Nevada MMIS 837P Transaction Companion Guide

Professional Health Care Claims
HIPAA Version 5010

Nevada Medicaid Management Information System (MMIS)

Department of Health and Human Services (DHHS)

Division of Health Care Financing and Policy (DHCFP)

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Change history for HIPAA Version 5010

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, 5.1, 6, 6.1 and 7.1; deleted section 8; deleted section 8.
12/30/2013	Updated sections 6 and 7.1 regarding dependent data.
11/12/2014	Updated information for Referring Provider in Loop 2310A and 2420F. Removed all references for Encounter claims. Removed section 3.3 (not applicable).
10/19/2015	Added information for Health Care Diagnosis Codes page 15. Added ICD-10 information to Claim Submissions Section 7.1.

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1. Introduction

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that Medicaid and all other health insurance payers in the United States comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services.

The X12N Health Care Implementation Guides have been established as the standards of compliance and are online at: http://store.x12.org/store/healthcare-5010-consolidated-guides.

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

1.1. Purpose

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

An EDI trading partner is defined by Nevada Medicaid as anybody such as a provider, software vendor and clearinghouse that exchanges transactions adopted under HIPAA.

DXC Technology, the fiscal agent for Nevada Medicaid, has prepared this companion guide and website, http://www.medicaid.nv.gov, to support Nevada Medicaid and Nevada Check Up billing. Hereafter, DXC Technology is referred to as Nevada Medicaid; Nevada Medicaid and Nevada Check Up are referred to as Medicaid unless otherwise specified.

This companion guide provides specific requirements for submitting professional claims (837P, CMS-1500) electronically to Nevada Medicaid.

1.2. Intended use

The following information is intended to serve only as a companion guide to the HIPAA American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N Technical Report Type 3 (TR3) document. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the ASC X12 TR3 document. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

2. Working together

2.1. Trading partner registration

An EDI trading partner is any entity (provider, billing service, clearinghouse, software vendor, etc.) that transmits electronic data to and receives electronic data from another entity. Nevada Medicaid requires all trading partners to complete EDI registration regardless of the trading partner type as defined below. Contact the EDI Helpdesk to register.

- Trading partner is an entity engaged in the exchange or transmission of electronic transactions.
- Vendor is an entity that provides hardware, software and/or ongoing technical support for covered entities. In EDI, a vendor can be classified as a software vendor, billing or network service vendor or clearinghouse.
- Software vendor is an entity that creates software used by billing services, clearinghouses and providers/suppliers to conduct the exchange of electronic transactions.
- Billing service is a third party that prepares and/or submits claims for a provider.
- Clearinghouse is a third party that submits and/or exchanges electronic transactions on behalf of a provider.

The Trading Partner agreement forms are located at:
http://www.medicaid.nv.gov/providers/edi.aspx

- FA-35 must be completed to enroll as a Trading Partner.
- FA-36 must be completed to enroll as a Trading Partner.
- FA-37 must be completed by the provider in order to link the provider to the Trading Partner.
- FA-39 is used for providers who will be billing using the Payerpath software.

2.2. Trading partner testing and certification

Nevada Medicaid requires that all newly registered trading partners complete basic transaction submission testing. Successful transaction submission and receipt of both valid responses and error responses is an indication that all systems involved can properly submit and receive transactions.

2.2.1. Trading partner ID

Once registration is completed, a 4-digit Trading Partner ID will be assigned.

2.2.2. File naming standard

Each file must be named with the ServiceCenter_filetype_uniqueID.dat or .txt.

- Trading Partner ID = 4-digit assigned example -- 0123
- Filetype = transaction type example – 270, 837P, 837D, 837I
- UniqueID = any unique ANSI qualifier example – DATETIMESTAMP [CCYYMMDDHHMMSSS as 201208301140512]

Here are some examples of good file naming standards:

- 0123_837P_201208301140512.dat
- 0123_837I_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 MMIS system.

2.2.3. Error messages

If an electronic file fails to upload, an error message will be returned online.

The error messages will be generated by the Secure File Transfer Protocol (SFTP) client software and it is up to the trading partner to choose which client software they will use. Nevada Medicaid does not provide or recommend any particular SFTP client software.

2.2.4. Response files

- Functional acknowledgement (999)
  The 999 will be returned for all files that have been successfully uploaded. This response is intended to convey HIPAA compliance errors.
- Interchange Acknowledgement (TA1)
  The TA1 will be returned for files that fail the Interchange Envelope content. This response is intended to report the status of processing on a failed interchange header and trailer.

2.2.5. Secure SFTP download – file retention

All electronic files that have been made available for download will remain available online for download as follows:

- 7 Days 999, TA1, 271
- 30 Days 277U
- 90 Days 835

After the allotted time frame has passed, the files will be removed from the list and will no longer be available for download. This applies to testing and production.

2.2.6. Testing transactions

The following transaction types are available for testing:

- 270 Eligibility Request/271 Eligibility Response
- 837D Dental Claim
- 837P Professional (CMS-1500) Claim
- 837I Institutional (UB-04) Claim

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

There is no limit to the number of files that may be submitted. Users will be allowed to move to production once a successfully compliant transaction is received and the appropriate responses returned.

2.3. Payer specific documentation

For additional information in regards to business processes related to eligibility, prior authorization and claims processing, please review the Provider Manual located on the Nevada Medicaid Website:
http://www.medicaid.nv.gov

For further information on specific payer prior authorization information please see the Nevada Medicaid website:
http://www.medicaid.nv.gov

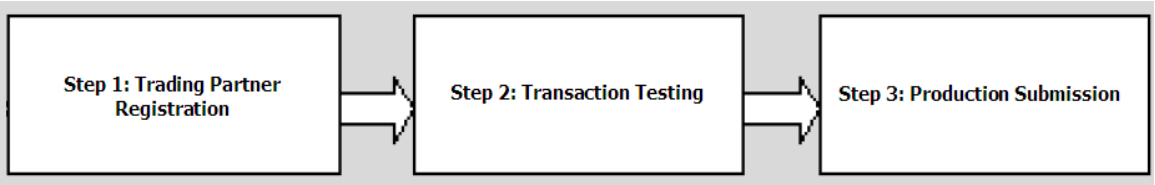
2.4. Testing contact information

All correspondence for assistance with testing should be submitted to the following email address:

NVMMIS.EDIsupport@dxc.com

3. Connectivity/communications

3.1. Process flows



3.2. Transmission procedures

Availability

24 hours/7 days a week

Downtime notification

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

Re-Transmission procedures

Trading partners may call Nevada Medicaid for assistance in researching problems with submitted transactions. Nevada Medicaid 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. Contact information

4.1. EDI customer service/technical assistance

EDI Helpdesk

Monday – Friday
8:00 a.m. – 5:00 p.m. PT

Technical, enrollment or setup questions:

Email: NVMMIS.EDIsupport@dxc.com

Telephone: 1 (877) 638-3472 options 2 then 4
Fax: 1 (775) 335-8594

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

4.2. Provider services

Provider Relations Department

The Provider Relations Department is composed of field representatives who are committed to assisting Nevada Medicaid providers in the submission of claims and the resolution of claims processing concerns.

Provider Relations Call Center

The Provider Relations Call Center communication specialists are available to respond to written and telephone inquiries from providers on billing questions and procedures, claim status, form orders, adjustments, use of the Automated Response System (ARS), electronic claims submission via EDI and remittance advice (RAs).

Both departments can be reached by calling:
(877) 638-3472

5. Control segments/envelopes

NOTE: The page numbers listed below in each of the tables represent the corresponding page number in the X12N 837P HIPAA Implementation Guide.

X12N EDI Control Segments
ISA – Interchange Control Header Segment
IEA – Interchange Control Trailer Segment
GS – Functional Group Header Segment
GE – Functional Group Trailer Segment
ST – Transaction Set Header
SE – Transaction Set Trailer
TA1 – Interchange Acknowledgement

5.1. ISA–Control header

Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

Segment	Name	Page in IG	Comments
ISA	Interchange Control Header		
ISA01	Authorization Information Qualifier	C.4	00 = No Authorization Information Present
ISA02	Authorization Information	C.4	Empty if ISA01 = 00
ISA03	Security Information Qualifier	C.4	00 = No Security Information Present
ISA04	Security Information	C.4	Empty if ISA03 = 00
ISA05	Interchange ID Qualifier	C.4	ZZ = Mutually Defined
ISA06	Interchange Sender ID	C.4	Use the 4-digit Service Center Code assigned by Nevada Medicaid.
ISA07	Interchange ID Qualifier	C.5	ZZ = Mutually Defined

Segment	Name	Page in IG	Comments
ISA08	Interchange Receiver ID	C.5	NVM FHSC FA
ISA09	Interchange Date	C.5	Format is YYMMDD
ISA10	Interchange Time	C.5	Format is HHMM
ISA11	Repetition Separator	C.5	^
ISA12	Interchange Control Version Number	C.5	00501
ISA13	Interchange Control Number	C.5	Must be identical to Interchange Trailer IEA02
ISA14	Acknowledgement Requested	C.6	0 = No Acknowledgement Requested or 1 = Acknowledgement Requested Note: A TA1 will be generated if the file fails the 'Interchange Envelope' content regardless of the value used.
ISA15	Interchange Usage Indicator	C.6	P = Production Data T = Test Data
ISA16	Component Element Separator	C.6	:

5.2. IEA–Control trailer

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

Segment	Name	Page in IG	Notes/Comments
IEA	Interchange Control Trailer		
IEA01	Number of Included Functional Groups	C.10	1
IEA02	Interchange Control Number	C.10	Must be identical to ISA13

5.3. GS–Functional group header

Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

Segment	Name	Page in IG	Comments
GS	Functional Group Header		
GS01	Functional Identifier code	C.7	HC
GS02	Application Sender's Code	C.7	Use the 4-digit Service Center Code assigned by Nevada Medicaid
GS03	Application Receiver's Code	C.7	NVM FHSC FA
GS04	Functional Group Creation Date	C.7	Format is CCYYMMDD
GS05	Functional Group Creation Time	C.8	Format is HHMM
GS06	Group Control Number	C.8	Must be identical to GE02
GS07	Responsible Agency Code	C.8	X = Accredited Standards Committee X12
GS08	Version/Release/Industry Identifier Code	C.8	005010X222A1

5.4. GE–Functional group trailer

Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

Segment	Name	Page in IG	Notes/Comments
GE	Functional Group Trailer		
GE01	Number of Transaction Sets Included	C.9	1
GE02	Group Control Number	C.9	Use the 4-digit Service Center Code assigned by Nevada Medicaid.

5.5. ST–Transaction set header

Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

Segment	Name	Page in IG	Notes/Comments
ST	Transaction Set Header		
ST01	Transaction Set Identifier Code	61	837
ST02	Transaction Set Control Number	61	Increment by 1 when multiple transaction sets are included. Must be identical to SE02.
ST03	Implementation Convention Reference	62	005010X222A1

5.6. SE–Transaction set trailer

Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

Segment	Name	Page in IG	Notes/Comments
SE	Transaction Set Trailer		
SE01	Transaction Segment Count	450	Number of segments included within the ST/SE segments
SE02	Transaction Set Control Number	450	Must be identical to ST02

6. Instruction tables

This table contains one or more rows for each segment for which supplemental instruction is needed.

NOTE: Nevada Medicaid will not accept 837P files with 2000C Loop data for recipient/dependent care information when using the Drug Identification loop in 2410.

Any 837P files containing dependent (2000C) with NDC (2410) data will be rejected.

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

6.1. 005010X222A1 Professional health care claims (837P)

Loop	Segment	Name	Page in IG	Comments
1000A	NM1	Submitter Name		
	NM109	Submitter ID	75	Use the 4-digit Service Center Code assigned Nevada Medicaid.
	PER	Submitter EDI Contact Information	76	The contact information in this segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter's organization.
	PER01	Contact Function Code	77	IC = Information Contact
	PER02	Submitter Contact Name	77	Submitter Name
	PER03	Communication Number Qualifier	77	EM = Email FX = Fax TE = Telephone
	PER04	Communication Number	77	Email address, fax number or telephone number (including the area code)

Loop	Segment	Name	Page in IG	Comments
1000B	NM1	Receiver Name		
	NM109	Receiver Primary Identifier	80	DHCFP
2000A	PRV	Billing Provider Specialty Information		
	PRV03	Provider Taxonomy Code	83	A taxonomy code is recommended when using a National Provider Identifier (NPI).
2010AA	N4	Billing Provider City/ Sate/ ZIP Code		
	N403	Billing Provider Postal Zone or ZIP Code	93	The billing provider's 9-digit ZIP code (along with the other address information in the 2010AA N3 segment) is required. The ZIP code may be used to determine claim pricing.
2010BA	NM1	Subscriber Name		
	NM108	Identification Code Qualifier	122-123	MI = Member Identification Number
	NM109	Subscriber Primary Identifier	123	Required when NM102 = 1
2010BB	REF	Billing Provider Secondary Identification		This loop is used when billing with an Atypical Provider (API) number.
	REF01	Reference Identification Qualifier	140	G2
	REF02	Billing Provider Secondary Identifier	141	Enter the billing provider's Atypical Provider Identifier.

Loop	Segment	Name	Page in IG	Comments
2300	CLM	Claim Information		
	CLM01	Patient Control Number	158	
	CLM05-3	Claim Frequency Code	159	1 = Original Claim 7 = Adjustment 8 = Void
2300	REF	Referral Number		
	REF01	Reference Identification Qualifier	193	9F = Referral Number
2300	REF	Prior Authorization		
	REF01	Reference Identification Qualifier	194	G1 = 11-digit Prior Authorization Number
	REF02	Prior Authorization Number	195	If G1 was entered in Data Element REF01, enter the 11-digit Authorization Number assigned by Nevada Medicaid.
2300	REF	Payer Claim Control Number		
	REF01	Reference Identification Qualifier	196	F8 = Adjust or void a claim (as specified in Data Element CLM05-3).
	REF02	Payer Claim Control Number	196	Enter the last paid Internal Control Number (ICN) that Nevada Medicaid assigned to the claim.

Loop	Segment	Name	Page in IG	Comments
2300	CR1	Ambulance Transport Information		
	CR106	Transport Distance	213	Required on all claims involving ambulance services. Report the base rate at the line level (2400, CR106); put the number of miles traveled in this segment.
2300	HI	Health Care Diagnosis Code		
	HI01-1	Diagnosis Type Code	226- 227	ABK = ICD-10 Principal Diagnosis BK = ICD-9 Principal Diagnosis
	HI01-2	Diagnosis Code	227	For services provided on or after October 1, 2015, this will need to contain an ICD-10 code set. For services provided prior to October 1, 2015, this will need to contain an ICD-9 code set.
2310A	NM1	Referring Provider Name		Use this segment when the servicing provider type requires a referring NPI to be submitted on the claim.
	NM101	Entity Identifier Code	258	DN = Referring Provider
	NM109	Referring Provider Identifier	259	NPI of the Referring Provider
2310A	REF	Referring Provider Secondary Identification		
	REF01	Reference Identification	260	0B = State License Number 1G = Provider UPIN

Loop	Segment	Name	Page in IG	Comments
		Qualifier		G2 = Provider Commercial Number
	REF02	Referring Provider Secondary Identifier	261	If qualifier G2 is used in REF01, a provider's Atypical Provider Identifier cannot be used as this will cause a rejection and will generate and return a negative 999 acknowledgment.
2310B	PRV	Rendering Provider Specialty Information		
	PRV03	Provider Taxonomy Code	265	A taxonomy code is recommended when using a National Provider Identifier (NPI).
2310B	REF	Rendering Provider Secondary Identification		
	REF01	Reference Identification Qualifier	267	0B = State License Number 1G = Provider UPIN G2 = Provider Commercial Number LU = Location Number
	REF02	Rendering Provider Secondary Identifier	268	If qualifier G2 was used in data element REF01, enter the billing provider's Atypical Provider Identifier.
2310C	N4	Service Facility Location City/ State/ ZIP		
	N403	Laboratory or Facility Postal Zone or ZIP Code	274	The facility's 9-digit ZIP code is required (along with the address in Loop 2310C, Segment N3). The ZIP code may be used to determine claim pricing.

Loop	Segment	Name	Page in IG	Comments
2320	SBR	Other Subscriber Information	295-298	If the recipient has Medicare or other coverage, repeat this loop for each other payer. Omit Nevada Medicaid coverage information.
	SBR09	Claim Filing Indicator Code	298	Use MB to indicate a Medicare payer on claims for Medicare coinsurance and/or deductible.
2320	CAS	Claim Level Adjustments: Claim Adjustment Reason Code	299-304	Adjustment amounts may be reported at both the claim line and at the service line, but they cannot duplicate each other. Use Claim Adjustment Reason Code (code source 139) to indicate the denial or cutback reason.
2420F	NM1	Referring Provider Name		Use this segment when the servicing provider type requires a referring NPI to be submitted on the claim and the referring provider differs from that reported at the claim level (loop 2310A).
	NM101	Entity Identifier Code	466	DN = Referring Provider
	NM109	Referring Provider Identifier	467	NPI of the Referring Provider
2420F	REF	Referring Provider Secondary Identification		
	REF01	Reference Identification Qualifier	468/469	0B = State License Number 1G = Provider UPIN G2 = Provider Commercial Number
	REF02	Referring Provider	469	If qualifier G2 is used in

Loop	Segment	Name	Page in IG	Comments
		Secondary Identifier		REF01, a provider's Atypical Provider Identifier cannot be used as this will cause a rejection and will generate and return a negative 999 acknowledgment.

Loop	Segment	Name	Page in IG	Comments
2320	AMT	COB Payer Paid Amount		
	AMT02	Payer Paid Amount	305	Use this segment, for the appropriate payer, to report all prior payments you have received for this claim. Omit Nevada Medicaid payment information.
2320	AMT	Remaining Patient Liability		
	AMT02	Remaining Patient Liability	307	Enter the amount that is owed from the recipient (patient responsibility amount). On claims for Medicare coinsurance and/or deductible, submit the Medicare allowed amount for the total claim.
2330A	NM1	Other Subscriber Name		
	NM109	Other Insured Identifier	315	On claims for Medicare coinsurance and/or deductible, enter the recipient's Medicare ID number.
2330B	NM1	Other Payer Name		
	NM109	Other Payer Primary Identifier	321	

Loop	Segment	Name	Page in IG	Comments
2400	SV1	Professional Service		
	SV101-1	Product or Service ID Qualifier	352-353	HC = HCPCS Codes NDCs will not be captured in this segment; however an NDC must be submitted in the LIN segment to supplement a J or Q procedure code.
	SV102	Line Item Charge Amount	354	On claims for Medicare coinsurance and/or deductible, enter the line charge amount billed to Medicare.
	SV103	Unit or Basis for Measurement Code	355	For anesthesia claims, enter UN when sending anesthesia units in Data Element SV104.
2400	CR1	Ambulance Transport Information		
	CR106	Transport Distance	370	When billing with a base rate code that does not require mileage, enter a 1 for quantity.
2400	CN1	Contract Information		
	CN101	Contract Type Code	395	
	CN102	Contract Amount	395	
2400	NTE	Line Note		
	NTE01	Note Reference Code	413	On transportation claims, enter ADD.
	NTE02	Line Note Text	413	Enter line level free-text remarks as needed (enter claim level remarks in Loop 2300).

Loop	Segment	Name	Page in IG	Comments
2410	LIN	Drug Identification		
	LIN02	Product or Service ID Qualifier	425	N4 = NDC
	LIN03	National Drug Code	425	An NDC is required when a J or Q procedure code is billed in Loop 2400, Segment SV1, Data Element SV101-2.
2410	CTP	Drug Quantity		
	CTP04	Quantity	426	Enter the actual NDC quantity dispensed.
	CTP05-1	Unit or Basis for Measurement Code	427	Enter the appropriate unit of measure: F2 = International Unit GR = Gram ME = Milligram ML = Milliliter UN = Unit
2410	REF	Prescription or Compound Drug Association Number		
	REF01	Prescription or Compound Drug Association Number	XZ	XZ = Pharmacy Prescription Number
2420A	PRV	Rendering Provider Specialty Information		
	PRV03	Provider Taxonomy Code	433	A taxonomy code is recommended when using a National Provider Identifier (NPI).

Loop	Segment	Name	Page in IG	Comments
2420A	REF	Rendering Provider Secondary Identification		
	REF01	Reference Identification Qualifier	434-435	0B = State License Number 1G = Provider UPIN G2 = Provider Commercial Number LU = Location Number
	REF02	Billing Provider Secondary Identifier	435	If qualifier G2 was used in data element REF01, enter the billing provider's Atypical Provider Identifier.
2420C	N4	Service Facility Location City/ State/ ZIP		
	N403	Laboratory or Facility Postal Zone or ZIP code	446	The Service Facility ZIP code (along with the address information in Loop 2420C, Segment N3) is required when the place of service is different than the billing ZIP code in Loop 2310C, Segment N3. The facility's 9-digit ZIP code is required.

Loop	Segment	Name	Page in IG	Comments
2420F	REF	Referring Provider Secondary Identification		
	REF01	Reference Identification Qualifier	468-469	0B = State License Number 1G = Provider UPIN G2 = Provider Commercial Number
	REF02	Referring Provider Secondary Identifier	469	If qualifier G2 was used in data element REF01, enter the billing provider's Atypical Provider Identifier.
2430	SVD	Line Adjudication Information		
	SVD01	Other Payer Primary Identifier	480	This Data Element is required if the payer identified in Loop 2330B adjudicated the claim previously and the service line has adjustments applied to it.

Loop	Segment	Name	Page in IG	Comments
2430	CAS	Line Adjustment: Adjustment Reason Code	484-489	This Data Element is required if the payer identified in Loop 2330B has adjudicated the claim previously and the service line has adjustments applied to it. Use Claim Adjustment Reason Code (code source 139) to indicate the denial or cutback reason.
	CAS01	Claim Adjustment Group Code	485	PR = Patient Responsibility (Non-Medicare TPL claim) This Data Element is required if the payer identified in Loop 2330B has adjudicated the claim previously and the service line has adjustments applied to it. Use qualifier PR to report balance due.
	CAS02	Adjustment Reason Code	486	Use Claim Adjustment Reason Code A7 to report balance due.
	CAS03	Adjustment Amount	486	This data element is required if the payer identified in Loop 2330B has adjudicated the claim previously and the service line has adjustments applied to it.

7. Payer specific business rules and limitations

The information when applicable under this section is intended to help the trading partner understand the business context of the EDI transaction.

7.1. Claim submissions

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

You may submit electronic claims 24 hours a day, 7 days a week. Transactions submitted after 4:00 p.m. Pacific Time (PT) are processed in the following day's cycle.

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

The Functional Acknowledgement (999 transaction) is normally available for retrieval one hour after submission.

Nevada Medicaid recipients should be reported as the Subscriber only; dependent data in the 2000C should never be used.

For services provided on or after October 1, 2015, the ICD-9 code sets used to report medical diagnoses have been replaced by ICD-10 code sets. Transactions with a date of service of October 1, 2015, or after that contain ICD-9 codes will be denied.