HP Enterprise Services

835 Companion Guide – Claim Payment/Advice Transactions

Nevada Medicaid Management Information System (NV MMIS)

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

In Support of the:
Nevada MMIS Takeover Project
Version 2.2
December 5, 2011

Revision history

Date (mm/dd/yyyy)	Description of Changes	Pages Impacted
08/22/2011	Removed yellow highlighting from email address and phone numbers and blank page in response to specific deliverable review comments.	2, 9
08/31/2011	Removed Confidentiality and Trademarks section for consistency with similar documentation.	ii
12/05/2011	Takeover HPES	All

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Introduction

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid and all other health insurance payers in the United States comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The X12N Health Care Implementation Guides have been established as the standards of compliance and are available online at http://www.wpc-edi.com/HealthCareFinal.asp.

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

Purpose of this document

HP Enterprise Services, Inc. has prepared this Companion Guide and the website, http://medicaid.nv.gov, to support Nevada Medicaid and Nevada Check Up Billing (Hereafter, Nevada Medicaid and Nevada Check Up are referred to as "Medicaid" unless otherwise specified.

This Companion Guide provides specific requirements for receiving electronic claim data from HP Enterprise Services. It supplements, but does not contradict the X12N Health Care Implementation Guides and should be used solely for the purpose of clarification.

The 835 Health Care Claim Payment Advice transaction set (hereafter called the "835 transaction"), communicates the results of claim adjudication. An 835 transaction is also called an "Electronic Remittance Advice" or "ERA."

The 835 transaction lists paid claims and denied claims (claims with a "pended" status are sent in a 277U transaction). Please work with your software vendor to ensure integration with your account management software.

The 835 transaction does not automatically issue an Electronic Funds Transfer (EFT). A provider must register to receive EFT payments by submitting form FA-32 on HP Enterprise Services' website, http://medicaid.nv.gov.

Standard HIPAA Claims Adjustment Codes and Remarks Codes will replace the edit and EOB codes on the 835 transaction.

835 Basic Business Flow

The basic business flow of the 835 transaction is from the payer to the health care provider that provided the service. Both the DHCFP and the provider may contract with other parties for the performance of various administrative services. A Value Added Network (VAN) or a Service Center may perform value added services or simply act as a communications pipeline.

An 835 transaction may be sent from HP Enterprise Services to:

- The provider
- The VAN to the provider
- The billing service to the provider
- The Service Center to the provider
- The independent practice association to the provider

Special Notes

Financial Adjustment Reason Codes - A composite reference identifier in the PLB03-02 segment describes a provider level Financial Adjustment Transaction. A component of this identifier is referred to as the DHCFP Financial Adjustment Reason Codes. These reason codes and their descriptions are available on the DHCFP website at http://dhcfp.nv.gov.

Questions

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

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

835 Health Care Claim Payment/Advice

Page	Loop	Segment	Data Element	Comments
B.3	N/A	ISA	ISA01: Authorization Information Qualifier	"00"= No authorization information present
B.3	N/A	ISA	ISA02: Authorization Information	Value - blanks
B.4	N/A	ISA	ISA03: Security Information Qualifier	"00" = No security information present
B.4	N/A	ISA	ISA04: Security Information	Value - blanks
B.4	N/A	ISA	ISA05: Interchange ID Qualifier	"ZZ" = Mutually Defined
B.4	N/A	ISA	ISA06: Interchange Sender ID	"NVM FHSC FA"
B.4	N/A	ISA	ISA07: Interchange ID Qualifier	"ZZ" = Mutually Defined
B.5	N/A	ISA	ISA08: Interchange Receiver ID	4-digit Service Center code assigned by HP Enterprise Services
B.5	N/A	ISA	ISA09: Interchange Date	Variable "YYMMDD" = Date of interchange (T)
B.5	N/A	ISA	ISA10: Interchange Time	Variable "HHMM" = Time of interchange (T)
B.5	N/A	ISA	ISA11: Interchange Control Standards Identifier	"U" = U.S. EDI Community
B.5	N/A	ISA	ISA12: Interchange Control Version Number	"00401" = Version Number
B.6	N/A	ISA	ISA14: Acknowledgment Requested	"0" = No acknowledgment requested
B.6	N/A	ISA	ISA15: Usage Indicator	"P" = Production "T" = Test
B.6	N/A	ISA	ISA16: Component Element Separator	">"
B.8	N/A	GS	GS02: Application Sender's Code	"NVM FHSC FA"
B.8	N/A	GS	GS03: Application Receiver's	4-digit Service Center code assigned by HP Enterprise Services

Page	Loop	Segment	Data Element	Comments
B.9	N/A	GS	GS08: Version/Release/Industry Identifier Code	"004010X091A1"
45	N/A	BPR	BPR01: Transaction Handling Code	"I" = Remittance information only "H" = Information Only if BPR02 = 0
46	N/A	BPR	BPR04: Payment Method Code	"ACH" = Automated Clearing House (if EFT is used) "CHK" = Paper check "NON" = No funds transmitted If BPR04 = "CHK" or "NON," then BPR05 through BPR12 are blank.
49	N/A	BPR	BPR10: Originating Company Identifier	DHCFP Fed Tax ID ("54-0849793") preceded by a "1."
52	N/A	TRN	TRN01: Trace Type Code	"1" = Current Transaction Trace Number
53	N/A	TRN	TRN02: Reference Identification	Check or EFT trace number
53	N/A	TRN	TRN03: Originating Company Identifier	DHCFP Fed Tax ID ("54-0849793") preceded by a "1."
53	N/A	TRN	TRN04: Reference Identification	If BPR04 = "ACH," the same value as BRP11 (Originating Company Supplemental Code) is used. If BPR04 = "CHK" or "NON," the RA ADVICE NUMBER is used.
57	N/A	REF	REF01: Reference Identification Qualifier	"EV" = Receiver ID
57	N/A	REF	REF02: - Reference Identification	Medicaid Service Center
60	N/A	DTM	DTM01: Date/Time	"405" = Production
61	N/A	DTM	DTM02: Date	Weekly End Date
62	1000A	N1	N101: Entity Identifier Code	"PR" = Payer
63	1000A	N1	N102: Name	Division of Health Care Financing and Policy
64	1000A	N3	N301: Address Information	1100 East William Street, Suite 101

Page	Loop	Segment	Data Element	Comments
65	1000A	N4	N401: City Name	Carson City
65	1000A	N4	N402: State or Province	Nevada
65	1000A	N4	N403: Postal Code	89701
73	1000B	N1	N103: Payee ID Qualifier	"XX" = NPI "FI" = Federal Tax ID or SSN
73	1000B	N1	N104: Payee ID	NPI or Federal Tax ID (depends on qualifier sent in N103).
78	1000B	REF	REF01: Payee ID Qualifier	"TJ" = Federal Tax ID
78	1000B	REF	REF02: Reference ID	The Federal Tax ID will be returned in this segment if the NPI is returned in N104.
78	1000B	REF	REF01: Payee ID Qualifier	"1D" = 10-digit API (Atypical Provider Identifier)
78	1000B	REF	REF02: Reference ID	The API will be returned in this segment if a NPI is not used.
79	2000	LX	LX01: Assigned Number	"01" = Nevada Medicaid "02" = Nevada Check Up "03" = Unmatched "ZZ" = Other
81	2000	TS3	TS301: Reference Identification	NPI or API of the servicing provider
81	2000	TS3	TS302: Facility Code Value	For institutional claims, this data element reflects the bill type. For professional claims, this data element reflects the place of service. The default value is "99."

Page	Loop	Segment	Data Element	Comments
89	2100	CLP	CLP01: Claim Submitter's Identifier	Claim Patient Account or Rx Number returned from 837 CLM01. If a Patient Account Number or Rx number was not provided on the claim, this field will display "0."
92	2100	CLP	CLP06: Claim Filing Indicator Code	"MC" = Medicaid "OF" = Other Federal Program "LM" = Liability Medical ("LM" is the default.)
93	2100	CLP	CLP07: Reference Identification	The 16-digit Internal Control Number assigned by Magellan Medicaid Administration is formatted as follows: 2- digit century, 2-digit year, 3-digit Julian date, 1-digit media type, 6-digit document number, 2-digit claim line number
93	2100	CLP	CLP08: Facility Code Value	Type of Bill or Place of Service returned from 837 CLM05-1. Default value is "99."
93	2100	CLP	CLP09: Claim Frequency Type Code	On 837I transactions only, this is returned from the CLM05-2 data element.
97	2100	CAS	CAS: Adjustment Reason Codes	If multiple errors are found with a claim, or when additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.
102	2100	NM1	NM101: Entity Identifier Code	"QC" = Patient
103	2100	NM1	NM108: Identification Code Qualifier	"MR" = Medicaid "MI" = Member ID (Other)
112	2100	NM1	MN101: Entity Identifier Code	"82" = Rendering Provider

Page	Loop	Segment	Data Element	Comments
113	2100	NM1	NM108: Identification Code Qualifier	"MC" = Medicaid "XX" = NPI
113	2100	NM1	NM109: Identification Code	This identification code will be the servicing provider's NPI.
122	2100	MIA	MIA20 through MIA24: Reference Identification - Remark Codes	If multiple errors are found with a claim, or when additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.
124	2100	MOA	MOA03 through MOA09: Reference Identification - Remark Codes	If multiple errors are found with a claim, or when additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.
126	2100	REF	REF01: Reference Identification Qualifier	"G1" = Prior Authorization Number "F8" = Original Reference Number (Magellan Medicaid Administration refers to this as the "Internal Control Number or "ICN.")
127	2100	REF	REF02: Reference Identification	If data element REF01 = "G1," the 11-digit Authorization Number and the prior authorization line number are displayed. If data element REF01 = "F8," the Internal Control Number (ICN) is displayed.

Page	Loop	Segment	Data Element	Comments
140	2110	SVC	SVC: Service Line	The service line loop will occur once for professional or pharmacy claims. For outpatient or home health services, this loop may occur once per revenue line.
141	2110	SVC	SVC01-3 through SVC01-6: Procedure Modifier	Up to four procedure modifiers can be displayed as reported on the claim.
150	2110	CAS	CAS: Claim Adjustment	For outpatient services, home health services, professional claims or pharmacy claims, this segment will appear at the line level. If multiple errors are found with a claim line, or when additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.
154	2110	REF	REF01: Reference Identification Qualifier	"6R" = Provider Control Number
155	2110	REF	REF02: Reference Identification	Line item control from 837
162	2110	LQ	LQ02: Industry Code - Remark Code	If multiple errors are found with a claim, or when additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.
165	Table 3	PLB	PLB03: Reference ID	The value in this field will be the NPI or the API.