trading Partner Profile (TPP) has been approved for testing
- Submit test files using SFTP until transaction sets pass compliance testing
- Receive Production Authorization letter containing the list of approved transactions that could be submitted to the production environment along with the connection information
- Upon completion of the testing process, you may begin submitting production files for all approved transactions via the Nevada Medicaid Provider Web Portal or SFTP

To begin the testing process, please review the Nevada Medicaid Trading Partner User Guide located at: https://www.medicaid.nv.gov/providers/edi.aspx.

3.2 File Naming Standard

Use the following naming standards when submitting files to Nevada Medicaid:

- Trading Partner ID = 8-digit assigned, example -- 01234567
- Filetype = transaction type, example -- 270, 276, 837P, 837D, 837I
- UniqueID = any unique ANSI qualifier, example -- DATETIMESTAMP [CCYYMMDDHHMMSSS as 201808301140512]

Here are some examples of good file naming standards:

- 01234567_837I_201708301140512.dat
- 01234567_837I_TRANS01_20170830.dat
- 01234567_837I_SMALL_FILE_2017_08.txt

The preferred extension is .dat; however, .txt is also allowed. Zip files (.zip) may also be submitted, but each zip file can contain only one encounter file, either .dat or .txt. Both the zip file and the encounter file it contains must meet the file naming standards.

If the file does not meet the file naming standard, the file will not be processed. In this instance, the Nevada Medicaid EDI Help Desk will notify the submitter of the issue and request correction and resubmittal. You will need to correct the file name and resubmit the file in order for it to process.

3.3 File Retention

All electronic files that have been made available for download will remain available online for download for sixty (60) days. This applies to Web Portal and SFTP Trading Partners.

After the 60 days' time frame, the files will be removed from the list and will no longer be available for download. This applies to testing and production environments.

3.4 Payer specific documentation

For additional information in regards to business processes related to eligibility, prior authorization and claims processing, please review the Billing Manual located on the Nevada Medicaid Billing Information webpage at: https://www.medicaid.nv.gov/providers/BillingInfo.aspx

4 Connectivity with Nevada Medicaid/Communications

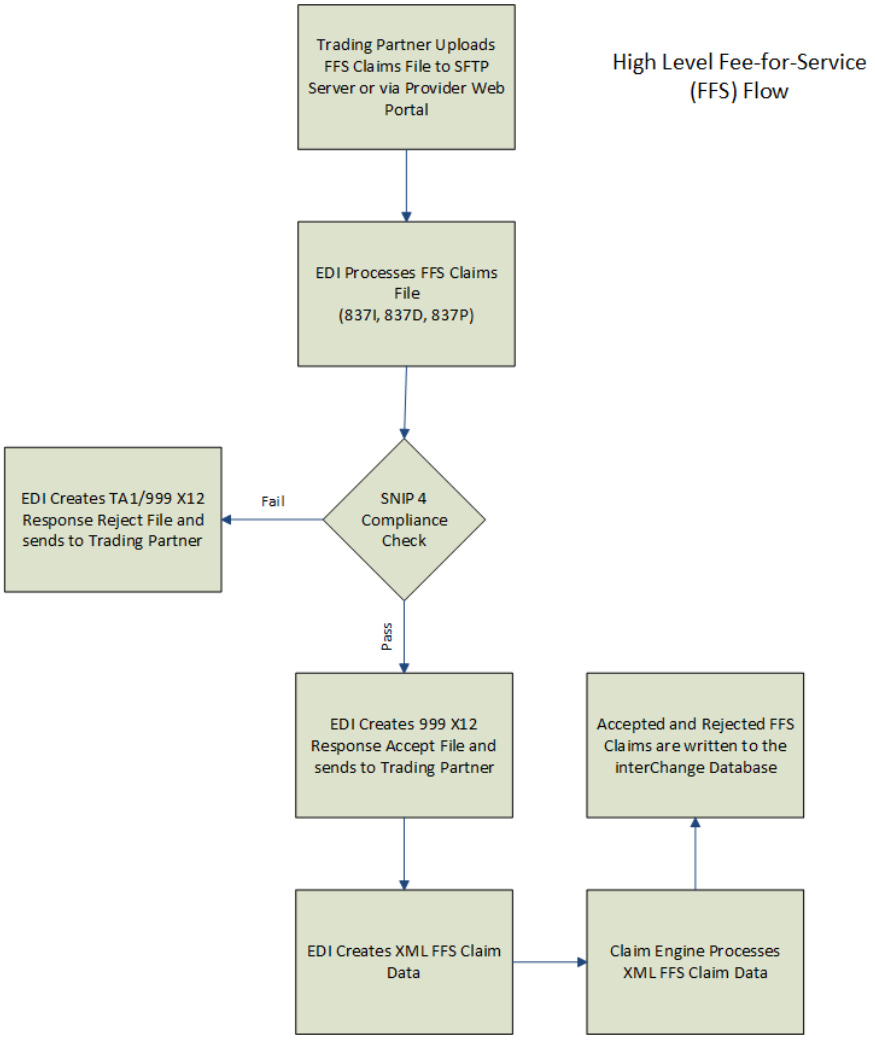
This section describes the process to submit HIPAA 837I transactions, along with submission methods, security requirements, and exception handling procedures.

Nevada Medicaid supports multiple methods for exchanging electronic healthcare transactions depending on the Trading Partner's needs. For HIPAA 837I transactions, the following can be used:

- Secure File Transfer Protocol (SFTP) (this only applies to batch transactions)
- The Nevada Medicaid Provider Web Portal

4.1 Process Flows

This section contains a process flow diagram and appropriate text.



4.2 Health Care Claim and Response

The response to an 837 batch transaction will consist of the following:

1. First level response: TA1 will be generated when errors occur within the outer envelope. If the ISA14 – Acknowledgement Requested is set as a "1", a TA1 will be provided regardless if the file passes compliance or errors occur. If you do not wish to receive a TA1 response for files that pass compliance, the ISA14 must be set to a "0".
2. Second level response: 999 will be generated.
    - A=Accepted (AK9=A)
    - R=Rejected (AK9=R) when errors occur during the compliance validation process. The entire file is rejected. The claim(s) in error will need to be corrected and the entire file resubmitted for processing.
    - P=Partial (AK9=P) when errors occur during the compliance validation process. The file was partially accepted. The file is rejected at the transaction set level (ST/SE). The claim(s) in error will need to be corrected and the transaction set(s) in error, will need to be resubmitted for processing.
    - E=Accepted, But Errors Were Noted (AK9=E). No action is needed as this means the entire file was accepted for processing, but warning or informational edits were found.

Each transaction is validated to ensure that the 837I complies with the 005010X223A2 TR3 Implementation Guide.

4.3 Transmission Administrative Procedures

This section provides Nevada Medicaid's specific transmission administrative procedures.

For details about available Nevada Medicaid Access Methods, refer to the Communication Protocol Specifications section below.

Nevada Medicaid is only available to authorized users. The submitter/receiver must be a Nevada Medicaid Trading Partner. Each submitter/receiver is authenticated using the Username and private SSH key provided by the Trading Partner as part of the enrollment process.

4.4 System Availability

The system is typically available 24X7 with the exception of scheduled maintenance windows as noted on the Nevada Medicaid website at https://www.medicaid.nv.gov/.

4.5 Transmission File Size

Transactions	Submission Method	File Size Limit	Other Conditions
837s	SFTP	300 MB	5,000 claims per transaction set
270 Batch	SFTP	30 MB	20,000 eligibility requests per file
276 Batch	SFTP	30 MB	
270 Real-Time	CORE		Real-time limited to 1 eligibility request per transaction

Transactions	Submission Method	File Size Limit	Other Conditions
276 Real-Time	CORE		Real-time limited to 1 claim status request per transaction
837s	Web Portal	4 MB	5,000 claims per transaction set
270 Batch	Web Portal	4 MB	
276 Batch	Web Portal	4 MB	

4.6 Re-Transmission Procedures

Nevada Medicaid does not require any identification of a previous transmission of a file with the Note exception listed below. All files sent should be marked as original transmissions.

Nevada Medicaid does identify duplicate files based on content of the file before it reaches the MMIS system. The duplicate check algorithm only checks for file content. It does not check for filename or file size.

> Note: If the same file was resubmitted using SFTP and the data content is the same content of another file, this file will be detected as a duplicate file. The EDI Helpdesk will contact the EDI contact listed on file to verify if the file was meant to be reprocessed.

4.7 Communication Protocol Specifications

This section describes Nevada Medicaid's communication protocol(s).

- **Secure File Transfer Protocol (SFTP)**: Nevada Medicaid allows Trading Partners to connect to the Nevada Medicaid SFTP server using the SSH private key and assigned user name. There is no password for the connection.
- **Nevada Medicaid Provider Web Portal**: Nevada Medicaid allows Trading Partners to connect to the Nevada Medicaid Provider Web Portal. Refer to the Trading Partner User Guide for instructions.

4.8 Passwords

Trading Partners must adhere to Nevada Medicaid's use of passwords. Trading Partners are responsible for managing their own data. Each Trading Partner is responsible for managing access to their organization's data through the interChange security function. Each Trading Partner must take all necessary precautions to ensure that they are safeguarding their information and sharing their data (e.g., granting access) only with users and entities who meet the required privacy standards. It is equally important that Trading Partners know who on their staff is linked to other providers or entities, in order to notify those entities whenever they remove access for that person in your organization(s).

5 Contact Information

Refer to this companion guide with questions, and then use the contact information below for questions not answered by this companion guide.

5.1 EDI Customer Service

This section contains detailed information concerning EDI Customer Service, especially contact numbers.

Most questions can be answered by referencing materials posted on the Nevada Medicaid website at https://www.medicaid.nv.gov.

If you have questions related to the Nevada Medicaid's 837I transaction, you may contact the EDI Help Desk at (877) 638-3472 options 2, 0, then 3, Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific Time, with the exception of Nevada State holidays or send an email to nvmmis.edisupport@dxc.

5.2 EDI Technical Assistance

This section contains detailed information concerning EDI Technical Assistance, especially contact numbers.

The Nevada Medicaid EDI Help Desk can help with connectivity issues or transaction formatting issues at (877) 638-3472 options 2, 0, then 3, Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific Time, with the exception of Nevada State holidays or send an email to nvmmis.edisupport@dxc.com.

Please have your 8-digit Trading Partner ID available. Trading Partners should have this number available each time they contact the Nevada Medicaid EDI Help Desk.

For written correspondence:

Nevada Medicaid
PO Box 30042
Reno, Nevada 89520-3042

5.3 Customer Service/Provider Enrollment

This section contains information for contacting Customer Service and Provider Enrollment.

Customer Service should be contacted instead of the EDI Help Desk for questions regarding claim status information and provider enrollment.

Customer Service

- Phone: (877) 638-3472 (select option 2, option 0 and then option 2)
- The Billing Manual can be found at: https://www.medicaid.nv.gov/Downloads/provider/NV_Billing_General.pdf

Provider Enrollment

- Phone: (877) 638-3472 (select option 2, option 0 and then option 5)
- Email: nv.providerapps@dxc.com (license updates and voluntary terminations only)
- Provider Enrollment Information Booklet can be found at: https://www.medicaid.nv.gov/Downloads/provider/NV_Provider_Enrollment_Information_Booklet.pdf.

5.4 Applicable Websites/Email

This section contains detailed information about useful websites.

- Accredited Standards Committee (ASC X12): ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org.
- Accredited Standards Committee (ASC X12N): ASC X12N develops and maintains X12 EDI and XML standards, standards interpretations, and guidelines as they relate to all aspects of insurance and insurance-related business processes. www.x12.org.
- American Dental Association (ADA): Develops and maintains a standardized data set for use by dental organizations to transmit claims and encounter information. www.ada.org.
- American Hospital Association Central Office on ICD-10-CM/ICD-10-PCS (AHA): This site is a resource for the International Classifications of Diseases, 10th edition, Clinical Modification (ICD-10-CM) codes, used for reporting patient diagnoses and (ICD-10-PCS) for reporting hospital inpatient procedures. www.ahacentraloffice.org.
- American Medical Association (AMA): This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org.
- Centers for Medicare & Medicaid Services (CMS): CMS is the unit within HHS that administers the Medicare and Medicaid programs. Information related to the Medicaid HIPAA Administrative Simplification provision, along with the Electronic Health-Care Transactions and Code Sets, can be found at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA.

  This site is the resource for information related to the Healthcare Common Procedure Coding System (HCPCS). www.cms.hhs.gov/HCPCSReleaseCodeSets/.
- Committee on Operating Rules for Information Exchange (CORE): A multi-phase initiative of Council for Affordable Quality Healthcare, CORE is a committee of more than 100 industry leaders who help create and promulgate a set of voluntary business rules focused on improving physician and hospital access to electronic patient insurance information at or before the time of care. www.caqh.org/CORE_overview.php.
- Council for Affordable Quality Healthcare (CAQH): A nonprofit alliance of health plans and trade associations, working to simplify healthcare administration through industry collaboration on public-private initiatives. Through two initiatives – the Committee on Operating Rules for Information Exchange and Universal Provider Datasource, CAQH aims to reduce administrative burden for providers and health plans. www.caqh.org.
- Designated Standard Maintenance Organizations (DSMO): This site is a resource for information about the standard-setting organizations and transaction change request system. www.hipaa-dsmo.org.
- Health Level Seven (HL7): HL7 is one of several ANSI-accredited Standards Development Organizations (SDOs), and is responsible for clinical and administrative data standards. www.hl7.org.
- Healthcare Information and Management Systems (HIMSS): An organization exclusively focused on providing global leadership for the optimal use of IT and management systems for the betterment of health care. www.himss.org.

- National Committee on Vital and Health Statistics (NCVHS): The National Committee on Vital and Health Statistics was established by Congress to serve as an advisory body to the Department of Health and Human Services on health data, statistics, and national health information policy. www.ncvhs.hhs.gov.
- National Council of Prescription Drug Programs (NCPDP): The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org.
- National Uniform Billing Committee (NUBC): NUBC is affiliated with the American Hospital Association. It develops and maintains a national uniform billing instrument for use by the institutional health-care community to transmit claims and encounter information. www.nubc.org.
- National Uniform Claim Committee (NUCC): NUCC is affiliated with the American Medical Association. It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org.
- Nevada Department of Health and Human Services (DHHS) Division of Health Care Financing and Policy (DHCFP): The DHCFP website assists with policy questions: dhcfp.nv.gov and this website assists providers with billing and enrollment support: www.medicaid.nv.gov.
- Office for Civil Rights (OCR): OCR is the office within the Department of Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa.
- United States Department of Health and Human Services (HHS): The DHHS website is a resource for the Notice of Proposed Rule Making, rules, and their information about HIPAA. www.aspe.hhs.gov/admnsimp.
- Washington Publishing Company (WPC): WPC is a resource for HIPAA-required transaction technical report type 3 documents and code sets. www.wpc-edi.com.
- Workgroup for Electronic Data Interchange (WEDI): WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org.

6 Control Segments/Envelopes

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

6.1 ISA-IEA

This section describes Nevada Medicaid's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

To promote efficient, accurate electronic transaction processing, please note the following Nevada Medicaid specifications:

- Nevada Medicaid requires Trading Partners to use the ASC X12 Extended Character Set.
- Each Trading Partner is assigned a unique Trading Partner ID.
- All dates are in the CCYYMMDD format, with the exception of the ISA09 which is YYMMDD.
- All date/times are in the CCYYMMDDHHMM format.
- Nevada Medicaid Payer ID is NVMED.
- Only one ISA/IEA will be present within a logical file.

Transactions transmitted during a session or as a batch are identified by an ISA header segment and IEA trailer segment, which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The tables below represent the interchange envelope information.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.3		ISA	Interchange Control Header			
C.4		ISA01	Authorization Information Qualifier	00, 03		
			No Authorization Information Present	00	2	
C.4		ISA02	Authorization		10	Space fill

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Information			
C.4		ISA03	Security Information Qualifier	00, 01		
			No Security Information Present	00	2	
C.4		ISA04	Security Information		10	Space fill
C.4		ISA05	Interchange ID Qualifier	01, 14, 20, 27-30, 33, ZZ		
			Mutually Defined	ZZ	2	
C.4		ISA06	Interchange Sender ID		15	The 8-digit Trading Partner ID assigned by NV Medicaid, left justified and space filled.
C.5		ISA07	Interchange ID Qualifier	01, 14, 20, 27-30, 33, ZZ		
			Mutually Defined	ZZ	2	
C.5		ISA08	Interchange Receiver ID	NVMED	15	NV Medicaid receiver ID, left justified and space filled.
C.5		ISA09	Interchange Date		6	Format is YYMMDD
C.5		ISA10	Interchange Time		4	Format is HHMM
C.5		ISA11	Repetition Separator	^	1	The repetition separator is a delimiter and not a data element. It is used to separate repeated occurrences of a simple data element or a composite data structure. This value must be different from the data element separator, component element separator, and the segment terminator.
C.5		ISA12	Interchange Control Version Number	00501	5	
C.5		ISA13	Interchange Control Number		9	Must be identical to the associated interchange control trailer IEA02.
C.6		ISA14	Acknowledgement Requested	0, 1		
			No interchange acknowledgement	0	1	A TA1 will be generated if the file fails the 'Interchange

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			requested			Envelope' content regardless of the value used.
			Interchange acknowledgement requested	1	1	
C.6		ISA15	Interchange Usage Indicator	T, P		
			Test data	T	1	
			Production data	P	1	
C.6		ISA16	Component Element Separator	:	1	The component element separator is a delimiter and not a data element. It is used to separate component data elements within a compostie data structure. This value must be different from the data element separator and the segment terminator.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C10		IEA	Interchange Control Trailer			
C.10		IEA01	Number of Included Functional Groups		1/5	Number of included Functional Groups.
C.10		IEA02	Interchange Control Number		9	The control number assigned by the interchange sender. Must be identical to the value in ISA13.

6.2 GS-GE

This section describes Nevada Medicaid's use of the functional group control segments.

It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how Nevada Medicaid expects functional groups to be sent and how Nevada Medicaid will send functional groups. These discussions will describe how similar transaction sets will be packaged and Nevada Medicaid's use of functional group control numbers. The tables below represent the functional group information.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.7		GS	Functional Group Header			
C.7		GS01	Functional Identifier Code	HC	2	
C.7		GS02	Application Sender's Code		8	Trading Partner ID supplied by NV Medicaid. This will be the same value in the ISA06.
C.7		GS03	Application Receiver's Code	NVMED	5	NV Medicaid receiver ID. This will be the same value in the ISA08.
C.7		GS04	Functional Group Creation Date		8	Format is CCYYMMDD
C.8		GS05	Functional Group Creation Time		4/8	Format is HHMM
C.8		GS06	Group Control Number		1/9	Must be identical to the value in the GE02.
C.8		GS07	Responsible Agency Code	X	1	
C.8		GS08	Version/Release / Industry Identifier Code		12	005010X223A2

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.9		GE	Functional Group Trailer			
C.9		GE01	Number of Transaction Sets Included		1/6	Total number of transaction sets included in the functional group.
C.9		GE02	Group Control Number		1/9	This is the same value as the GS06.

6.3 ST-SE

This section describes Nevada Medicaid's use of transaction set control numbers.

Nevada Medicaid recommends that Trading Partners follow the guidelines set forth in the TR3 Implementation Guide – start the first ST02 in the first file with 000000001 and increment from there. The TR3 Implementation Guide should be reviewed for how to create compliant transactions set control segments.

The 837 Institutional files may contain multiple ST-SE segments.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
67		ST	Transaction Set Header			
67		ST01	Transaction Set Identifier Code	837	3	
67		ST02	Transaction Set Control Number		4/9	Increment by 1 when multiple transaction sets are included. Must be identical to SE02.
67		ST03	Implementation Convention Reference		12	005010X223A2

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
488		SE	Transaction Set Trailer			
488		SE01	Transaction Segment Count		1/10	Total number of segments included in a transaction set including ST and SE segments.
488		SE02	Transaction Set Control Number		4/9	Transaction set control number. Must be identical to ST02

6.4 Control Segment Notes

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.

6.5 File Delimiters

Nevada Medicaid requests that submitters use the following delimiters on your 837 file. If used as delimiters, these characters (* : ~ ^) must not be submitted within the data content of the transaction sets.

- **Data Element**: Byte 4 in the ISA segment defines the data element separator to be used throughout the entire transaction. The recommended data element delimiter is an asterisk (*).
- **Repetition Separator**: ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a caret (^).
- **Component-Element**: ISA16 defines the component element delimiter to be used throughout the entire transaction. The recommended component-element delimiter is a colon (:).
- **Data Segment**: Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The recommended data segment delimiter is a tilde (~).

7 Nevada Medicaid Specific Business Rules and Limitations

This section describes Nevada Medicaid's specific business rules and limitations for the 837 Institutional Health Care Claim.

Before submitting 837 Institutional claims to Nevada Medicaid, please review the appropriate HIPAA Technical Report Type 3 (TR3) Implementation Guide and Nevada Medicaid Companion Guide.

It is also recommended that users review the billing instructions for specific provider types. They are available on the Nevada Medicaid Billing Information webpage located at: https://www.medicaid.nv.gov/providers/BillingInfo.aspx..

7.1 Logical File Structure

There can only be one interchange (ISA/IEA) per logical file. The interchange can contain multiple functional groups (GS/GE); however, the functional groups must be the same type.

7.2 Compliance Checking

Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. Refer to Appendix B for a list of SNIP Level 4 edits.

7.3 Dependent Data

Nevada Medicaid recipients should be reported as the Subscriber only; dependent data should never be used.

7.4 Trading Partner

If an 837I transaction is submitted by a non-approved Trading Partner, it will result in a TA1 response.

7.5 Claims with TPL

To avoid claims denied for TPL, current billing procedures require providers to attach an EOB when the primary TPL carrier denies the claim or pays zero. The claim will suspend for review by the claims team. This could be eliminated if the adjustment reason code on 837s is received by the other carrier. These adjustment reason codes will override or ignore the TPL edit, since it provides a valid reason why the TPL will not apply. No EOB attachment is needed.

7.6 Medicare Claims with Part B Payments

Claims should be submitted as inpatient claims and not as inpatient crossover claims. Part B payment information should be placed in the TPL related fields, 2320 SBR and AMT segments. The SBR09 data element will contain an "MB" for Medicare Part-B and the AMT02 data element will contain the payer paid amount.

7.7 Submission of Claims

Trading Partners 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 12:00 p.m. PT on Fridays to be included in the following Friday's electronic remittance advice (835 transaction).

7.8 Document Level Rejection

Files are processed at the transaction set level (ST/SE). This means if one compliance error is received at the transaction set level (ST/SE), that transaction set will be rejected and the error reported on the 999 transaction. This may create a partially accepted file if the file contains multiple transaction sets.

The claim(s) that caused the rejection needs to be corrected and the entire transaction set (ST/SE) needs to be resubmitted for processing.

7.9 Claim Attachments

The Paperwork (PWK) segment, also referred to as the Claim Supplemental Information segment, will be used when the provider needs to submit a claim attachment. The claim attachment will be submitted by the provider, using the Provider Web Portal (PWP).

The following steps are used when submitting claim attachments:

1. The provider will upload the attachment using the File Exchange panel in the PWP. It is recommended that the attachment should be uploaded prior to the 837 X12 claim being submitted. The provider is responsible for creating a unique Attachment Control Number (ACN) for each attachment uploaded using the PWP. The following approach can be used to ensure a unique ACN is created.
    - ACN = Provider ID (10-digit NPI or API) + 11-digit Recipient ID + 6 or 8-digit Date of Service + 4-digit Sequence Number
    - Examples of the recommended file naming standard are shown below:
        - 10-digit Provider NPI/API example 0000000000
        - Plus 11-digit Recipient Medicaid ID example 11111100000
        - Plus 6- or 8-digit date of service example 010120 or 01012020
        - Plus 4-digit sequence number of your choice example 6789
    - Example of a unique ACN showing all digits and no spaces:

      00000000001111110000000101206789
2. The 837 X12 claim is submitted with the PWK/Claim Supplemental Information segment, which includes the ACN of the claim attachment from step 1.
    a. The 837 X12 claim must include the following fields:
        - PWK01 – Report Type code (Selected from the list of valid codes in the ASC X12 Guide; your vendor/Clearinghouse should have the list of valid codes.)
        - PWK02 – Must contain 'EL'
        - PWK05 – Must contain 'AC'
        - PWK06 – Attachment Control Number (The number used to identify the attachment uploaded using the Provider Web Portal)

Additional Information:

- The ACN on the 837 X12 claim MUST match the ACN used on the attachment uploaded using the PWP.
- The 837 X12 claims will suspend and recycle for up to 35 days waiting to find a matching attachment based on the ACN.

If a match is not found by the end of the recycle period, the claim will deny, regardless of whether the attachment is required for payment or not.

8 Acknowledgements and/or Reports

This section contains information and examples on any applicable payer acknowledgements.

8.1 The TA1 Interchange Acknowledgement

The TA1 allows the receiver of a file to notify the sender that an invalid interchange structure was received or that problems were encountered. The TA1 verifies only the interchange header (ISA/GS) and trailer (IEA/GE) segments of the file envelope.

If ISA or GS errors were encountered, then the generated TA1 report with the Interchange Header errors will be returned for pickup.

What to look for in the TA1

The TA1 segment indicates whether or not the submitted interchange control structure passed the HIPAA compliance check.

If TA104 is “R”, then the transmitted interchange control structure header and trailer were rejected because of errors. The submitter will need to correct the errors and resubmit the corrected file to Nevada Medicaid.

Example:

TA1*000100049*130716*0935*R*020~

The data elements in the TA1 segment are defined as follows:

- TA101 contains the Interchange Control Number (ISA13) from the file to which this TA1 is responding (“000100049” in the example above).
- TA102 contains the Interchange Date (“130716” in the example above).
- TA103 contains the Interchange Time (“0935” in the example above).
- TA104 code indicates the status of the interchange control structure (“R” in the example above). The definition of the code is as follows: “R” – The transmitted interchange control structure header and trailer are rejected because of errors.
- TA105 code indicates the error found while processing the interchange control structure (“020” in the example above). The definitions of the codes are as follows:

Code	Description
000	No Error
001	The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgement.
002	This Standard as Noted in the Control Standards Identifier is Not Supported
003	This Version of the Controls is Not Supported
004	The Segment Terminator is Invalid
005	Invalid Interchange ID Qualifier for Sender
006	Invalid Interchange Sender ID

Code	Description
007	Invalid Interchange ID Qualifier for Receiver
008	Invalid Interchange Receiver ID
009	Unknown Interchange Receiver ID
010	Invalid Authorization Information Qualifier Value
011	Invalid Authorization Information Value
012	Invalid Security Information Qualifier Value
013	Invalid Security Information Value
014	Invalid Interchange Date Value
015	Invalid Interchange Time Value
016	Invalid Interchange Standards Identifier Value
017	Invalid Interchange Version ID Value
018	Invalid Interchange Control Number Value
019	Invalid Acknowledgement Requested Value
020	Invalid Test Indicator Value
021	Invalid Number of Included Groups Value
022	Invalid Control Structure
023	Improper (Premature) End-of-File (Transmission)
024	Invalid Interchange Content (e.g., Invalid GS Segment)
025	Duplicate Interchange Control Number
026	Invalid Data Element Separator
027	Invalid Component Element Separator
028	Invalid Delivery Date in Deferred Delivery Request
029	Invalid Delivery Time in Deferred Delivery Request
030	Invalid Delivery Time Codeine Deferred Delivery Request
031	Invalid Grade of Service Code

The TA1 segment will be sent within its own interchange (i.e., ISA-TA1-IEA)

Example of a TA1 within its own interchange:

ISA*00* *00* *ZZ*NVMED *ZZ*TPID1234
*171222*0106*^*00501*000000001*0*P*:~TA1*000100049*130716*0935*R*020~IEA*0*000000001~

For additional information, consult the Interchange Control Structures, X12.5 Guide. TR3 documents may be obtained by logging on to www.wpc-edi.com and following the links to ”EDI Publications” and ”5010 Technical Reports.”

8.2 The 999 Implementation Acknowledgement

If a 5010 X12 file is submitted to Nevada Medicaid, a 999 acknowledgement is sent to the submitter normally within one hour; however, it could take as long as 24 hours. A 999 does not guarantee processing of the transaction. It only signifies that Nevada Medicaid received the Functional Group.

The following sections explain how to read the 999 to find out whether a file is Accepted, Rejected, Partially Accepted or Accepted, But Errors Were Noted. If a Functional Group is Accepted or Accepted, But Errors Were Noted, no action is required by the submitter. If the Functional Group is Partially Accepted or Rejected, the submitter must correct the errors and re-submit the corrected file or transaction set(s) to Nevada Medicaid.

What to look for in the 999

Locate the AK9 segment. These segments indicate whether or not the submitted Functional Group passed the HIPAA compliance check.

If the AK9 segment appears as AK9*A (Accepted), the entire file was accepted for processing.

If the AK9 segment appears as AK9*R (Rejected), the entire file was rejected.

If the AK9 segment appears as AK9*P (Partially Accepted), the transaction set(s) was rejected.

If the AK9 segment appears as AK9*E (Accepted, But Errors Were Noted), the entire file was accepted for processing, but warning or informational edits were found.

Example of the 999 Acknowledgement:

ST*999*0001*005010X231~

AK1*HC*6454*005010X231~

AK2*837*0001~

IK5*A~

AK2*837*0002~

IK3*CLM*22*22**8~

CTX*CLM01:123456789~

IK4*2*782*1~

IK5*R*5~

AK9*P*2*2*1~

SE*8*0001~

AK1

This segment refers to the (GS) Group Set level of the original file sent to Nevada Medicaid.

- AK101 is equal to GS01 from the original file (e.g., the AK101 of an 837 claims file would be “HC”; the AK101 of a 270 Eligibility Inquiry file would be “HS”).
- AK102 is equal to GS06 from the original file (Group Control Number).
- AK103 is equal to GS08 from the original file (EDI Implementation Version).

AK2

This segment refers to the (ST) Transaction Set level of the original file sent to Nevada Medicaid.

- AK201 is equal to ST01 from the original file (e.g., the AK201 of an 837 claims file would be "837"; the AK201 of a 270 Eligibility Inquiry file would be "270").
- AK202 is equal to ST02 from the original file (Transaction Set Control Number).
- AK203 is equal to ST03 from the original file (EDI Implementation Version).

IK3

This segment reports errors in a data segment.

Example:

IK3*CLM*22**8~

- IK301 contains the segment name that has the error. In the example above, the segment name is "CLM".
- IK302 contains the numerical count position of this data segment from the start of the transaction set (a "line count"). The erroneous "CLM" segment in the example above is the 22nd segment line in the Transaction Set. Transaction Sets start with the "ST" segment. Therefore, the erroneous segment in the example is the 24th line from the beginning of the file because the first two segments in the file, ISA and GS, are not part of the transaction set.
- IK303 may contain the loop ID where the error occurred.
- IK304 contains the error code and states the specific error. In the example above, the code " 8" states "Segment Has Data Element Errors."

Code	Description
1	Unrecognized segment ID
2	Unexpected segment
3	Required segment missing
4	Loop occurs over maximum times
5	Segment Exceeds Maximum Use
6	Segment not in defined transaction set
7	Segment not in proper sequence
8	Segment has data element errors
I4	Implementation "Not Used" segment present
I6	Implementation Dependent segment missing
I7	Implementation loop occurs under minimum times
I8	Implementation segment below minimum use
I9	Implementation Dependent "Not Used" segment present

CTX

This segment describes the Context/Business Unit. The CTX segment is used to identify the data that triggered the situational requirement in the IK3.

Example:

IK3*CLM*22**8~

CTX*CLM01:123456789~

IK4

This segment reports errors in a data element.

Example:

IK4*2*782*1~

- IK401 contains the data element position in the segment that is in error. The “2” in the example above represents the second data element in the segment.

Code	Description
1	Required data element missing
2	Conditional required data element missing
3	Too many data elements
4	Data element too short
5	Data element too long
6	Invalid character in data element
7	Invalid code value
8	Invalid date
9	Invalid time
10	Exclusion condition violated
12	Too many repetitions
13	Too many components
I6	Code value not used in implementation
I9	Implementation dependent data element missing
I10	Implementation “Not Used” data element present
I11	Implementation too few repetitions
I12	Implementation pattern match failure
I13	Implementation Dependent “Not Used” element present

Note: IK404 may contain a copy of the bad data element.

IK5

This segment reports errors in a transaction set.

Example:

IK5*R*5~

- IK501 indicates whether the transaction set is:
  - A = Accepted
  - R = Rejected

  The "R" in the example above means the transaction set was rejected due to errors.
- IK502 indicates the implementation transaction set syntax error. The "5" in the example above indicates "One or More Segments in Error."

Below is a sample of IK502 error codes. Please refer to the 999 TR3 document for a complete list of these error codes.

Code	Description
1	Transaction Set not supported
2	Transaction Set trailer missing
3	Transaction Set Control Number in Header/Trailer do not match
5	One or more segments in error

AK9

This segment reports the functional group compliance status.

Example:

AK9*P*2*2*1~

- AK901 indicates whether the entire functional group is:
  - A = Accepted
  - P = Partially Accepted. The transaction set(s) rejected and will NOT be forwarded for processing. The transaction set(s) will need to be corrected and resubmitted.
  - R = Rejected. The functional group was rejected and will NOT be forwarded for processing. The file will need to be corrected and resubmitted.
  - E = Accepted, But Errors Were Noted. No action is needed as this means the entire file was accepted for processing, but warning or informational edits were found.

  The "P" in the example above means the functional group was partially accepted and at least one transaction set was rejected.
- AK902 contains the total number of transaction sets. In the example above, two transaction sets were submitted.
- AK903 contains the number of received transaction sets. In the example above, two transaction sets were received.

- AK904 contains the number of accepted transaction sets in a Functional Group. In the example above, one transaction set was accepted.
- AK905 contains the Functional Group Syntax Error Code.

Below is a sample of AK905 error codes. Please refer to the 999 TR3 document for a complete list of error codes.

Code	Description
1	Functional group not supported
2	Functional group version not supported
3	Functional group trailer missing
4	Group Control Number in the functional group Header and Trailer do not agree
5	Number of included transaction sets does not match actual count
6	Group Control Number violates syntax
17	Incorrect message length (Encryption only)
18	Message authentication code failed
19	Functional Group Control Number not unique within interchange

For additional information, consult the Implementation Acknowledgement for Health Care Insurance (999) Guide. TR3 documents may be obtained by logging onto www.wpc-edi.com and following the links to “HIPAA” and “HIPAA Guides. “

8.3 Report Inventory

There are no acknowledgement reports at this time.

9 Trading Partner Agreements

Trading Partners who intend to conduct electronic transactions with Nevada Medicaid must agree to the terms of the Nevada Medicaid Trading Partner Agreement.

An EDI Trading Partner is defined as any entity (provider, billing service, software vendor, employer group, financial institution, etc.) that conducts electronic transactions with Nevada Medicaid. The Trading Partner and Nevada Medicaid acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Each party agrees to take all steps reasonably necessary to ensure that all electronic transactions between them conform to all HIPAA regulations.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

A copy of the agreement is available on the Nevada Medicaid EDI webpage at: https://www.medicaid.nv.gov/providers/edi.aspx.

10 Transaction Specific Information

This section describes how ASC X12N TR3 Implementation Guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Nevada Medicaid has something additional, over and above, the information in the TR3s. That information can:

- Limit the repeat of loops or segments
- Limit the length of a simple data element
- Specify a sub-set of the TR3 internal code listings
- Clarify the use of loops, segments, composite, and simple data elements
- Any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Nevada Medicaid

In addition to the row for each segment, one or more additional rows are used to describe Nevada Medicaid's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

10.1 Institutional Health Care Claims (837I)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
68		BHT	Beginning of Hierarchical Transaction			
68		BHT02	Transaction Set Purpose Code	00, 18		
			Original	00	2	
69		BHT06	Transaction Type Code	31, CH, RP		
			Chargeable	CH	2	
71	1000A	NM1	Submitter Name			
72	1000A	NM109	Identification Code		8	The Trading Partner ID assigned by Nevada Medicaid.
73	1000A	PER	Submitter EDI Contact Information			
74	1000A	PER02	Name		1/60	Required if different than the name contained in the Submitter Name (Loop 1000A-NM1 segment).
74	1000A	PER03	Communication Number Qualifier	EM, FX, TE	2	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
74	1000A	PER04	Communication Number			Email Address, Fax Number or Telephone Number (including the area code)
76	1000B	NM1	Receiver Name			
77	1000B	NM103	Name Last or Organization Name		1/60	NEVADA MEDICAID
77	1000B	NM109	Identification Code	NVMED	5	
80	2000A	PRV	Billing Provider Specialty Information			
80	2000A	PRV03	Reference Identification		10	Billing Provider Taxonomy Code
84	2010AA	NM1	Billing Provider Name			
86	2010AA	NM109	Identification Code		10	Billing Provider NPI
87	2010AA	N3	Billing Provider Address			
87	2010AA	N301	Address Information		1/55	
88	2010AA	N4	Billing Provider City/ State/ ZIP Code			
89	2010AA	N403	Zip Code		9	Billing Provider Zip Code + 4 digit postal code (excluding punctuation and blanks).
90	2010AA	REF	Billing Provider Tax Identification			Healthcare providers must send NPI in the associated NM109.
90	2010AA	REF01	Reference Identification Qualifier	EI	2	
90	2010AA	REF02	Reference Identification		9	
107	2000B	HL	Subscriber Hierarchical Level			For Nevada Medicaid, the insured and the patient are always the same person. Use this HL segment to identify the member and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C).

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
108	2000B	HL04	Hierarchical Child Code	0, 1		
			No Subordinate HL Segment in This Hierarchical Structure	0	1	For NV Medicaid the Member is the Subscriber so there should never be a Dependent Level.
109	2000B	SBR	Subscriber Information			
109	2000B	SBR01	Payer Responsibility Sequence Number Code	A-H, P, S, T, U		
			Primary	P	1	
			Secondary	S	1	
			Tertiary	T	1	
110	2000B	SBR09	Claim Filing Indicator Code	11-17, AM, BL, CH, CI, DS, FI, HM, LM, MA, MB, MC, OF, TV, VA, WC, ZZ		
			Medicaid	MC	2	The value sent at this level should always be 'MC'.
112	2010BA	NM1	Subscriber Name			
113	2010BA	NM102	Entity Type Qualifier	1, 2		
			Person	1	1	
113-114	2010BA	NM108	Identification Code Qualifier	II, MI		
			Member Identification Number	MI	2	
114	2010BA	NM109	Identification Code		11	11-digit Nevada Medicaid Recipient ID.
122	2010BB	NM1	Payer Name			

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
123	2010BB	NM103	Name Last or Organization Name	DHCFP	5	
124	2010BB	NM108	Identification Code Qualifier	PI, XV		
			Payer Identification	PI	2	
124	2010BB	NM109	Identification Code	NVMED	5	
129	2010BB	REF	Billing Provider Secondary Identification			
129	2010BB	REF01	Reference Identification Qualifier	G2, LU	2	
130	2010BB	REF02	Reference Identification			
143	2300	CLM	Claim Information			
144	2300	CLM01	Claim Submitter's Identifier			Patient Account Number Value received will be returned on the '835' Remittance Advice.
145	2300	CLM05-1	Facility Type Code		2	Value received is the 1st two positions of the Type of Bill (TOB).

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
145	2300	CLM05-3	Claim Frequency Code	1, 2, 3, 4, 7, 8	1	Value received is the 3rd position of the Type of Bill (TOB). Frequency Code also indicates whether the current claim is an original claim, an interim claim, a void, or an adjustment. Valid values are as follows: '1' = Original Claim '2' = Interim – 1st Claim '3' = Interim – Continuing Claim '4' = Interim – Last Claim '7' = Adjustment (Replacement of Paid Claim) '8' = Void (Credit only) The ICN to credit should be placed in the REF02 where REF01='F8' if the values of '7' or '8' are used. Providers must use the most recently paid ICN when voiding or adjusting a claim.
149	2300	DTP	Discharge Hour			
149	2300	DTP01	Date/Time Qualifier	096	3	
149	2300	DTP02	Date Time Period Format Qualifier	TM	2	
149	2300	DTP03	Date Time Period		4	Time Expressed in Format HHMM
150	2300	DTP	Statement Dates			
150	2300	DTP01	Date/Time Qualifier	434	3	
150	2300	DTP02	Date Time Period Format Qualifier	RD8	3	
150	2300	DTP03	Date Time Period		17	Dates Expressed in Format CCYYMMDD-CCYYMMDD. When the statement is for a single date of service, the from/through date are the same.
153	2300	CL1	Institutional Claim Code			

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
153	2300	CL101	Admission Type Code		1	Required when patient is being admitted for inpatient services.
153	2300	CL102	Admission Source Code		1	Required for all inpatient and outpatient services when TOB (CLM05-1) = 11, 13, 14, 21, 22, 32 or 33.
154	2300	PWK	Claim Supplemental Information			This is required when attachments are sent electronically (PWK = EL). The claim attachment must be submitted using the Provider Web Portal (PWP). Refer to section 7.9 for additional information.
155-156	2300	PWK01	Report Type Code		2	
156	2300	PWK02	Report Transmission Code	EL	2	EL = Electronically Only
157	2300	PWK05	Identification Code Qualifier	AC	2	AC = Attachment Control Number
157	2300	PWK06	Identification Code			The Attachment Control Number (ACN) needs to be in the following format: Provider ID (NPI or API) + Recipient ID + Date of Service + Sequence Number (four numeric digits of your choice). Example: 12345678900000000000010801201900001
166	2300	REF	Payer Claim Control Number			
166	2300	REF01	Reference Identification Qualifier	F8	2	
166	2300	REF02	Reference Identification		13	Enter the 13-digit last paid Internal Control Number (ICN) that Nevada Medicaid assigned to the claim.
170	2300	REF	Claim Identifier for Transmission Intermediaries			
170	2300	REF01	Reference Identification Qualifier	D9	2	F8 = Original Reference Number Adjust or void a claim (as indicated by CLM05-3).
170	2300	REF02	Reference Identification		1/20	
184	2300	HI	Principal Diagnosis			

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
184-185	2300	HI01-1	Code List Qualifier Code	ABK, BK	2/3	ABK = ICD-10 Principal Diagnosis
185	2300	HI01-2	Industry Code		3/7	For ICD-10, length allowed is 3-7
187	2300	HI	Admitting Diagnosis			
188	2300	HI01-1	Code List Qualifier Code	ABJ, BJ	2/3	ABJ = ICD-10 Admitting Diagnosis
188	2300	HI01-2	Industry Code		3/7	For ICD-10, length allowed is 3-7
189	2300	HI	Patient's Reason for Visit			Required when claim involves outpatient visits.
190	2300	HI01-1	Code List Qualifier Code	APR, PR	2/3	APR = ICD-10 Patient's Reason for Visit Diagnosis
190	2300	HI01-2	Industry Code		3/7	For ICD-10, length allowed is 3-7
193	2300	HI	External Cause of Injury			
194	2300	HI01-1	Code List Qualifier Code	ABN, BN	2/3	ABN = ICD-10 External Cause of Injury Diagnosis
218	2300	HI	Diagnosis Related Group (DRG) Information			
218	2300	HI01-1	Code List Qualifier Code	DR	2	
219	2300	HI01-2	Industry Code		3/5	
220	2300	HI	Other Diagnosis			Other Diagnosis Codes that co-exist with the principal diagnosis co-exist at the time of admission or develops subsequently during member's treatment. The 837I allows for 2 Other Diagnosis Information segments for a total of 24 other diagnosis codes per claim.
221	2300	HI01-1	Code List Qualifier Code	ABF, BF	2/3	ABF = ICD-10 Other Diagnosis
221	2300	HI01-2	Industry Code		3/7	For ICD-10, length allowed is 3-7
239	2300	HI	Principal Procedure Information			
240	2300	HI01-1	Code List Qualifier Code	BBR, BR, CAH	2/3	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
240	2300	HI01-2	Industry Code		3/7	For ICD-10, length allowed is 3-7
240	2300	HI01-3	Date Time Period Format Qualifier	D8	2	
240	2300	HI01-4	Date Time Period		8	Principal Procedure Date. (CCYYMMDD)
242	2300	HI	Other Procedure Information			
243	2300	HI01-1	Code List Qualifier Code	BBQ, BQ	2/3	
243	2300	HI01-2	Industry Code		3/7	For ICD-10, length allowed is 3-7
243	2300	HI01-3	Date Time Period Format Qualifier	D8	2	
243	2300	HI01-4	Date Time Period		8	Other Procedure Date. (CCYYMMDD)
319	2310A	NM1	Attending Provider Name			
321	2310A	NM109	Identification Code		10	Attending Provider NPI ID
322	2310A	PRV	Attending Provider Specialty Information			
322	2310A	PRV03	Reference Identification		10	Billing Provider Taxonomy Code
324	2310A	REF	Referring Provider Secondary Identification			
324	2310A	REF01	Reference Identification Qualifier	0B, 1G, G2, LU		
325	2310A	REF02	Reference Identification			
326	2310B	NM1	Operating Physician Name			
327	2310B	NM101	Entity Identifier Code	72	2	
328	2310B	NM109	Identification Code		10	Operating Physician NPI ID

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
331	2310C	NM1	Other Operating Physician Name			
332	2310C	NM101	Entity Identifier Code	ZZ	2	
333	2310C	NM109	Identification Code		10	Other Operating Physician NPI ID
334	2310C	REF	Referring Provider Secondary Identification			
334	2310C	REF01	Reference Identification Qualifier	0B, 1G, G2, LU		
334	2310C	REF02	Reference Identification			
341	2310E	NM1	Service Facility Provider Name			
342	2310E	NM101	Entity Identifier Code	77	2	
342	2310E	NM109	Identification Code		10	Service Facility Provider NPI ID
344	2310E	N3	Service Facility Location Address			
344	2310E	N301	Address Information		1/55	
345	2310E	N4	Service Facility Location City, State, Zip Code			
346	2310E	N403	Zip Code		9	Service Facility Provider Zip Code + 4 postal code (excluding punctuation and blanks).
349	2310F	NM1	Referring Provider Name			Use this segment when the servicing provider type requires a referring NPI to be submitted on the claim. Information in this loop applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420D.
350	2310F	NM101	Entity Identifier Code	DN	2	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
351	2310F	NM109	Identification Code		10	Referring Provider NPI ID.
354	2320	SBR	Other Subscriber Information			If the recipient has Medicare or other coverage, repeat this loop for each other payer. Omit Nevada Medicaid coverage information.
355	2320	SBR01	Payer Responsibility Sequence Number Code	A-H, P, S, T, U		
			Primary	P	1	
			Secondary	S	1	
			Tertiary	T	1	
356	2320	SBR09	Claim Filing Indicator Code	11-17, AM, BL, CH, CI, DS, FI, HM, LM, MA, MB, MC, OF, TV, VA, WC, ZZ	2	
358	2320	CAS	Claim Level Adjustments		1/3	For Inpatient: '1' – Deductible '2' – Coinsurance '66' – Blood Deductible Other external code source values from code source 139 are allowed.
359-363	2320	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17	Adjustment Reason Code		1/3	If Adjustment Group Code (CAS01)=PR and Adjustment Reason Code value is: '1' enter the Medicare Deductible Amount. '2' enter the Medicare Coinsurance Amount. '66' enter the Medicare Blood Deductible.
364	2320	AMT	Coordination of Benefits (COB)			

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
			Payer Paid Amount			
364	2320	AMT01	Amount Qualifier Code	D	1	
364	2320	AMT02	Payer Paid Amount		10	
384	2320	NM1	Other Payer Name			
385	2330B	NM109	Identification Code		2/80	This number must be identical to the occurrences of the 2430-SVD01 to identify the other payer if the 2430 loop is present. Note: The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 15 times for a single detail.
389	2330B	DTP	Claim Check or Remittance Date			This segment must be absent if 2430 DTP is present.
389	2330B	DTP01	Date Claim Paid	573	3	
389	2330B	DTP02	Date Time Period Format Qualifier	D8	2	
389	2330B	DTP03	Date Time Period		8	TPL Adjudication Date (CCYYMMDD)
423	2400	LX	Service Line Number			
423	2400	LX01	Line Counter			Nevada Medicaid will accept up to 999 lines per claim.
424	2400	SV2	Institutional Service Line			
424	2400	SV201	Service Line Revenue Code		4	
425	2400	SV202-1	Product/Service ID	ER, HC, HP, IV, WK	2	
449	2410	LIN	Drug Identification			
451	2410	LIN02	Product or Service ID Qualifier	N4	2	National Drug Code in 5-4-2 Format.
451	2410	LIN03	National Drug Code			An NDC code is required when a J procedure code is billed in Loop 2400,

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
						Segment SV1, Data Element SV101-2.
452	2410	CTP	Drug Quantity			
452	2410	CTP04	National Drug Unit Count		8	Enter the actual NDC quantity dispensed.
453	2410	CTP05-1	Unit or Basis for Measurement Code	F2, GR, ME, ML, UN	2	
454	2410	REF	Prescription or Compound Drug Association Number			
454	2410	REF01	Prescription or Compound Drug Association Number	XZ	2	
471	2420D	NM1	Referring Provider Name			Use this segment when the servicing provider type requires a referring NPI to be submitted on the claim and the referring provider differs from that reported at the claim level (loop 2310F).
472	2420D	NM101	Entity Identifier Code	DN	2	Referring Provider
473	2420D	NM109	Identification Code		10	Referring Provider NPI ID
476	2430	SVD	Line Adjudication Information			
476	2430	SVD01	Identification Code		2/80	This number should the occurrence of the 2330B-NM109 identifying Other Payer.
477	2430	SVD02	Service Line Paid Amount		1/10	
480	2430	CAS	Claim Level Adjustments			
482-484	2430	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17	Adjustment Reason Code		1/3	For Outpatient: '1' = Deductible Amount '2' = Coinsurance Amount '66' = Blood Deductible Other external code source values from code source 139 are allowed.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/ Comments
486-489	2430	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Adjustment Amount		10	If Adjustment Group Code (CAS01)=PR and Adjustment Reason Code value is: '1' enter the Medicare Deductible Amount ' 2' enter the Medicare Coinsurance Amount '66' enter the Medicare Blood Deductible
486	2430	DTP	Claim Check or Remittance Date			
486	2430	DTP01	Date/Time Qualifier	573	3	
486	2430	DTP02	Date Time Period Format Qualifier	D8	2	
486	2430	DTP03	Date Time Period		8	TPL Detail Level Adjudication Date (CCYYMMDD)

Appendix A: Implementation Checklist

This appendix contains all necessary steps for submitting transactions with Nevada Medicaid.

1. Call the Nevada Medicaid EDI Help Desk with any questions at (877) 638-3472 options 2, 0, and then 3 or send an email to: nvmmis.edisupport@dxc.com.
2. Check the Nevada Medicaid website at www.medicaid.nv.gov regularly for the latest updates.
3. Review the Trading Partner User Guide which includes enrollment and testing information. This can be found on the EDI webpage at: https://www.medicaid.nv.gov/providers/edi.aspx.
4. Confirm you have completed your Trading Partner Agreement and been assigned a Trading Partner ID.
5. Make the appropriate changes to your systems/business processes to support the updated companion guides. If you use a third party software, work with your software vendor to have the appropriate software installed.
6. Identify the transactions you will be testing:
    - Health Care Eligibility/Benefit Inquiry and Information Response (270/271)
    - Health Care Claim Status Request and Response (276/277)
    - Health Care Claim: Dental (837D)
    - Health Care Claim: Institutional (837I)
    - Health Care Claim: Professional (837P)
7. Confirm providers have registered all the NPIs on the Nevada Medicaid Provider Web Portal. If the entity testing is a billing intermediary or software vendor, they should use the provider's identifiers on the test transaction.
8. When submitting test files, make sure the recipients/claims you submit are representative of the type of service(s) you provide to Nevada Medicaid providers.

Appendix B: SNIP Edit (Compliance)

The Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) recommends seven types of testing to determine compliance with HIPAA. Nevada Medicaid has adopted this through SNIP Level 4 edits. At this level a claim's inter-segment relationships are validated. For example, if element A exists, then element B should be populated. The following SNIP Level 4 edits are applied for 837I transactions:

LOOP	MESSAGE
2010AA	2010AA PER02 must be present for first iteration of PER
2010AA	2310E NM1 must be different from 2010AA NM1
2010AA	2310E N3/N4 must be different from 2010AA N3/N4
2010AC	2010AC can only be present when BHT06 = 31
2010AC	2010AC NM108 = "XV" when 2010AC REF_2U present
2010AC	2320 AMT01 = "D" is required when 2010AC is used
2000B	2000C HL must be absent when 2000B SBR02 = "18"
2000B	2010BA N3 must be present when 2000B SBR02 = "18"
2000B	2010BA DMG must be present when 2000B SBR02 = "18"
2000B	2300 CLM loop req'd in 2000B when 2000B SBR02 = "18"
2000B	2300 CLM loop not allowed in 2000B when 2000B SBR02 absent
2000B	2010BA N4 must be present when 2000B SBR02 = "18"
2000B	2000C required when 2000 SBR02 = "18" is absent
2000B	2320 SBR must be present when 2000B SBR01 = "P"
2010BA	2010BA N3 must be absent when SBR02 ="18"
2010BA	2010BA DMG must be absent when SBR02 = "18"
2010BA	2000B SBR02 = "18" must be present when 2010BA N4 is present
2010BB	2010BB NM108 = "XV" when 2010BB REF_2U present
2010BB	2010BB REF01 = "G2";"LU" must be absent if 2010AA NM109 present
2310A	2310A REF_0B;1G;G2;LU must be absent if 2310A NM109 present
2310B	2310B REF_0B;1G;G2;LU must be absent if 2310B NM109 present
2310C	2310B is required when 2310C is used
2310C	2310C REF_0B;1G;G2;LU must be absent if 2310C NM109 present
2310D	2310D REF_0B;1G;G2;LU must be absent if 2310D NM109 present
2310F	2310F REF_0B;1G;G2 must be absent if 2310F NM109 present
2330B	2330B DTP must be absent if 2430 DTP present
2420A	2420A REF_0B;1G;G2;LU must be absent if 2420A NM109 present
2420B	2420B REF_0B;1G;G2;LU must be absent if 2420B NM109 present
2420C	2420C REF_0B;1G;G2;LU must be absent if 2420C NM109 present

2420D	2420D REF_0B;1G;G2 must be absent if 2420D NM109 present
2320	2320 SBR01 (except U) must not equal 2000B SBR01
2320	Within 2300 loop 2320 SBR01 (except U) must be unique
2320	When present ((2320 AMT_D) & ABSENT (2430 FOR PAYER) present (2330B DTP_573))
2320	When present ((2430 SVD FOR 2320 PAYER) present (2320 AMT_D))
2430	2430 SVD01 must = 2330B NM109

Appendix C: Transmission Examples

This is an example of an 837I batch file containing two claims within the first transaction for the same provider, different members, and one claim within the second transaction. For Nevada Medicaid batch files have the ability to loop at the functional group, transaction and hierarchical levels. Each functional group within an interchange has to be the same transaction type.

ISA*00* *00* *ZZ*TPID1234 *ZZ*NVMED *170528*1500*^*00501*022963926*1*T*:~

GS*HC*TPID1234*NVMED*20170528*150021*22963926*X*005010X223A2~

ST*837*000000001*005010X223A2~

BHT*0019*00*000000001*20170528*150021*CH~

NM1*41*2*SUBMITTER INC*****46*12345678~

PER*IC*CONTACT NAME*TE*8001231234~

NM1*40*2*NEVADA MEDICAID*****46*NVMED~

HL*1**20*1~

PRV*BI*PXC*207P00000X~

NM1*85*2*BILLING PROVIDER HOSPITAL*****XX*BILLPNPI123~

N3*BILL PROV STREET~

N4*HENDERSON*NV*890143586~

REF*EI*BILLTAXID~

PER*IC*BILLCONTACT*TE*8001234567~

HL*2*1*22*0~

SBR*P*18*******MC~

NM1*IL*1*MEMLNAME*MEMFNAME****MI*MEMID123456~

N3*123 MEMBER STREET~

N4*HENDERSON*NV*89014~

DMG*D8*19520207*F~

NM1*PR*2*DHCFP*****PI*NVMED~

CLM*PATACT1*383.6***13:A:1**A*Y*Y~

DTP*434*RD8*20170820-20170822~

CL1*2*1*01~

REF*D9*TRACEREFNUMBER1~

REF*EA*MEDRECNUM~

HI*ABK:Z3800~

HI*APR: Z3800~

HI*BH:11:D8: 20170820~

NM1*71*1*PRVLNAME*PRVFNAME****XX*PROVNPI123~

LX*1~

SV2*0403*HC:77052*42.3*UN*1~

DTP*472*D8*20170820~

LX*2~

SV2*0403*HC:77057*341.3*UN*1~

DTP*472*D8*20170820~

HL*3*1*22*0~

SBR*P*18*******MC~

NM1*IL*1*MLNAME*MFNAME****MI*MEMID123456~

N3*456 MEMBER STREET~

N4*HENDERSON*NV*89014~

DMG*D8*19600616*F~

NM1*PR*2*DHCFP*****PI*NVMED~

CLM*PATACT2*589.6***13:A:1**A*Y*Y~

DTP*434*RD8*20170820-20170820~

CL1*1*1*01~

REF*D9*TRACEREFNUMBER2~

REF*EA*MEDRECNUM2~

HI*ABK:T161XXA~

HI*APR:T161XXA~

HI*BH:11:D8:20170820~

NM1*71*1*PRVLNAME*PRVFNAME****XX*PROVNPI123~

NM1*72*1*PRVLNAME*PRVFNAME****XX*PROVNPI456~

LX*1~

SV2*0250**84*UN*1~

DTP*472*D8*20170820~

LX*2~

SV2*0251**84*UN*1~

DTP*472*D8*20170820~

LX*3~

SV2*0450*HC:99282*421.6*UN*2~

DTP*472*D8*20170820~

SE*61*000000001~

ST*837*000000002*005010X223A2~

BHT*0019*00*000000002*20170528*150021*CH~

NM1*41*2*SUBMITTER INC*****46*12345678~

PER*IC*CONTACT NAME*TE*8001231234~

NM1*40*2*NEVADA MEDICAID*****46*NVMED~

HL*1**20*1~

PRV*BI*PXC*207P00000X~

NM1*85*2*BILLING HOSPITAL*****XX*BILLNPI789~

N3*123 SOUTH STREET~

N4*HENDERSON*NV*890143586~

REF*EI*TAXIDBILL~

PER*IC*CONTACT*TE*8001234567~

HL*2*1*22*0~

SBR*P*18*******MC~

NM1*IL*1*MEMLNAM*MFNAM*C***MI*MEMID987654~

N3*STREET MEMBER~

N4*HENDERSON*NV*89014~

DMG*D8*19511222*M~

NM1*PR*2*DHCFP*****PI*NVMED~

CLM*ACCTNUM*60.1***13:A:1**A*Y*Y~

DTP*434*RD8*20170914-20170914~

CL1*2*1*01~

REF*D9*TRACEREFNUMBER3~

REF*EA*MEDRECNUM3~

HI*ABK:Z4802~

HI*APR: Z4802~

HI*BH:11:D8:20170914~

NM1*71*1*PRVLNAME*PRVFNAME****XX*PROVNPI123~

LX*1~

SV2*0250**6.4*UN*1~

DTP*472*D8*20170914~

LX*2~

SV2*0272**53.7*UN*4~

DTP*472*D8*20170914~

SE*35*000000002~

GE*2*22963926~

IEA*1*022963926~

Appendix D: Frequently Asked Questions

This appendix contains a compilation of questions and answers relative to 837 Institutional claims submitted to Nevada Medicaid.

Q: As a Trading Partner or clearinghouse, who should I contact if I have questions about testing, specifications, Trading Partner enrollment or if I need technical assistance with electronic submission?

A: After visiting the EDI webpage located at: https://www.medicaid.nv.gov/providers/edi.aspx if you still have questions regarding EDI testing and Trading Partner enrollment, support is available Monday through Friday 8 a.m.-5 p.m. Pacific Time by calling toll-free at (877) 638-3472 option 2, 0, and then 3. You can send an email to nvmmis.edisupport@dxc.com.

Q: Who should I contact if I have questions pertaining to billing or to check on the status of a submitted claim?

A: Trading Partners should contact the Customer Service Center for any non-EDI related questions at (877) 638-3472 and follow the prompts for the department you wish to speak with.

Q: How do I request and submit EDI files through the secure Nevada Medicaid SFTP server in production?

A: Once you have satisfied testing, you will receive an approval letter via email, which will contain the URL to connect to production.

Q: What types of acknowledgement reports will Nevada Medicaid return following EDI submission?

A: A TA1 will be generated when errors occur within the interchange envelope ISA/IEA. A 999 acknowledgement will be returned on an 837I batch. If the Trading Partner is approved for 835s and the provider has registered the Trading Partner to receive the files, an 835 (ERA) will be returned to the payee provider or Trading Partner delegated by the provider if the claims were accepted electronically and forwarded for claims adjudication.

Q: Where can I find a copy of the HIPAA ANSI TR3 documents?

A: The TR3 documents must be purchased from the Washington Publishing Company at www.wpc-edi.com.

Appendix E: Change Summary

This section describes the differences between the current Companion Guide and previous versions of the guide.

Published / Revised	Section / Nature of change
06/18/2018	Initial version published.
04/29/2019	Updated section 2.1 to Trading Partner Enrollment. Updated provider website link in section 2.1. Updated provider website link in section 3.4. Added notes in section 4.5 for batch 270 (other conditions). Updated contact information in section 5.3. Updated provider website link in section 7. Updated length and notes/comments in 2300 REF02 (Payer Claim Control Number) segment in the table in section 10.1. Added notes, codes and length to the 2410 LIN02 segment in the table in section 10.1.
09/16/2019	Added Claim Attachments section 7.9. Added 2300 PWK/Claim Supplemental Information segment to the table in section 10.1.
03/13/2020	Updated Claim Attachments section 7.9. Updated Snip Edit (Compliance) table in Appendix B.