Hewlett Packard Enterprise

Nevada Medicaid

HIPAA Transaction Standard Companion Guide

Refers to the Technical Report Type 3 Document

Based on ASC X12N version: 005010X279A1

Health Care Eligibility Benefit Inquiry and Information Response (270/271)

February 2, 2015

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 and Nevada Check Up companion guide is intended to serve as a companion document to the corresponding Accredited Standards Committee (ASC) X12N/005010X279 Health Care Eligibility/Benefit Inquiry and Information Response (270/271), its related Addenda (005010X279A1), and its related Errata (005010X279E1). The document further specifies the requirements to be used when preparing, submitting, receiving, and processing electronic health care administrative data. The document supplements, but does not contradict, disagree, oppose, or otherwise modify the 005010X279 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 and Nevada Check Up website at http://www.medicaid.nv.gov/providers/edi.aspx regularly for the latest updates.

About DHCFP

The Nevada Department of Health and Human Services' Division of Health Care Finaincing 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.

- Nevada Medicaid website: Web announcements, billing manual, billing guidelines, forms, pharmacy information: https://www.medicaid.nv.gov.
- DHCFP website: Medicaid Services Manual, rates, policy updates, public notices: http://dhcfp.nv.gov.
- Contact for further information on this companion guide:
  Nevada Medicaid EDI Helpdesk
  Email: nvmmis.edisupport@hpe.com
  Phone: (877) 638-3472 options 2, 0, and then 3
  Fax: (775) 335-8594

Preface

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.

Important confidentiality notice

This document has a sensitivity rating of "high" based on Nevada Information Technology Security Standard 4.31. Those parties to whom it is distributed shall exercise a high degree of custody and care of the information included. It is not to be disclosed, in whole or in part, to any third parties without the express written authorization of DHCFP.

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1. Introduction

Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that Nevada Medicaid and all other health insurance payers in the United States comply with the EDI standards for health care as established by the Secretary of Health and Human Services (HHS). The American National Standards Institute (ANSI) X12N implementation guides have been established as the standards of compliance for electronic health care transactions.

1.1. Scope

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

The standard adopted by HHS for electronic health care transactions is ANSI ASC X12N Version 005010 and is effective January 1, 2012. The unique version/release/industry identifier code for the Health Care Eligibility Benefit Inquiry and Response transactions is 005010X279A1.

This companion guide assumes compliance with all loops, segments, and data elements contained in the 005010X279A1.

This companion guide does NOT include any of the required loops, segments, or data elements defined in the 005010X279A1 with the exception of those loops, segments, or data elements that require further clarification.

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 270/271 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 and Nevada Check Up website at http://www.medicaid.nv.gov/Home.aspx.

1.3. References

The implementation guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The 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 http://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

2.1. Working with Nevada Medicaid

This section describes how to interact with Hewlett Packard Enterprise's (HPE) EDI department.

Nevada Medicaid trading partners should exchange electronic health care transactions with HPE via the Nevada Provider Web Portal, Secure File Transfer Protocol (SFTP), CORE-certified multi-format network Interface, or through a Nevada Medicaid approved Value Added Network (VAN).

After establishing a transmission method, each trading partner must successfully complete testing. Additional information is provided in the next section of this companion guide. After successful completion of testing, production transactions may be exchanged.

2.2. Trading partner registration

This section describes how to register as a trading partner with HPE. EDI enrollment forms can be found at http://www.medicaid.nv.gov/providers/edi.aspx.

2.2.1. EDI enrollment forms

- FA-35 Electronic Transaction Agreement for Service Center – This form is required to enroll as a new Service Center.
- FA-36 Service Center Operational Information – Each Service Center must complete and submit this form for processing. This form notifies HPE of the Service Center's contact information, electronic transaction types, and software vendor information. Each box must be checked for each electronic transaction they will provide. They must test each of these transactions prior to being able to submit or retrieve them in production. Service Centers are required to notify HPE of any change to information presented on this form within five business days. To change the Service Center information, the box near the top of the form next to "This is a change to my previous information on file with Hewlett Packard Enterprise" should be marked. The form is required to enroll as a new Service Center.
- FA-37 Service Center Authorization Form – This form notifies that a provider or Service Center wishes to authorize or terminate electronic transaction services. Providers sending and receiving electronic transactions on their own behalf must complete and submit this form designating their own practice as the Service Center. Providers must submit a Service Center Authorization for each National Provider Identifier (NPI) or Atypical Provider Identifier (API) used when submitting claims to HPE. For example, if a provider has three different NPIs, that provider must submit three Service Center Authorizations.

  A provider uses the Service Center Authorization to: Authorize transactions with a Service Center, Terminate transactions with a Service Center, Authorize a Service Center to process the provider's Remittance Advice, and Terminate authorization for a Service Center to process the provider's Remittance Advice.

The forms must be signed with signatures and mailed in to the Nevada EDI department. Forms must be mailed to: Attention: EDI Coordinator Hewlett Packard Enterprise PO Box 30042 Reno, Nevada 89520-3042. The forms can also be emailed Attention: EDI Coordinator Hewlet Packard Enterprise nvmmis.edisupport@hpe.com or faxed to (775) 335-8502.

If you have already completed these forms, you will not be required to complete them again.

Trading partners must also submit a Secure Shell (SSH) public key file to HPE 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 HPE external SFTP servers. If you have not already supplied HPE with your SSH key, please do so now.

Failure to submit the requested forms and SSH key file to HPE will result in your trading partner enrollment request being rejected and the inability to submit to Nevada Medicaid/Nevada Check Up transactions electronically. Please submit your SSH public key via email within five business days. Should you require additional assistance with information on SSH keys, please contact the Nevada EDI helpdesk at (877) 638-3472 options 2, 0, and then 3.

2.3. Certification and testing overview

All trading partners will be certified through the completion of trading partner testing.

All trading partners that exchange electronic transactions with Nevada Medicaid must complete trading partner testing. This includes billing agents, clearinghouses, or software vendors.

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

Before exchanging production transactions with Nevada Medicaid, each trading partner must complete testing. All trading partners who plan to exchange transactions must contact the HPE EDI Helpdesk at (877) 638-3472 options 2, 0, and then 3 in advance to discuss the testing process, criteria, and schedule. Trading partner testing includes HIPAA compliance testing, as well as validating the use of conditional, optional, and mutually defined components of the transaction.

For batch and real-time transactions that have an associated response (e.g., 270/271, 276/277), HPE will process these transactions in a test environment to verify that the file structure and content meet HIPAA standards and Nevada Medicaid-specific data requirements and provide the associated response transaction. Once this validation is complete, the trading partner may submit production transactions to HPE for processing.

HPE recommends a test file must have a minimum of 10 and a maximum of 50 test claims.

For Eligibility Inquiry/Response, the following conditions should be addressed in one or more test files:

- The ability to perform a 270 inquiry using the Nevada Medicaid Recipient Identification Number.
- The ability to perform a 270 inquiry using the Nevada Medicaid Recipient First Name, Last Name, and Social Security Number.
- The ability to perform a 270 inquiry using the Nevada Medicaid Recipient First Name, Last Name, and Date of Birth.
- The ability to perform a 270 inquiry using the Nevada Medicaid Recipient Social Security Number and Date of Birth.

4. Connectivity with Nevada Medicaid/Communications

This section describes the process to submit HIPAA 270 transaction real-time or batch, along with various submission methods, security requirements, and exception handling procedures.

Nevada Medicaid supports multiple methods for exchanging electronic healthcare transactions:

- Secure File Transfer Protocol (SFTP) (Batch Only)
- CORE-certified multi-format network Interface (Real-Time and Batch)
- Nevada Medicaid approved Value Added Network (VAN) (Real-Time)

4.1. Process flows

This section contains a process flow diagram and appropriate text.

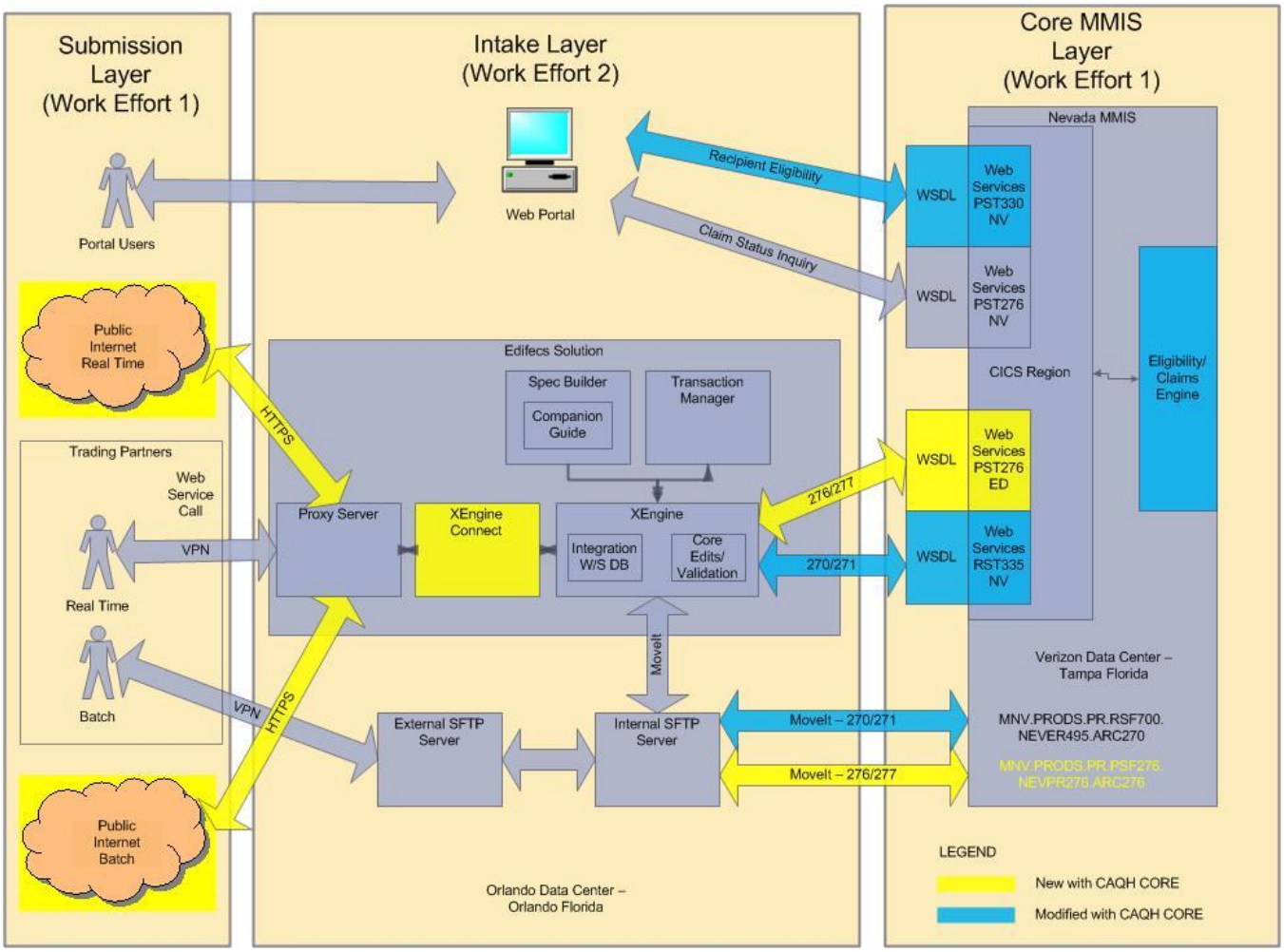
4.1.1. Batch and real-time eligilibility benefit inquiry and response

The response to a batch and real-time eligibility benefit inquiry transaction will consist of the following:

1. First level response: TA1 will be generated when errors occur within the outer envelope (no 999 or 271 will be generated).
2. Second level response: 999 will be generated. "Rejected" 999 when errors occur during 270 compliance validation or "Accepted" 999 if no errors are detected during the compliance validation.
3. Third level response: 271 will be generated indicating either the eligibility and benefits or AAA errors within request validation.

Each transaction is validated to ensure that the 270 complies with the 005010X279A1 TR3 document.

Transactions that fail this compliance check will generate a "Rejected" 999 file back to the sender with an error message indicating the compliance error. Transactions that pass this compliance check will generate an "Accepted" 999 file back to the sender with AK9*A to indicate that the file passed compliance. Transactions with multiple ST/SE loops that fail this compliance check in some of the ST/SE loops will generate a "Partial" 999 file back to the sender with an error message indicating the compliance error (all inquires in the ST/SE envelopes that pass compliance will be processed and a 271 will be generated without the ST/SE loop(s) that failed compliance). Transactions that pass compliance checks, but failed to process (e.g., due to Recipient not being found) will generate a 271 response transaction, including an AAA segment indicating the nature of the error. Transactions that pass compliance checks and have not failed to process (e.g., the Recipient was found with enrollment within the requested dates) do not generate AAA segments, but will create a 271 using the information in our eligibility and benefit system.



4.1.2. Real-time eligibility benefit inquiry and response

The response to a real-time eligibility transaction will consist of a 271 response being generated indicating the eligibility and benefits OR indicating errors using the AAA segment.

Each transaction is validated to ensure that the 270 complies with the 005010X279A1 TR3 document. Transactions that pass compliance checks but fail to process (e.g., due to Recipient not being found) will generate a real-time 271 response transaction with the appropriate AAA segment(s) indicating the nature of the error. Transactions that pass compliance checks and have not failed to process (e.g., the Recipient was found with eligibility within the requested dates) will create a 271 using the information in our eligibility and benefit system without AAA segments.

4.2. Transmission administrative procedures

4.2.1. System availability

The system is typically available 24X7 with the exception of scheduled maintenance windows.

4.2.2. Downtime notification

HPE will notify the trading partners in the case of any planned downtime or unexpected downtime using email distribution.

4.2.3. Transmission file size

For Batch: There is typically no file size limitation for any file submitted to Nevada Medicaid. All files must be transmitted in an unzipped or uncompressed format. Refer to ST-SE segment for file limitations.

For Real-Time: EDI will allow one request per file.

4.2.4. Transmission errors

When processing a real-time or batch EDI transaction that has Interchange Header errors, a TA1 will be generated. If the Interchange Header is valid but the transaction fails, compliance a 999 will be generated.

4.2.5. Batch production file-naming convention

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

Each file must be named with the Trading Partner_filetype_uniqueID.dat or .txt Trading Partner ID = four digit Nevada Medicaid assigned.

Example: 0123_Filetype = transaction type example – 270, 276, 837P, 837D, 837I_UniqueID = any unique ANSI qualifier example – DATETIMESTAMP [CCYYMMDDHHMMSSS as 201208301140512]

Here are some examples of good file naming standards:

- 0123_270_201208301140512.dat
- 0123_270_trans01_20120830.dat
- 0123_270_small_file_2012_08.txt

If the file does not meet the file naming standard, the file will not load into the Medicaid Management Information System (MMIS). You will need to correct the file name and resubmit the file in order for it to process.

Preferred extension is .dat; however, other extensions such as .txt are allowed.

4.3. Re-transmission procedure

Nevada Medicaid does not require any identification of a previous transmission of a file. All files sent should be marked as original transmissions.

Trading partners may call HPE for assistance in researching problems with submitted transactions. HPE will not edit trading partner data and/or resubmit transactions for processing on behalf of a trading partner. The trading partner must correct any errors found and resubmit.

4.4. Communication protocol specifications

This section describes Nevada Medicaid's communication protocols.

- Secure File Transfer Protocol (SFTP): Nevada Medicaid allows submitters to connect to the HPE SFTP server using your SSH private key and your assigned user name. There is no password for the connection.
- Network Routing Module (NRM) Service: HPE provides an NRM, which is an interactive server that is a multi-threaded windows service responsible for listening for input from a configured VAN data present port using socket connections. For more information, please contact the EDI Customer Service Helpdesk at (877) 638-3472 options 2, 0, and then 3.
- CORE-certified multi-format network Interface (Real-Time and Batch): Edifecs XEConnect provides CORE-certified transactional SSL or non-SSL messages exchange over public or private networks in Real-Time or Batch modes using Multipart or Simple Object Access Protocol/Web Services Description Language messaging. For more information, please contact the EDI Customer Service Helpdesk at (877) 638-3472 options 2, 0, and then 3.

4.5. Passwords

Providers must adhere to Nevada Medicaid's use of passwords. Providers are responsible for managing their own data. Each provider is responsible for managing access to their organization's data through the MMIS security function. Each provider 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 providers 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).

For more information regarding passwords and use of passwords, contact the HPE EDI Helpdesk at (877) 638-3472 options 2, 0, and then 3

5. Contact information

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

5.1. EDI Customer Service

The Customer Service Contact Center should be contacted instead of the EDI Customer Service Helpdesk for questions regarding the details of a Recipient's benefits, claim status information, credentialing, and many other services. Customer Service Contact Center is available at (877) 638-3472, Monday through Friday, 8:00 a.m. to 5:00 p.m. PST, with the exception of Holidays.

Have the applicable provider identifier, the NPI or API for health care providers, available for tracking and faster issue resolution.

5.2. EDI technical assistance

HPE EDI Helpdesk 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. PST, with the exception of holidays.

Trading Partner ID: The 4-digit Trading Partner ID is Nevada Medicaid's key to accessing trading partner information. Trading partners should have this number available each time they contact the HPE EDI Services team. This used to be referred to as the Service Center ID.

For written correspondence:

HPE, Nevada Medicaid
PO Box 30042
Reno, Nevada 89520-3042

Email: nvmmis.edisupport@hpe.com

Nevada Medicaid website: http://www.medicaid.nv.gov

5.3. Provider Service

For Nevada Provider Training Phone: (877) 638-3472 (select option 2, option 0, and then option 4)

Fax: (775) 624-5979

E-mail: NevadaProviderTraining@hpe.com

For Nevada Provider Enrollment Phone: (877) 638-3472 (select option for "Provider Enrollment")

Fax: (775) 335-8593

5.4. Applicable websites/Email

Additional information is available on the following 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-9-CM (AHA): This site is a resource for the International Classifications of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes used in medical transcription and billing, and for Level 1 HCPCS. www.ahacentraloffice.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. CMS provides the Electronic Health-Care Transactions and Code Sets Model Compliance Plan at www.cms.hhs.gov/HIPAAGenInfo/.

  This site is the resource for information related to the Healthcare Common Procedure Coding System (HCPCS). www.cms.hhs.gov/HCPCSReleaseCodeSets/.

  This site is the resource for Medicaid HIPAA informational related to the Administrative Simplification provision. www.cms.gov/medicaid/hipaa/adminsim.
- 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.
- Medicaid HIPAA Compliant Concept Model (MHCCM): This site presents the Medicaid HIPAA Compliance Concept Model, information, and a toolkit. www.mhccm.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 Policy and Financing (DHCFP): The DHCFP website assists 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

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 NVM FHSC FA.
- Batch responses are not returned until all inquires are processed.
- Only one ISA/IEA is allowed per logical file.
- Utilize BHT Segment for Transaction Set Inquiry Response association.
- Utilize TRN Segments for Subscriber Inquiry Response association.

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.

270 (Inbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.3		ISA	Interchange Control Header			
C.4		ISA01	Authorization Information Qualifier	00	2	
C.4		ISA02	Authorization Information		10	Space fill
C.4		ISA03	Security Information Qualifier	00	2	
C.4		ISA04	Security Information		10	Space fill
C.4		ISA05	InterChange ID Qualifier	ZZ	2	
C.4		ISA06	InterChange Sender ID		15	4-digit Trading Partner ID supplied by Nevada Medicaid, left justified, and space filled.
C.4		ISA07	InterChange ID Qualifier	ZZ	2	
C.4		ISA08	InterChange Receiver ID		15	Value 'NVM FHSC FA' = Nevada MMIS Trading Partner ID, left justified, and space filled.
C.5		ISA09	InterChange Date		6	Format is YYMMDD
C.5		ISA10	InterChange Time		4	Format is HHMM

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
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 IEA01.
C.6		ISA14	Acknowledgment Requested	0, 1	1	0 = No Interchange Acknowledgment Requested (TA1). 1 = Interchange Acknowledgment Requested (TA1). NOTE: A TA1 will be generated regardless of the value used.
C.6		ISA15	Usage Indicator	T, P		P = Production Data T = Test Data

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
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 composite 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
C.10		IEA	Interchange Control Trailer			
C.10		IEA01	Number of Included Functional Groups		1/5	Number of included Functional Groups. Must equal '1' for the real-time transaction to qualify for immediate response.
C.10		IEA02	Interchange Control Number		9	The control number assigned by the interchange sender. Must be identical to the value in ISA13.

271 (Outbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.3		ISA	Interchange Control Header			
C.4		ISA01	Authorization Information Qualifier	00	2	
C.4		ISA02	Authorization Information		10	Space fill
C.4		ISA03	Security Information Qualifier	00	2	
C.4		ISA04	Security Information		10	Space fill
C.4		ISA05	InterChange ID Qualifier	ZZ	2	
C.4		ISA06	InterChange Sender ID		15	Value = 'NVM FHSC FA' – Nevada MMIS Trading Partner ID, left justified space fill
C.4		ISA07	InterChange ID Qualifier	ZZ	2	
C.4		ISA08	InterChange Receiver ID		15	4-digit Trading Partner ID will be returned as entered in the 270 inquiry.
C.5		ISA09	InterChange Date		6	Format is YYMMDD
C.5		ISA10	InterChange Time		4	Format is HHMM

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
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	Identical to the associated interchange control trailer IEA01.
C.6		ISA14	Acknowledgment Requested	0	1	0 = No interchange acknowledgment requested
C.6		ISA15	Usage Indicator	T, P	1	P = Production Data T = Test Data
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 composite 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
C.10		IEA	Interchange Control Trailer			
C.10		IEA01	Number of Included Functional Groups		1/5	Number of included Functional Groups included in an interchange.
C.10		IEA02	Interchange Control Number		9	The control number assigned by the interchange sender. Same value as 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.

270 (Inbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.7		GS	Functional Group Header			
C.7		GS01	Functional ID Code	HS	2	
C.7		GS02	Application Sender's Code		2/15	4-digit Trading Partner ID supplied by Nevada Medicaid.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.7		GS03	Application Receiver's Code		2/15	Value = 'NVM FHSC FA' – Nevada MMIS Trading Partner ID. This will equal the value in the ISA08.
C.7		GS04	Date		8	Format is CCYYMMDD
C.8		GS05	Time		4/8	Format is HHMM
C.8		GS06	Group Control Number		1/9	Group control number. Must be identical to the value in GE02.
C.8		GS07	Responsible Agency Code	X	1/2	
C.8		GS08	Version/Release/Industry ID Code		1/12	005010X279A1

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	Number of included Transaction Sets. Must equal '1' for the real-time transaction to qualify for immediate response.
C.9		GE02	Group Control Number		1/9	The functional group control number. Same value as GS06.

271 (Outbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.7		GS	Functional Group Header			
C.7		GS01	Functional ID Code	HB	2	
C.7		GS02	Application Sender's Code		2/15	Value = 'NVM FHSC FA' – Nevada MMIS Trading Partner ID.
C.7		GS03	Application Receiver's Code		2/15	4 digit Trading Partner ID supplied by Nevada Medicaid. This will equal the value in ISA06.
C.7		GS04	Date		8	Format is CCYYMMDD
C.8		GS05	Time		4/8	Format is HHMM
C.8		GS06	Group Control Number		1/9	Group control number. Identical to the value in GE02.
C.8		GS07	Responsible Agency Code	X	1/2	
C.8		GS08	Version/Release/Industry ID Code		1/12	005010X279A1

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	The functional group control number. Same value as 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 – start the first ST02 in the first file with 000000001 and increment from there. The TR3 should be reviewed for how to create compliant transactions set control segments.

If using the CORE-certified multi-format network Interface Batch method, the transaction set (ST-SE) cannot contain more than 99 inquiries. If submitting more than 99 inquires, this will produce a negative 999.

270 (Inbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
61		ST	Transaction Set Header			
61		ST01	Transaction Set Identifier Code	270	3	
62		ST02	Transaction Set Control Number		4/9	Transaction control number. Identical to the value in SE02.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
63		ST03	Implementation Convention Reference		1/35	005010X279A1

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
200		SE	Transaction Set Trailer			
200		SE01	Number of Included Segments		1/10	Total number of segments included in a transaction set including ST and SE segments.
200		SE02	Transaction Set Control Number		4/9	Transaction set control number. Identical to the value in ST02.

271 (Outbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
209		ST	Transaction Set Header			
209		ST01	Transaction Set Identifier Code	271	3	
210		ST02	Transaction Set Control Number		4/9	Transaction control number. Identical to the value in SE02.
211		ST03	Implementation Convention Reference		1/35	005010X279A1

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
450		SE	Transaction Set Trailer			
450		SE01	Number of Included Segments		1/10	Total number of segments included in a transaction set including ST and SE segments.
450		SE02	Transaction Set Control Number		4/9	Transaction set control number. Identical to the value in ST02.

7. Nevada Medicaid specific business rules and limitations

This section describes Nevada Medicaid's business rules, for example:

- Communicating payer specific edits
- Billing for specific services

Before submitting electronic claims to Nevada Medicaid, please review the appropriate HIPAA implementation guide and Nevada Medicaid companion guide. In addition, Nevada Medicaid recommends that you review the Nevada provider billing guides. The CMS-1500 and UB-04 claim form instructions provide additional billing instructions for specific provider types. These guides are located on the Nevada Medicaid website at www.medicaid.nv.gov/providers/BillingInfo.aspx.

The following sections outline recommendations, instructions, and conditional data requirements for transactions submitted to Nevada Medicaid. This information is designed to help trading partners construct transactions in a manner that will allow Nevada Medicaid to efficiently process transactions.

7.1. Eligibility search criteria

- Inquiry by 11-digit Recipient identification (ID) number
- Inquiry by Recipient's first name, last name, and Social Security Number (SSN)
- Inquiry by Recipient's first name, last name, and DOB
- Inquiry by SSN and Date of Birth (DOB)

When doing an eligibility inquiry, the date of service must be within a one month date range. If it is over one month, the error code returned is '56'.

7.2. Logical file structure

For real-time 270/271 transactions, there can be only one interchange (ISA/IEA), one functional group (GS/GE), and one transaction (ST/SE) per logical file. Within the transaction (ST/SE), there can only be one request. This has been defined as the Eligibility or Benefit Inquiry (EQ) segment within Loop 2110C.

For Batch 270/271 transactions, there can be only one interchange (ISE/IEA) per logical file. The interchange can contain multiple functional groups (GS/GE); however, the functional groups must be the same type.

7.3. Subscriber Date (Subscriber Information 2100C Loop)

For eligibility inquires, the date of service must be within a one month date range. If inquiries span over a one month period, the 271 response will contain an AAA03=56 (Inappropriate Date).

7.4. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)

On January 16, 2009, HHS published a final rule adopting ICD-10-CM and ICD-10-PCS to replace ICD-9-CM and ICD-9-PCS in HIPAA transactions, effective implementation date of October 1, 2013. The implementation of ICD-10 was delayed from October 1, 2013 to October 1, 2014, by final rule CMS-0040-F issued on August 24, 2012.

Until that time, October 1, 2014, the codes in ICD-10-CM are not valid for any purpose or use. If Nevada Medicaid receives any transaction that contains the ICD-10-CM or ICD-10-PCS qualifiers, the transaction will fail compliance. The submitter will need to correct the compliance failure and resubmit the transaction for processing.

7.5 Acceptable Characters

For real-time the HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. For batch the HIPAA transactions can contain carriage returns and line feeds, however it is recommended the data is received in one, continuous stream without carriage return and line feeds. Nevada Medicaid requires trading partners to use the ASC X12 Extended Character set. Uppercase characters are recommended.

8. Acknowledgements and/or Reports

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 for batch and real-time, 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*900000001*090721*1700*R*006~

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 ("900000001" in the example above).
- TA102 contains the Interchange Date ("090721" in the example above).
- TA103 contains the Interchange Time ("1700" 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 ("006" 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 Acknowledgment.
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

Code	Description
006	Invalid InterChange Sender ID
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 Acknowledgment 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 Code in 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* NVM FHSC FA *ZZ*RECEIVER *110721*1701*^*00501*000000001*0*P*:~TA1*900000001*110720*1245*R*006~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

For batch, each time a 5010 X12 file is submitted to Nevada Medicaid, a 999 acknowledgement is sent to the submitter within one business day. For real-time, a 999 acknowledgement is generated only if the 270 eligibility request fails compliance. 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 or rejected. If a Functional Group is accepted, no action is required by the submitter. If the Functional Group is rejected, the submitter must correct the errors and submit the corrected file to Nevada Medicaid.

What to look for in the 999

Locate every AK9 segment. These segments indicate whether or not the submitted Functional Group passed the HIPAA compliance check. If each AK9 segment appears as AK9*A, this means the entire Functional Group was accepted for processing. The transaction will process.

If any AK9 segment begins with AK9*R (Rejected) or AK9*P (Partially Accepted – At least one transaction set was rejected), you should review the IK5 segments for any and all IK5*R values. This segment displays which transaction set or sets have been rejected.

Example of the 999 Acknowledgment:

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

Code	Description
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.
- IK402 contains the data element reference number as found in the appropriate TR3 document. The "782" in the example above represents the CLM02 data element from the 837P.
- IK403 contains the error code and states the specific error. The "1" in the example above represents "Required Data Element Missing."

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

Code	Description
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

- 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

  Other codes such as M, W, or X are for security decryption purposes but are rarely used. 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

Code	Description
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, at least one transaction set was rejected. The rejected transaction set within the functional group needs to be corrected and resubmitted.
  - R = Rejected, the functional group was rejected and was NOT forwarded for further processing. The file will need to be corrected and resubmitted.

  Other codes such as M, W, or X are for security decryption purposes but are rarely used. 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)

Code	Description
18	Message authentication code failed
19	Functional Group Control Number not unique within interchange

For additional information, consult the Implementation Acknowledgment 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

Providers who intend to conduct electronic transactions with Nevada Medicaid must sign the Nevada Medicaid Trading Partner Agreements. A copy of the agreement is available on the Nevada Medicaid website at http://www.medicaid.nv.gov/providers/edi.aspx.

9.1. Trading partners

Providers who intend to conduct electronic transactions with Nevada Medicaid must sign the Nevada Medicaid Trading Partner Agreements. A copy of the agreement is available on the Nevada Medicaid website at http://www.medicaid.nv.gov/providers/edi.aspx.

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 the HIPAA and regulations promulgated there under.

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.

10. Transaction specific information

This section describes how ASC X12N TR3 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 TR3s 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. 270 (Inbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
63		BHT	Beginning of Hierarchical Transaction			
64		BHT02	Transaction Set Purpose Code	13	2	13 = 'Request'

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
64		BHT03	Reference Identification		50	Required when the transaction is used in real-time. In 270 batch, may be provided at the sender's discretion. In 271 real-time, value received on the 270 will be returned on the 271.
66	2000A	HL	Information Source Level			Per HIPAA requirement, there can only be one 2000A Loop within a transaction (ST/SE).
69	2100A	NM1	Information Source Name			
69-70	2100A	NM101	Entity Identifier Code	PR	2	PR = 'Payer'
70	2100A	NM102	Entity Type Qualifier	2	1	2 = 'Non-Person Entity'
70	2100A	NM103	Name Last or Organization Name		26	DHCFP
71	2100A	NM108	Identification Code Qualifier	PI	2	PI = 'Payor Identification'
71	2100A	NM109	Identification Code		5	NVM FHSC FA
72	2000B	HL	Information Receiver Level			Per HIPAA requirement there can only be one 2000 Loop within a transaction (ST/SE).
75	2100B	NM1	Information Receiver Name			Information received within the 2100B NM1 segment will be echoed back on the 271 response.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
75-76	2100B	NM101	Entity Identifier Code	1P	2	1P = 'Provider'
77	2100B	NM108	Identification Code Qualifier	SV, XX	2	SV = Service provider's Atypical Provider Identifier. XX = Service provider's National Provider Identifier (NPI).
78	2100B	NM109	Identification Code			If NM108=SV, use the Atypical Provider Number. If NM108=XX, use the National Provider Identifier (NPI).
86-57	2000C	HL	Subscriber Level			
89	2000C	HL04	Hierarchical Child Code	0	1	0 = 'No Subordinate HL Segment in This Hierarchical Structure' For Nevada Medicaid, the Recipient is the Subscriber so there should never be a Dependent Level.
90	2000C	TRN	Subscriber Trace Number			
91	2000C	TRN02	Reference Identification		50	Trace Number. Value received on the 270 will be returned on the 271.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
91	2000C	TRN03	Originating Company Identifier		10	Value received on the 270 will be returned on the 271. Per HIPAA, the first position must be: '1' if an EIN is used. '3' if a DUNS is used. '9' if a user-assigned identifier is used.
91	2000C	TRN04	Reference Identification		50	Additional Trace Number. Value received on the 270 will be returned on the 271.
97	2100C	REF	Subscriber Additional Identification			If the Patient Account Number is on the 270 request, it will be returned on the 271 response.
98-99	2100C	REF01	Reference Identification Qualifier	EJ	2	EJ = 'Patient Account Number'
99	2100C	REF02	Reference Identification		38	Nevada Recipient Patient Account Number.
122	2100C	DTP	Subscriber Date			
123	2100C	DTP01	Date/Time Qualifier	291	3	291 = 'Plan'
123	2100C	DTP02	Date Time Period Format Qualifier	D8, RD8	2/3	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
123	2100C	DTP03	Date Time Period		16	To date of service if DTP02=D8 Format CCYYMMDD. From/To date of service if DTP02=RD8 Format CCYYMMDD-CCYYMMDD.

Nevada Medicaid supports multiple search criteria for an eligibility inquiry. An inquiry may be submitted using:

- Nevada Medicaid Recipient ID
- Recipient First Name, Last Name, and Social Security Number
- Recipient First Name, Last Name, and DOB
- Recipient Social Security Number and Date of Birth

Inquiry by Medicaid Recipient ID

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
92	2100C	NM1	Subscriber Name			
95	2100C	NM108	Identification Code Qualifier	MI	2	MI = 'Member Identification Number'
96		NM109	Identification Code		12	Use the 11-digit Medicaid Recipient's ID. If Recipient is not found, information received on this NM1 will be echoed back on the 271.

Inquiry by Recipient First Name, Last Name, and Social Security Number

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
92	2100C	NM1	Subscriber Name			If a Recipient is not found based on this search criteria submitted, information received will be echoed back on the 271.
93	2100C	NM103	Name Last or Organization Name		60	A maximum of 25 characters will be used for the search.
93	2100C	NM104	Name First		35	A maximum of 20 characters will be used for the search.
97	2100C	REF	Subscriber Additional Identification			
98-99	2100C	REF01	Reference Identification Qualifier	SY	2	SY = 'Social Security Number'
99	2100C	REF02	Reference Identification		9	9-digit Nevada Medicaid Recipient Social Security Number.

Inquiry by Recipient First Name, Last Name, and Date of Birth

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
92	2100C	NM1	Subscriber Name			If a Recipient is not found based on this search criteria submitted, information received will be echoed back on the 271.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
93	2100C	NM103	Name Last or Organization Name		60	A maximum of 25 characters will be used for the search.
93	2100C	NM104	Name First		35	A maximum of 20 characters will be used for the search.
107	2100C	DMG	Subscriber Demographic Information			
108	2100C	DMG01	Date Time Period Format	D8	2	'D8' Format = CCYYMMDD
109	2100C	DMG02	Date Time Period		8	Recipient Date of Birth. Format: CCYYMMDD

Inquiry by Recipient Social Security Number and Date of Birth

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
97	2100C	REF	Subscriber Additional Identification			If a Recipient is not found based on this search criteria submitted, information received will be echoed back on the 271.
98-99	2100C	REF01	Reference Identification Qualifier	SY	2	SY = 'Social Security Number'
99	2100C	REF02	Reference Identification		9	9-digit Nevada Recipient Social Security Number.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
107	2100C	DMG	Subscriber Demographic Information			
108	2100C	DMG01	Date Time Period Format	D8	2	'D8' Format = CCYYMMDD
109	2100C	DMG02	Date Time Period		8	Recipient Date of Birth. Format: CCYYMMDD

10.2. 271 (Outbound) Active Coverage Response

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
218	2100A	NM1	Information Source Name			
218-219	2100A	NM101	Entity Identifier Code	PR	2	PR = 'Payer'
219	2100A	NM102	Entity Type Qualifier	2	1	2 = 'Non-Person Entity'
219	2100A	NM103	Name Last or Organization Name		26	DHCFP
220	2100A	NM108	Identification Code Qualifier	PI	2	PI = 'Payor Identification'
220	2100A	NM109	Identification Code		5	NVMED FHSC
232	2100B	NM1	Information Receiver Name			2100B NM1 segment will contain the information that was received on the 270.
243	2000C	HL	Subscriber Level			

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
245	2000C	HL04	Hierarchical Child Code	0	1	0 = 'No Subordinate HL Segment in This Hierarchical Structure'
246	2000C	TRN	Subscriber Trace Number			Number received on the 270.
247-248	2000C	TRN01	Trace Type Code	2	1	2 = 'Referenced Transaction Trace Numbers'
248	2000C	TRN02	Reference Identification		50	Value received on the 270: 2000C-TRN02.
248	2000C	TRN03	Originating Company Identifier		10	Value received on the 270: 2000C-TRN03.
248	2000C	TRN04	Reference Identification		50	Value received on the 270: 2000C-TRN04.
249	2100C	NM1	Subscriber Name			
250	2100C	NM103	Name Last or Organization Name		25	Recipient Last Name. A maximum of 25 characters will be used for the search. If not found, the value submitted on the 270 will be returned on the 271.
250	2100C	NM104	Name First		20	Recipient First Name. A Maximum of 20 characters will be used for the search. If not found, the value submitted on the 270 will be returned on the 271.
251	2100C	NM108	Identification Code Qualifier	MI	2	MI = 'Member Identification Number'

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
252	2100C	NM109	Identification Code		12	11-digit Nevada Recipient Medicaid ID. If not found, the value submitted on the 270 will be returned on the 271.
253	2100C	REF	Subscriber Additional Identification			
254-255	2100C	REF01	Reference Identification Qualifier	EJ, SY, NQ		If EJ (Patient Account Number), SY (Social Security Number), or HJ (Recipient ID) was sent on the 270 inquiry, this value is returned here.
268	2100C	DMG	Subscriber Demographic Information			
269	2100C	DMG01	Date Time Period Format Qualifier	D8		'D8' Format = CCYYMMDD
269	2100C	DMG02	Date Time Period		8	If Recipient found, Nevada Medicaid date of birth is returned. If not found, the value submitted on the 270 will be returned on the 271.
283	2100C	DTP	Subscriber Date			
283	2100C	DTP01	Date/Time Qualifier	307	3	Eligibility
123	2100C	DTP02	Date Time Period Format Qualifier	D8, RD8	2, 3	'D8' Format = CCYYMMDD
123	2100C	DTP03	Date Time Period		8	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
283	2100C	DTP	Subscriber Date			
283	2100C	DTP01	Date/Time Qualifier	458	3	Certification
123	2100C	DTP02	Date Time Period Format Qualifier	D8	2	'D8' Format = CCYYMMDD
123	2100C	DTP03	Date Time Period		8	
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	1	1	
292	2110C	EB02	Benefit Coverage Level Code	IND	3	
298	2110C	EB03	Service Type Code	MC	1/2	Refer to TR3 Guide for values
298	2110C	EB04	Insurance Type Code	MC	2	MC = 'Medicaid'
315	2110C	REF	Subscriber Additional Identification			
315-316	2110C	REF01	Reference Identification Qualifier	1L	2	1L = 'Group or Policy Number'
316	2100C	REF02	Reference Identification		50	Plan Number

Potential AAA (Reject Reason Code) Information that can be returned within the 2100B (Information Receiver Request Validation)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
238	2100B	AAA	Request Validation			
239	2100B	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
239	2100B	AAA03	Reject Reason Code	50 & 51	2	
239	2100B	AAA03	Provider who is ineligibile for inquiries or enrolled as an Ordering, Prescribing or Referring (OPR) Provider	50	2	TR3 Description: **Provider Ineligible for Inquiries**
239	2100B	AAA03	Provider not found on database or a non-numeric Provider ID was received	51	2	TR3 Description: Provider Not on File
239	2100B	AAA04	Follow-up Action Code	C	1	C = Please Correct and Resubmit

Potential AAA (Reject Reason Code) Information that can be returned within the 2100C (Subscriber Request Validation)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
262	2100C	AAA	Subscriber Request Validation			

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
262	2100C	AAA01	Yes/No Condition or Response Code	N	1	N = 'No'
262/ 263	2100C	AAA03	Reject Reason Code	42, 52, 56, 57, 58, 62, 72, 73, 75 & 76	2	
262	2100C	AAA03	System problem/error	42	2	TR3 Description: Unable to Respond at Current Time
262	2100C	AAA03	Provider NPI that is inactive	52	2	TR3 Description: **Service Dates Not Within Provider Plan Enrollment**
262	2100C	AAA03	Inappropriate date	56	2	TR3 Description: Inappropriate Date
262	2100C	AAA03	Invalid service dates	57	2	TR3 Description: Invalid/Missing Date(s) of Service
262	2100C	AAA03	Enrollee ID not received AND Date of Birth received but is an invalid date	58	2	TR3 Description: Invalid/Missing Date-of-Birth
262	2100C	AAA03	Dates of service not within range	62	2	TR3 Description: Date of Service Not Within Allowable Inquiry Period

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
263	2100C	AAA03	Enrollee ID received but not numeric OR Enrollee ID not received, SSN was received but is not numeric OR Enrollee ID not received AND (Date of Birth, First and Last Name, and SSN are all blank OR SSN AND First and Last Name are blank OR SSN and Date of birth are blank) OR Enrollee ID is received, but cannot be found on the database	72	2	TR3 Description: Invalid/Missing Subscriber/Insured ID

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
264	2100C	AAA03	Enrollee ID not received AND Name received is invalid (either the first or last name is blank)	73	2	TR3 Description: Invalid/Missing Subscriber/Insured Name
264	2100C	AAA03	Enrollee ID not received and SSN not received AND First and Last name AND Date of birth are blank	75	2	TR3 Description: Subscriber/Insured Not Found
264	2100C	AAA03	Multiple eligible Enrollees found OR More than 10 matches found	76	2	TR3 Description: Duplicate Subscriber/Insured ID Number
264	2100C	AAA04	Follow-up Action Code	C	1	C = Please Correct and Resubmit

10.3. Various repetitions of 2110C (Subscriber Eligibility or Benefit Information Responses)

Inactive Response

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	6	1	Recipient is not eligible for the request period
292	2110C	EB02	Benefit Coverage Level Code	IND	3	
298	2110C	EB04	Insurance Type Code	MC	2	MC = 'Medicaid'

Medicare Part A

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	R	2	R = 'Other or Additional Payer'
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage'

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
298	2110C	EB04	Insurance Type Code	OT	2	
298	2110C	EB05	Plan Coverage Description		50	MEDICARE OPS CTR PART A
315	2110C	REF	Subscriber Additional Identification			
315-316	2110C	REF01	Reference Identification Qualifier	1L	2	1L = 'Group or Policy Number'
316	2100C	REF02	Reference Identification		50	Plan Number

Medicare Part B

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	R	1	R = 'Other or Additional Payer'
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage
298	2110C	EB04	Insurance Type Code	OT	2	
298	2110C	EB05	Plan Coverage Description		50	MEDICARE OPS CTR PART B

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
315	2110C	REF	Subscriber Additional Identification			
315-316	2110C	REF01	Reference Identification Qualifier	1L	2	1L = 'Group or Policy Number'
316	2100C	REF02	Reference Identification		50	Plan Number

Medicare Part D

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	R	1	R = 'Other or Additional Payer'
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage
298	2110C	EB04	Insurance Type Code	OT	2	
298	2110C	EB05	Plan Coverage Description		50	MEDICARE OPS CTR PART D
315	2110C	REF	Subscriber Additional Identification			

Third Party Liability (TPL)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2110C	EB	Subscriber Eligibility or Benefit Information			
291-292	2110C	EB01	Eligibility or Benefit Information	R	1	R = 'Other or Additional Payer'
293-298	2110C	EB03	Service Type Code	30	2	30 = 'Health Benefit Plan Coverage'
298	2110C	EB04	Insurance Type Code	OT	2	OT = 'Other'
299	2110C	EB05	Plan Coverage Description		50	Coverage Description
315	2110C	REF	Subscriber Additional Identification			
315-316	2110C	REF01	Reference Identification Qualifier	IL	2	1L = 'Group or Policy Number'
316	2100C	REF02	Reference Identification		50	Plan Number
328	2110C	LS	Loop Header			
328	2110C	LS01	Loop Identifier Code	2120	4	'2120'
329	2120C	NM1	Subscriber Benefit Related Entity Name			

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
330	2120C	NM101	Entity Identifier Code	IP	2	IP = 'Provider'
331	2120C	NM102	Entity Type Qualifier	2	1	2 = 'Non-Person Entity'
331	2120C	NM103	Name Last or Organization Name		60	'Carrier Name'
339	2120C	PER	Subscriber Benefit Related Entity Contact Information			
340	2120C	PER01	Contact Function Code	IC	2	
341	2120C	PER03	Communication Number Qualifier	TE	2	
341	2120C	PER04	Benefit Related Entity Communication Number		10	Benefit Related contact phone number
346	2110C	LE	Loop Trailer			
346	2110C	LE01	Loop Identifier Code	2120	4	'2120'

Appendix A. Implementation Checklist

This appendix contains all necessary steps for going live with Nevada Medicaid.

1. Call the Hewlett Packard Enterprise EDI Helpdesk with any questions at (877) 638-3472 options 2, 0, and then 3.
2. Check the Nevada Medicaid website at www.medicaid.nv.gov/ regularly for the latest updates.
3. Confirm you have completed your Trading Partner Agreement and been assigned a Trading Partner ID.
4. Make the appropriate changes to your systems/business processes to support the updated companion guides.
5. 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 (837D)
    - Health Care Claim: Professional (837P)
6. Confirm you have reported all the NPIs you will be using for testing by validating them with Nevada Medicaid. If you have associated multiple Nevada Medicaid provider IDs to one NPI and/or taxonomy code, make sure your claim(s) successfully pay to your correct Provider ID. If the entity testing is a billing intermediary or software vendor, they should use the provider's identifiers on the test transaction.
7. 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.
8. Schedule a tentative week for the initial test.
9. Confirm the email/phone number of the testing contact and confirm that the person you are speaking with is the primary contact for testing purposes.

Appendix B. Business Scenarios

This appendix contains typical business scenarios. The actual data streams linked to these scenarios are included in Appendix C.

- 5010 Nevada Medicaid 270 transaction inquiring with Nevada Medicaid Recipient ID:
    - Submitter: PEACHTREE CLINIC
    - NPI#: 1111111112
    - Recipient ID: 121212121213
    - Recipient Name: LNAME, FNAME
    - Recipient DOB: 08-27-1934
    - Recipient SSN: 123001234
- 5010 Nevada Medicaid 270 transaction inquiring with Nevada Medicaid Recipient First Name, Last Name, and Social Security Number.
- 5010 Nevada Medicaid 270 transaction inquiry with Nevada Medicaid Recipient Social Security Number and Date of Birth.

Appendix C. Transmission Examples

This appendix contains actual data streams. The business scenarios linked to the data streams are included in Appendix B.

Batch Transaction Examples:

1. Nevada Medicaid 270 transaction (Nevada Medicaid Recipient ID Inquiry):

   ISA*00* *00* *ZZ*TPID *ZZ* NVM FHSC FA *130207*0800*^*00501*505043666*0 *T*:~

   GS*HS*TPID* NVM FHSC FA*20130207*0800*43666*X*005010X279A1~

   ST*270*0001*005010X279A1~

   BHT*0022*13*TEST01*20130207*1200~

   HL*1**20*1~

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

   HL*2*1*21*1~

   NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~

   HL*3*2*22*0~

   TRN*1*TRACE-NUMBER1*1~

   NM1*IL*1******MI*121212121213~

   DTP*291*RD8*20130101-20130115~

   EQ*30~

   SE*12*0001~

   GE*1*43666~

   IEA*1*505043666~

   Nevada Medicaid Response 271 transaction for inquiry with Nevada Medicaid Recipient ID:

   ISA*00* *00* *ZZ* NVM FHSC FA *ZZ*TPID *130207*0801*!*00501*000000001*0 *T*:~

   GS*HB* NVM FHSC FA* TPID *20130207*0801*00002*X*005010X279A1~

   ST*271*0001*005010X279A1~

   BHT*0022*11*TEST01*20130207*0801~

   HL*1**20*1~

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

   HL*2*1*21*1~

NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~

HL*3*2*22*0~

TRN*2*TRACE-NUMBER1*1~

NM1*IL*1*MLAST*MFIRST****MI*121212121213~

REF*SY*123456789

DMG*D8*19340824 ~

DTP*307*RD8*20130101-20130115~

DTP*458*D8*20060413~EB*1*IND*1!33!35!47!48!50!86!88!98!AL!MH!UC*MC*MEDICAID FFS**0

REF*9F*100000000001~

EB*1*IND**MC*XIX MAN NNEV~

REF*9F*100000000000~

LS*2120~

NM1*1P*2*HEALTH PLAN OF NEVADA, INC~

PER*IC**TE*7021234567~

LE*2120~

SE*23*0001~

GE*1*00002~

IEA*1*000000001~

2. Nevada Medicaid 270 transaction (Nevada Medicaid Recipient First/Last Name and Social Security Number Inquiry):

   ISA*00* *00* *ZZ*TPID *ZZ* NVM FHSC FA *130207*0800*^*00501*505043666*0 *T*:~

   GS*HS*TPID* NVM FHSC FA*20130207*0800*43666*X*005010X279A1~

   ST*270*0002*005010X279A1~

   BHT*0022*13*TEST02*20130207*1200~

   HL*1**20*1~

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

   HL*2*1*21*1~

   NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~

   HL*3*2*22*0~

   TRN*1*TRACE-NUMBER2*2~

NM1*IL*1*MLAST*MFIRST~

REF*SY*123001234~

DTP*291*RD8*20130101-20130115~

EQ*30~

SE*13*0002~

GE*1*43666~

IEA*1*505043666~

Nevada Medicaid Response 271 transaction for inquiry with Nevada Medicaid Recipient First/Last Name and Social Security Number:

ISA*00* *00* *ZZ*NVM FHSC FA *ZZ*TPID *130207*0801*!*00501*000000001*0 *T*:~

GS*HB* NVM FHSC FA* TPID *20130207*0801*00002*X*005010X279A1~

ST*271*0001*005010X279A1~

BHT*0022*11*TEST02*20130207*0801~

HL*1**20*1~

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

HL*2*1*21*1~

NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~

HL*3*2*22*0~

TRN*2*TRACE-NUMBER2*2~

NM1*IL*1*MLAST*MFIRST****MI*121212121213~

REF*SY*123001234~

DMG*D8*19340824 ~

DTP*307*RD8*20130101-20130115~

DTP*458*D8*20121002~

EB*1*IND*1!33!35!47!48!50!86!88!98!AL!MH!UC*MC*MEDICAID FFS**0

REF*9F*100000000001~

EB*1*IND**MC*XIX MAN NNEV~

REF*9F*100000000000~

LS*2120~

NM1*1P*2*HEALTH PLAN OF NEVADA, INC~

PER*IC**TE*7021234567~

LE*2120~

SE*24*0001~

GE*1*00002~

IEA*1*000000001~

3. Nevada Medicaid 270 transaction (Nevada Medicaid Recipient Social Security Number and Date of Birth Inquiry):

ISA*00* *00* *ZZ*TPID *ZZ* NVM FHSC FA *130207*0800*^*00501*505043666*0 *T*:~

GS*HS*TPID* NVM FHSC FA*20130207*0800*43666*X*005010X279A1~

ST*270*0003*005010X279A1~

BHT*0022*13*TEST03*20130207*1200~

HL*1**20*1~

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

HL*2*1*21*1~

NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~

HL*3*2*22*0~

TRN*1*TRACE-NUMBER3*3~

NM1*IL*1 ~

REF*SY*123001234~

DMG*D8*19340824 ~

DTP*291*RD8*20130101-20130115~

EQ*30~

SE*14*0003~

GE*1*43666~

IEA*1*505043666~

Nevada Medicaid Response 271 transaction for inquiry with Nevada Medicaid Recipient Social Security Number and Date of Birth:

ISA*00* *00* *ZZ*NVM FHSC FA *ZZ*TPID *130207*0801*!*00501*000000001*0 *T*:~

GS*HB* NVM FHSC FA* TPID *20130207*0801*00002*X*005010X279A1~

ST*271*0001*005010X279A1~

BHT*0022*11*TEST03*20130207*0801~

HL*1**20*1~

NM1*PR*2*NEVADA HEALTH PARTNERSHIP*****PI*NVMED FHSC~

HL*2*1*21*1~

NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~

HL*3*2*22*0~

TRN*2*TRACE-NUMBER3*3~

NM1*IL*1*MLAST*MFIRST****MI*121212121213~

REF*SY*123001234~

DMG*D8*19340824 ~

DTP*307*RD8*20130101-20130115~

DTP*458*D8*20121002~

EB*1*IND*1!33!35!47!48!50!86!88!98!AL!MH!UC*MC*MEDICAID FFS**0

REF*9F*100000000001~

EB*1*IND**MC*XIX MAN NNEV~

REF*9F*100000000000~

LS*2120~

NM1*1P*2*HEALTH PLAN OF NEVADA, INC~

PER*IC**TE*7021234567~

LE*2120~

SE*24*0001~

GE*1*00002~

IEA*1*000000001~

Batch Transaction Example:

This is an example of a batch file containing three inquires; two within the first transaction for the same provider, different Recipients and one 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*TPID *ZZ* NVM FHSC FA
*130207*0800*^*00501*505043666*0 *T*:~

GS*HS*TPID* NVM FHSC FA*20130207*0800*43666*X*005010X279A1~

ST*270*0001*005010X279A1~

BHT*0022*13*TEST03*20130207*1200~

HL*1**20*1~

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

HL*2*1*21*1~

NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~

HL*3*2*22*0~

TRN*1*TRACE-NUMBER1*4~

NM1*IL*1*LNAME*FNAME*M***MI*123456789012~

DMG*D8*19340824 ~

DTP*291*RD8*20130101-20130115~

EQ*30~

HL*4*2*22*0~

TRN*1*TRACE-NUMBER2*5~

NM1*IL*1~

REF*SY*123001234~

DMG*D8*19350828 ~

DTP*291*D8*20130101~

EQ*30~

SE*20*0001~

ST*270*0002*005010X279A1~

BHT*0022*13*TEST04*20130207*1200~

HL*1**20*1~

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

HL*2*1*21*1~

NM1*1P*2*PEACHTREE CLINIC*****XX*1111111112~

HL*3*2*22*0~

TRN*1*TRACE*6~

NM1*IL*1*MLAST*MFIRST~

REF*SY*555555555~

DTP*291*RD8*20130201-20130205~

EQ*30~

SE*13*0002~

GE*2*43666~

IEA*1*505043666~

Appendix D. Frequently Asked Questions

This appendix contains a compilation of questions and answers relative to Nevada Medicaid and its providers.

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: EDI testing and trading partner enrollment support is available Monday through Friday 8 a.m.-5 p.m. by calling toll-free at 877-638-3472 option 2, 0, and then 3.

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

A: Providers 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 Hewlett Packard Enterprise 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: How long will 835, 277, TA1, and/or 999s be available for download on the secure Hewlett Packard Enterprise SFTP server?

- 7 Days: 999, TA1, 271
- 30 Days: 27
- 90 Days: 835

Q: What types of acknowledgment reports will Hewlett Packard Enterprise 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 batch 270 (Eligibility) and 276 (Claim Status), and failed 270 Real-Time (Eligibility Requests) and 276 Real-Time (Claim Status) transaction types. For those real-time 270 and 276 transactions that pass compliance, the respective 271 and 277 transactions will be generated. The 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. The 277 in the 005010X212 format, is returned if there was a problem with the claims that prevented the claims adjudication system from processing the claims (for example, Invalid NPI or Provider Not on File).

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

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

Published/ Revised	Section/ Nature of change
02/03/2012	Initial version
10/14/2012	Changed all Magellan/MMA references to HP Enterprise Services (HPES) and updated all contact information. Changed pagination from chapter-based to sequential. Other updates/corrections to sections 2, 3.3, 5.1, 5.2, 7.2 and 7.3; deleted section 8.
02/03/2014	Complete revision to comply with CAQH® (Council for Affordable Quality Healthcare) CORE™ (Committee on Operating Rules for Information Exchange) v5010 Master Companion Guide Template. Transaction specific data elements, and their values, were not changed. All previous versions are obsolete.
03/11/2014	Added ASC X12 Extended Character Set requirement (sections 6.1 and 7.5), removed references to name normalization, and updated Appendix C Transmission Examples.
02/02/15	Page 47: Added reject reason code of 50 Page 47: Removed "is not active" from code 51 name field Page 48: Added reject reason code of 52 Page 51 Section 10.3 (Inactive Response): Added comments for EB01