## Revision history

<table>
<thead>
<tr>
<th>Date</th>
<th>Description of Changes</th>
<th>Pages Impacted</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/2006</td>
<td>Updates were made to several pages</td>
<td>Pages 83, 84, 158, 176, 177, 178, 191, 192, 365, 372, 373, 376, 403, 411 and 496</td>
</tr>
<tr>
<td>04/2007</td>
<td>Updates were made to accommodate NPI</td>
<td>Highlighted cells in the table that begins on page 3</td>
</tr>
<tr>
<td>10/2007</td>
<td>Added National Drug code (NDC) specifications; changes are effective for claims received January 1, 2008 and later.</td>
<td>Highlighted table rows beginning on page 3</td>
</tr>
<tr>
<td>04/09/2009</td>
<td>Inserted additional comments for MCO encounter claims</td>
<td>Highlighted rows in the &quot;837I Institutional Health Care Claims and MCO Encounter Claims&quot; table.</td>
</tr>
<tr>
<td>03/02/2010</td>
<td>Added specifications for the CTP segment (data elements CTP03, CTP04 and CTP05). This segment must be completed when billing for physician/outpatient-facility administered drugs.</td>
<td></td>
</tr>
<tr>
<td>8/22/2011</td>
<td>Updated Table of Contents, removed yellow highlighting from email address and phone numbers, and corrected wording/spelling error in response to specific deliverable review comments.</td>
<td>All</td>
</tr>
<tr>
<td>08/31/2011</td>
<td>Removed Confidentiality and Trademarks section for consistency with similar documentation.</td>
<td>ii</td>
</tr>
<tr>
<td>12/05/2011</td>
<td>Takeover HPES</td>
<td>All</td>
</tr>
</tbody>
</table>
Table of contents

Introduction .........................................................................................................1
Purpose...............................................................................................................1
Availability and Requirements...........................................................................1
Questions..........................................................................................................2
837I Institutional Health Care Claims and MCO Encounter Claims......................3
Introduction

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

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

Purpose

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

This Companion Guide provides specific requirements for submitting institutional claims (837I, UB-04) electronically to HP Enterprise Services.

It supplements but does not contradict the X12N Health Care Implementation Guides and should be used solely for the purpose of clarification.

Availability and Requirements

You may submit electronic claims 24 hours a day, 7 days a week. Transactions submitted after 4 PM Pacific Standard Time (PST) are processed in the following day’s cycle.

Claims must be submitted before 1 PM PST on Fridays to be included in the following Friday’s electronic remittance advice (835 transaction).

The Functional Acknowledgement (997 transaction) is normally available for retrieval one hour after submission.

Submit MCO encounter claims and non-encounter claims in separate ISA-IEA envelopes.
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.
**837I Institutional Health Care Claims and MCO Encounter Claims**

<table>
<thead>
<tr>
<th>Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Data Element</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.3</td>
<td>N/A</td>
<td>ISA</td>
<td>ISA01: Authorization Information Qualifier</td>
<td>“00” = No Authorization Information Present</td>
</tr>
<tr>
<td>B.3</td>
<td>N/A</td>
<td>ISA</td>
<td>ISA03: Security Information Qualifier</td>
<td>“00” = No Security Information Present</td>
</tr>
<tr>
<td>B.3</td>
<td>N/A</td>
<td>ISA</td>
<td>ISA05: Interchange ID Qualifier</td>
<td>“ZZ” = Mutually Defined</td>
</tr>
<tr>
<td>B.3</td>
<td>N/A</td>
<td>ISA</td>
<td>ISA06: Interchange Sender ID</td>
<td>Use the 4-digit Service Center Code assigned by HP Enterprise Services.</td>
</tr>
<tr>
<td>B.3</td>
<td>N/A</td>
<td>ISA</td>
<td>ISA08: Interchange Receiver ID</td>
<td>“NVM FHSC FA”</td>
</tr>
<tr>
<td>B.3</td>
<td>N/A</td>
<td>ISA</td>
<td>ISA14: Acknowledgement Requested</td>
<td>“0” = No Acknowledgement Requested</td>
</tr>
<tr>
<td>B.3</td>
<td>N/A</td>
<td>GS</td>
<td>GS02: Application Sender’s Code</td>
<td>Use the 4-digit Service Center Code assigned by HP Enterprise Services.</td>
</tr>
<tr>
<td>B.3</td>
<td>N/A</td>
<td>GS</td>
<td>GS03: Application Receiver’s Code</td>
<td>“NVM FHSC FA”</td>
</tr>
<tr>
<td>B.3</td>
<td>N/A</td>
<td>GS</td>
<td>GS08: Version/Release Industry ID Code</td>
<td>“004010X096A1”</td>
</tr>
<tr>
<td>60</td>
<td>N/A</td>
<td>REF</td>
<td>REF02: Transmission Type Code</td>
<td>“004010X096A1”</td>
</tr>
</tbody>
</table>
| 68   | 1000A: Submitter Name | NM1 | NM109: Submitter Primary ID | Use the 4-digit Service Center Code assigned by HP Enterprise Services.  
For MCO encounter claims, enter the MCO’s “Southern or Northern Medicaid Submitter ID.” |
<p>| 68   | 1000B: Receiver | NM1 | NM109: Receiver Primary ID | “DHCPF” |
| 73   | 2000A: Billing/Pay-To Provider | PRV | PRV03: Provider Taxonomy Code | A taxonomy code is recommended when using a National Provider Identifier (NPI). |</p>
<table>
<thead>
<tr>
<th>Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Data Element</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 77   | 2010AA: Billing Provider Name | NM1 | NM108: ID Code Qualifier | “24” = Employer’s Identification Number  
“34” = Social Security Number  
“XX” = NPI  
When “XX,” is used, the Employer’s Identification Number or the provider’s SSN must be sent in the REF segment in this loop. |
| 81   | 2010AA: Billing Provider Name | N4 | N403: Billing Provider’s Zip Code | The billing provider’s 9-digit zip code (along with the other address information in the 2010AA N3 segment) is required. The zip code may be used to determine claim pricing. |
| 83   | 2010AA: Billing Provider Secondary ID | REF | REF01: Reference ID Qualifier | Medicaid issues payment to the “billing” provider—not the “pay to” provider (Loop 2010AB).  
“1D” = API  
“1C” = Medicare  
“EI” = Employer’s Identification Number  
“SY” = Social Security Number  
“EI” or “SY” must be used when a NPI is sent in the Billing Provider Name segment of this loop. |
| 84   | 2010AA: Billing Provider Secondary ID | REF | REF02: Billing Provider Secondary ID | If qualifier “1D” was used in data element REF01, enter the billing provider’s API. |
| 110  | 2010BA: Subscriber Name | NM1 | NM108: ID Code Qualifier | “MI” = Member Identification Number |
| 110  | 2010BA          | NM1 | NM109: Subscriber Primary ID | Use the recipient’s 11-digit Recipient ID. |
| 158  | 2300: Claim Information | CLM | CLM01: Claim Submitter’s ID | For MCO encounter claims, enter the MCO’s claim number. |
| 159  | 2300: Claim Information | CLM | CLM05-3: Claim Frequency Code | “1” = Original Claim  
“7” = Adjustment  
“8” = Void |
<p>| 176  | 2300: Claim Information | CN1 | CN101: Contract Type Code | This segment is required on MCO encounter claims. |</p>
<table>
<thead>
<tr>
<th>Page</th>
<th>Loop</th>
<th>Segment</th>
<th>Data Element</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>177</td>
<td>2300: Claim Information</td>
<td>CN1</td>
<td>CN102: Amount</td>
<td>On MCO encounter claims, enter the paid amount.</td>
</tr>
<tr>
<td>178</td>
<td>2300: Claim Information</td>
<td>AMT</td>
<td>AMT02: Payer Estimated Amount Due</td>
<td>Use “C5” on COB claims to report the amount owed from Medicaid. This amount is reported at the claim level only.</td>
</tr>
<tr>
<td>191</td>
<td>2300: Claim Information</td>
<td>REF</td>
<td>REF01: Reference ID Qualifier</td>
<td>“F8” = Adjust or void a claim (as indicated by CLM05-3).</td>
</tr>
<tr>
<td>192</td>
<td>2300: Claim Information</td>
<td>REF</td>
<td>REF02: Claim Original Reference Number</td>
<td>On Fee For Service (FFS) claims, enter the last paid Internal Control Number (ICN) that HP Enterprise Services assigned to the claim. On MCO encounter claims, enter the MCO’s claim number (CLM01 from last claim).</td>
</tr>
<tr>
<td>198</td>
<td>2300: Claim Information</td>
<td>REF</td>
<td>REF01: Reference ID Qualifier</td>
<td>“9F” = Referral Number “G1” = 11-digit Authorization Number</td>
</tr>
<tr>
<td>199</td>
<td>2300: Claim Information</td>
<td>REF</td>
<td>REF02: Prior Authorization Number</td>
<td>Enter the 11-digit Authorization Number assigned by HP Enterprise Services.</td>
</tr>
<tr>
<td>206</td>
<td>2300: Claim Information</td>
<td>NTE</td>
<td>NTE02: Claim Note Text</td>
<td>Provide free-text remarks, if needed. HP Enterprise Services will use the first occurrence of this segment.</td>
</tr>
<tr>
<td>209</td>
<td>2300: Claim Information</td>
<td>NTE</td>
<td>NTE02: Billing Note Text</td>
<td>Provide free-text remarks if necessary.</td>
</tr>
<tr>
<td>228</td>
<td>2300: Claim Information</td>
<td>HI</td>
<td>HI02-1: Diagnosis Code List Qualifier</td>
<td>“BJ” = Admitting Diagnosis “ZZ” = Patient Reason for Visit If this field is submitted, use only ICD-9-CM diagnosis codes.</td>
</tr>
<tr>
<td>242</td>
<td>2300: Claim Information</td>
<td>HI</td>
<td>HI01-1: Principal Procedure Information</td>
<td>“BR” = ICD-9-CM If this field is submitted, use only ICD-9-CM diagnosis codes.</td>
</tr>
<tr>
<td>244 - 255</td>
<td>2300: Claim Information</td>
<td>HI</td>
<td>HI01-1 through HI12-1: Code List Qualifier Code</td>
<td>“BQ” = ICD-9-CM If this field is submitted, use only ICD-9-CM diagnosis codes.</td>
</tr>
<tr>
<td>323</td>
<td>2310A: Attending Physician Name</td>
<td>NM1</td>
<td>NM108: ID Code Qualifier</td>
<td>“24” = Employer’s Identification Number “34” = Social Security Number “XX” = NPI</td>
</tr>
<tr>
<td>Page</td>
<td>Loop</td>
<td>Segment</td>
<td>Data Element</td>
<td>Comments</td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td>---------</td>
<td>--------------</td>
<td>----------</td>
</tr>
<tr>
<td>326</td>
<td>2310A: Attending Physician Name</td>
<td>REF</td>
<td>REF01: Reference ID Qualifier</td>
<td>“1D” = API</td>
</tr>
<tr>
<td>327</td>
<td>2310A: Attending Physician Name</td>
<td>REF</td>
<td>REF02: Attending Physician Secondary ID</td>
<td>If qualifier “1D” was used in data element REF01, enter the billing provider’s API.</td>
</tr>
<tr>
<td>329</td>
<td>2310B: Operating Physician Name</td>
<td>NM1</td>
<td>NM108: ID Code Qualifier</td>
<td>“24” = Employer’s Identification Number “34” = Social Security Number “XX” = NPI</td>
</tr>
<tr>
<td>333</td>
<td>2310B: Operating Physician Name</td>
<td>REF</td>
<td>REF01: Reference ID Qualifier</td>
<td>“1D” = API</td>
</tr>
<tr>
<td>334</td>
<td>2310B: Operating Physician Name</td>
<td>REF</td>
<td>REF02: Operating Physician Secondary ID</td>
<td>If qualifier “1D” was used in data element REF01, enter the billing provider’s API.</td>
</tr>
<tr>
<td>340</td>
<td>2310C: Other Provider Name</td>
<td>REF</td>
<td>REF01: Reference ID Qualifier</td>
<td>“1D” = API</td>
</tr>
<tr>
<td>341</td>
<td>2310C: Other Provider Name</td>
<td>REF</td>
<td>REF02: Other Physician Secondary ID</td>
<td>If qualifier “1D” was used in data element REF01, enter the billing provider’s API.</td>
</tr>
<tr>
<td>359</td>
<td>2320: Other Subscriber Information</td>
<td>SBR</td>
<td>TPL, Medicare or MCO</td>
<td>If the recipient has Medicare or other coverage, repeat this loop for each other payer. Omit Nevada Medicaid coverage information. For MCO encounter claims, if CAS reason codes are submitted, then use one iteration of this loop to represent the MCO.</td>
</tr>
<tr>
<td>Page</td>
<td>Loop</td>
<td>Segment</td>
<td>Data Element</td>
<td>Comments</td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td>---------</td>
<td>--------------</td>
<td>----------</td>
</tr>
<tr>
<td>363</td>
<td>2320: Other Subscriber Information</td>
<td>SBR</td>
<td>SBR09: Claim Filing Indicator</td>
<td>Use “MA” or “MB” to indicate a Medicare payer on claims for Medicare coinsurance and/or deductible.</td>
</tr>
<tr>
<td>365</td>
<td>2320: Other Subscriber Information</td>
<td>CAS</td>
<td>CAS: Claim Adjustment Reason Code</td>
<td>Adjustment amounts may be reported at both the claim line and the service line, but they may not duplicate each other. For MCO encounter claims, use Claim Adjustment Reason Code (code source 139) to indicate the denial or cutback reason. Use the following qualifiers on claims for Medicare coinsurance and deductible: “01” = Deductible Amount “02” = Coinsurance Amount “66” = Blood Deductible Amount</td>
</tr>
<tr>
<td>371</td>
<td>2320: Other Subscriber Information</td>
<td>AMT</td>
<td>AMT01: Amount Qualifier</td>
<td>“C4” = Prior Payment Actual</td>
</tr>
<tr>
<td>371</td>
<td>2320: Other Subscriber Information</td>
<td>AMT</td>
<td>AMT02: Payer Prior Payment</td>
<td>“C4” = Non-Medicare TPL Payment Use this segment, for the appropriate payer, to report all prior payments you have received for this claim. Omit Nevada Medicaid payment information.</td>
</tr>
<tr>
<td>372</td>
<td>2320: Other Subscriber Information</td>
<td>AMT</td>
<td>AMT02: COB Total Allowed Amount</td>
<td>“B6” = Total Allowed Amount from Medicare</td>
</tr>
<tr>
<td>373</td>
<td>2320: Other Subscriber Information</td>
<td>AMT</td>
<td>AMT02: COB Total Submitted Charges</td>
<td>“T3” = Total Billed Charges Submitted to Medicare</td>
</tr>
<tr>
<td>376</td>
<td>2320: Other Subscriber Information</td>
<td>AMT</td>
<td>AMT02: COB Total Medicare Paid Amount</td>
<td>“N1” = Total Medicare Paid Amount</td>
</tr>
<tr>
<td>Page</td>
<td>Loop</td>
<td>Segment</td>
<td>Data Element</td>
<td>Comments</td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td>---------</td>
<td>--------------</td>
<td>----------</td>
</tr>
<tr>
<td>403</td>
<td>2330A: Other Subscriber Name</td>
<td>NM1</td>
<td>NM109: Other Insured ID</td>
<td>On claims for Medicare coinsurance and/or deductible, enter the recipient’s Medicare ID.</td>
</tr>
<tr>
<td>411</td>
<td>2330B: Other Payer Name</td>
<td>NM1</td>
<td>NM109: Other Payer Primary ID#</td>
<td>On MCO encounter claims, enter the 4-digit Service Center Code that HP Enterprise Services assigned to the electronic submitter (clearinghouse, trading partner or direct submitter).</td>
</tr>
<tr>
<td>446</td>
<td>2400: Service Line</td>
<td>SV2</td>
<td>Recommendation</td>
<td>HP Enterprise Services recommends submitting fewer than 240 claim lines per institutional claim. Claims submitted with more than 240 claim lines may be subject to processing delays. NDC codes will not be captured in this segment, however an NDC must be sent in the LIN segment to supplement a “J” procedure code (see instructions for “Loop 2410: Drug Identification” on Addenda page 36).</td>
</tr>
<tr>
<td>495</td>
<td>2430</td>
<td>CAS</td>
<td>CAS02: Claim Adjustment Reason Code</td>
<td>For denied MCO encounter claims, use CAS02 Claim Adjustment Reason Code (code source 139)</td>
</tr>
<tr>
<td>496</td>
<td>2430: Line Adjudication Information</td>
<td>CAS</td>
<td>CAS: Claim Adjustment Reason Code</td>
<td>Adjustment amounts may be reported at both the claim line and the service line, but they may not duplicate each other. For MCO encounter claims, use Claim Adjustment Reason Code (code source 139) to indicate the denial or cutback reason. Use the following qualifiers on claims for Medicare coinsurance and deductible: “01” = Deductible Amount “02” = Coinsurance Amount “66” = Blood Deductible Amount</td>
</tr>
<tr>
<td>Page</td>
<td>Loop</td>
<td>Segment</td>
<td>Data Element</td>
<td>Comments</td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td>---------</td>
<td>--------------</td>
<td>----------</td>
</tr>
<tr>
<td>36 Addenda</td>
<td>2410: Drug Identification</td>
<td>LIN</td>
<td>LIN02: Product or Service ID Qualifier</td>
<td>“N4” = NDC code</td>
</tr>
<tr>
<td>36 Addenda</td>
<td>2410: Drug Identification</td>
<td>LIN</td>
<td>LIN03: National Drug Code</td>
<td>An NDC code is required when a “J” procedure code is billed in Loop 2400, Segment SV1, Data Element SV101-2.</td>
</tr>
<tr>
<td>75: Addenda</td>
<td>2410: Drug Identification</td>
<td>CTP</td>
<td>CTP03: Drug Unit Price</td>
<td>This value is required for this segment to be complete, but Nevada Medicaid will not use this value in pricing. A zero dollar amount is acceptable.</td>
</tr>
<tr>
<td>75: Addenda</td>
<td>2410: Drug Identification</td>
<td>CTP</td>
<td>CTP04: Quantity</td>
<td>Enter the actual NDC quantity dispensed.</td>
</tr>
<tr>
<td>75: Addenda</td>
<td>2410: Drug Identification</td>
<td>CTP</td>
<td>CTP05: Composite Unit of Measure</td>
<td>Enter the appropriate unit of measure: F2 = International Unit GR = Gram ML = Milliliter UN = Unit</td>
</tr>
</tbody>
</table>