ACS EDI GATEWAY, INC.

ANSI ASC X12N 837 Healthcare Claim (Version 4010A) Professional, Institutional, and Dental

Washington State Medical Assistance Administration Companion Guide

March 31, 2005

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Companion Guide Documentation Change Control

Documentation change control is maintained in this document through the use of the Change Control Table shown below. All changes made to this companion guide after the creation date are noted along with the author, date, and reason for the change.

Change Control Table				
Author of Change	**Page**	**Change**	**Reason**	**Date**
G. Webb	All	Version 1.0	Creation of document	June 27, 2003
T. Dorsey	33	Version 1.01	Added Transmission Numbers	July 25, 2003
T. Dorsey	34	Version 1.01	Revised Data Clarifications for ISA and GS Segments	July 25, 2003
T. Dorsey	8, 19	Version 1.02	Added website address	October 20, 2003
J. Ruby	36,40,45	Version 1.03	Added Data Clarifications for 2010BB Segments	December 10, 2003
J. Ruby	36-39, 42-43, 45, 48-50	Version 1.04	Added Data Clarifications for 2010BA, 2300, 2330B, 2410 Segments	January 23, 2004
J. Ruby	36, 42, 48	Version 1.05	Added Payer Code	February 4, 2004
L. Kershaw		Version 1.06	Removed NDM references	October 18, 2004
A. Starr		Updated references to ACS EDI Support Unit	Call center transition	February 22, 2005
S. Dumas	35-40, 43, 45-48, 53-54	Added new 837P,I,D transactions descriptions. Removed claim frequency type code 6 references.	Added new transaction descriptions	March 31, 2005

Disclaimer

Purpose of the ANSI ASC X12N 837 Healthcare Claim Transaction Companion Guide

This companion guide for the ANSI ASC X12N 837 Professional, Institutional and Dental Healthcare Claim transaction has been created for use in conjunction with the standard Implementation Guide. It should not be considered a replacement for the Implementation Guide, but rather used as an additional source of information. The companion guide contains data clarifications derived from specific business rules that apply exclusively to Medicaid processing for Washington State Medical Assistance Administration (MAA). The guide also includes useful information about sending and receiving data to and from ACS EDI Gateway, Inc.

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AT A GLANCE

Chapter 1, Introduction

Chapter 1 includes a brief overview of ACS EDI Gateway and the services it provides.

Chapter 2, Transmission Methods

Chapter 2 discusses the transmission methods of electronic data interchange with ACS EDI Gateway.

Chapter 3, Transmission Responses

Chapter 3 discusses confirmation and error responses to transactions submitted.

Chapter 4, Testing

Chapter 5 discusses transaction testing procedures.

Chapter 5, Payer Specific Data

Chapter 5 includes information on Enrollment and ACS EDI Support Unit contact information.

Chapter 6, Transaction Description - V4010.A1

Chapter 6 offers specific data values used by the Washington State MMIS this clarification is intended for developers to use in conjunction with the ANSI X12N Implementation Guides.

CHAPTER 1 INTRODUCTION

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) includes requirements that national standards be established for electronic health care transactions, and national identifiers for providers, health plans, and employers. These standards are being adopted to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

The Washington State Medical Assistance Administration is striving to assist their Medicaid providers in achieving this transition. Washington MAA chose ACS EDI Gateway, Inc. as a partner in this process. ACS EDI Gateway supplies EDI services to Washington State Medicaid Clients and Providers. Washington State Medicaid clients and providers will have access to a variety of EDI services delivering an array of tools that allow you to:

- Easily submit all of your transactions to one source
- Submit transactions twenty-four hours a day, seven days a week
- Receive confirmation of receipt of each file transferred

Healthcare plans that participate with ACS EDI Gateway, Inc. are referred to as payers. Transactions are accepted electronically into our data center in Tallahassee, Florida and are processed through the ACS State Healthcare Clearinghouse (SHCH) engine. The ACS SHCH provides connectivity for the flow of electronic health care transactions between medical providers, billing services, vendors, other clearinghouses and the Washington State MMIS (WA MMIS) system. Additionally, ACS SHCH provides translation to and from ANSI ASC X12N standard formats.

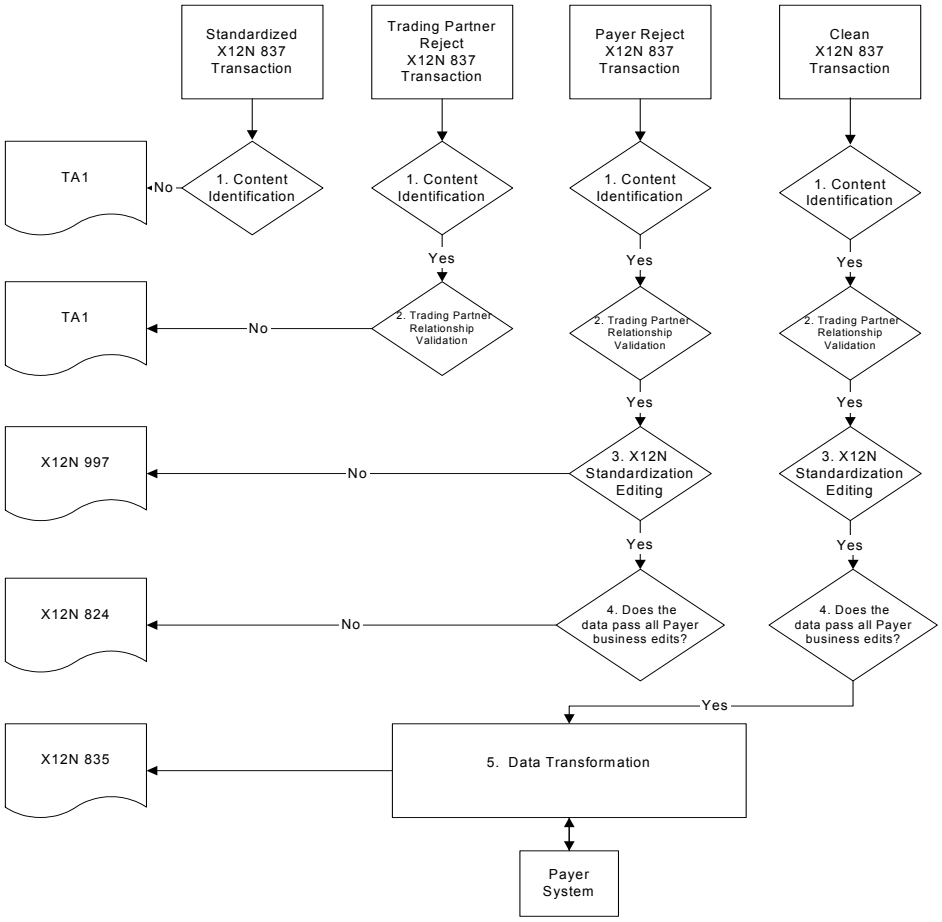
The ANSI ASC X12N 837 Professional, Institutional and Dental claim transaction data will be submitted to the ACS State Healthcare Clearinghouse (SHCH) for processing. ACS SHCH validates submission of ANSI X12N format(s). If the file contains syntactical error(s), the segment(s) and elements(s) where the error(s) occurred will be reported in a 997 Functional Acknowledgement. The TA1 Interchange Acknowledgment report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship. If the data fails payer specific edits, the 824 Application Advice will be returned to the submitter. The ANSI ASC X12N 835 Remittance Advice will contain information related to payees, payers, dollar amounts, and payments.

AUDIENCE

This Companion Guide is intended for trading partner use in conjunction with the ANSI ASC X12N National Implementation Guide. The ANSI ASC X12N Implementation Guides can be accessed at http://www.wpc-edi.com/Insurance_40.asp. This guide outlines the procedures necessary for engaging in Electronic Data Interchange (EDI) with ACS EDI Gateway, Inc. and specifies data clarification where applicable.

EDITING AND VALIDATION FLOW DIAGRAM

The process flowchart below shows how an incoming ANSI ASC X12N 837 Professional, Institutional and Dental transaction is validated for syntax by ACS SHCH. The diagram shows the three error reports that are generated by the clearinghouse.



LEGEND:

1. **Content Identification:** Data identification is attempted. If the data is corrupt or intended for another resource, a TA1 (Interchange Acknowledgement) will be returned. If the data can be identified, it is then checked for Trading Partner Relationship Validation.
2. **Trading Partner Relationship Validation:** The trading partner information is validated. If the trading partner information is invalid, a TA1 (Interchange Acknowledgement) will be returned to the submitter. If the trading partner relationship is valid, the data will **be** passed for X12N syntax validation.
3. **X12N Syntax Validation:** A determination will be made as to whether the data is ANSI ASC X12N. A 997 (Functional Acknowledgement**)** will be returned to the submitter. The 997 contains **ACCEPT** or **REJECT** information. If the file contained syntactical errors, the segment(s) and element(s) where the error(s) occurred will be reported. If the data passes X12N syntax validation, payer business edits will be performed.
4. **Payer Business Edits:** Front-end editing of the data will occur. If the data does not pass this edit level, an X12N 824 (Application Advice) will be sent detailing errors. If the data passes this level, it will proceed to the data transformation for processing.
5. **Data Transformation:** The data is transformed and passed to the payer system. An ANSI ASC X12N 835 **Remittance Advice** will be returned for submitter pickup.

CHAPTER 2 TRANSMISSION METHODS

DATA SUBMISSION

This section describes the available transmission modes to ACS EDI Gateway. Providers will have an option to select an appropriate transmission mode. Providers may also opt for two different modes of receipt and delivery. This means that the provider may submit transactions in one transmission mode and receive the return transactions via an alternate mode. Please note that some modes of transmission have additional costs that are the responsibility of the external trading partner.

Asynchronous Dial-Up

ACS EDI Gateway provides an interactive, menu-driven Host Data Exchange System (HDE) that allows you to upload your transaction files and receive immediate confirmation of the status of your transfer. This Host Data Exchange System can be accessed using a standard modem and supports modem speeds of up to 56,000 bps. Transaction transmission is available twenty-four hours a day, seven days a week. This availability is subject to scheduled and unscheduled host downtime. It is operational policy to schedule preventative maintenance periods on weekends whenever possible.

Hardware Requirements

Hayes-compatible 2400-56K BPS asynchronous modem.

Software Requirements

PKZIP or WINZIP
XMODEM, YMODEM, ZMODEM, or Kermit

Communication Protocols

ACS currently supports the following communication options:

XMODEM, YMODEM, ZMODEM, and Kermit

Teleprocessing Requirements

The general specifications for communication with ACS are:

Telecommunications	Hayes-compatible 2400-56K BPS asynchronous modem.
File Format	ASCII text data.

Compression Techniques	PKZIP will compress one or more files into a single ZIP archive. WINZIP will compress one or more files into a single ZIP archive. ACS accepts transmission with any of the above compression techniques, as well as non-compression files.
Data Format	8 data bit, 1stop bit, no parity, full duplex.
Transmission Protocol	ZMODEM uses 128 byte to 1024 byte variable packets and a 16-bit or 32-bit Cyclical Redundancy Check (CRC). XMODEM uses 128 byte blocks and a 16-bit CRC. YMODEM uses 1024 byte blocks and a 16-bit CRC. KERMIT can be accepted if X, Y, or ZMODEM capabilities are not available with your communication software.

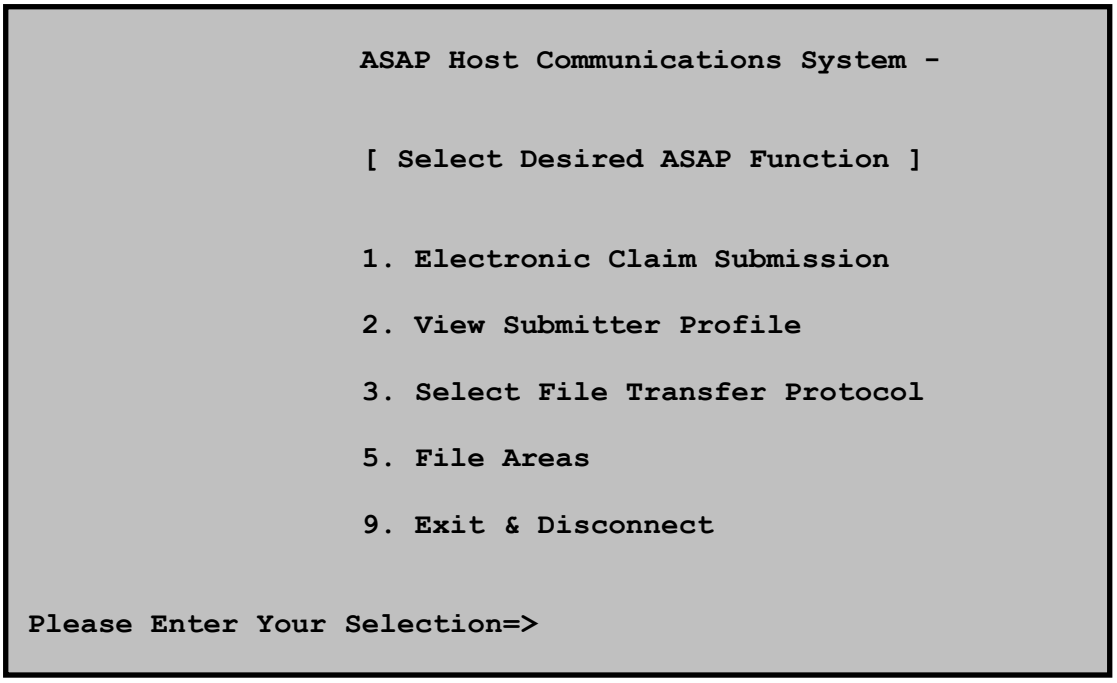
Teleprocessing Settings

ASCII Sending	Send line ends with line feeds (should not be set). Echo typed characters locally (should not be set). Line delay 0 milliseconds. Character delay 0 milliseconds.
ASCII Receiving	Append line feeds to incoming line ends should not be checked. Wrap lines that exceed terminal width.
Terminal Emulation	VT100 or Auto.

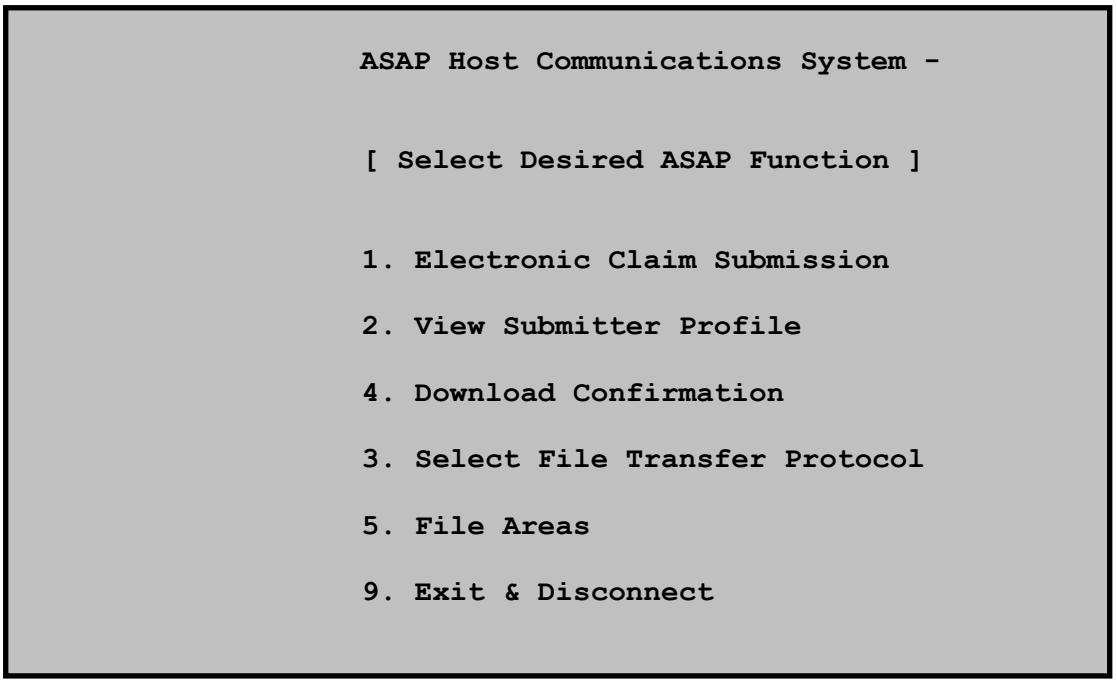
Transmission Procedures

```
LAPM/V42BIS

Welcome to ASAP HOST Communication System!

Please Enter your User name =>77045

Checking user file..

Please Enter your password =>770451111
```

SUBMITTER	HOST SYSTEM
1. Dials ACS Host	Answers call, negotiates a common baud rate, and sends to the trading partner: **"Please enter your User Name=>"**
2. Enter Logon Name <CR>	Receives User Name (Logon Name) and sends to the trading partner: **"Please enter your password=>"**
3. Enter Password <CR>	Receives Logon and verifies if trading partner is an authorized user. Sends HOST selection menu followed by a user prompt:



	"Please Select from the Menu Options Below=>"
4. Enter "1" to send file <CR>	#1. Electronic Claims Submission: Assigns and sends the transmission file name then waits for ZMODEM (by default) file transfer to be initiated by the trading partner. Receives ZMODEM (or other designated protocol) file transfer. Upon completion, initiates file confirmation. Sends file confirmation report. Sends HOST selection menu followed by a user prompt=>



"Please Select from the Menu Options Below=>"

4. Enter "4" to Confirm the File Download <CR>	**#4. Download Confirmation:** This menu option will appear to validate the files that were sent were loaded onto the system.
5. Enter "9" to Exit <CR>	**#9. Exit & Disconnect:** Terminates connection.

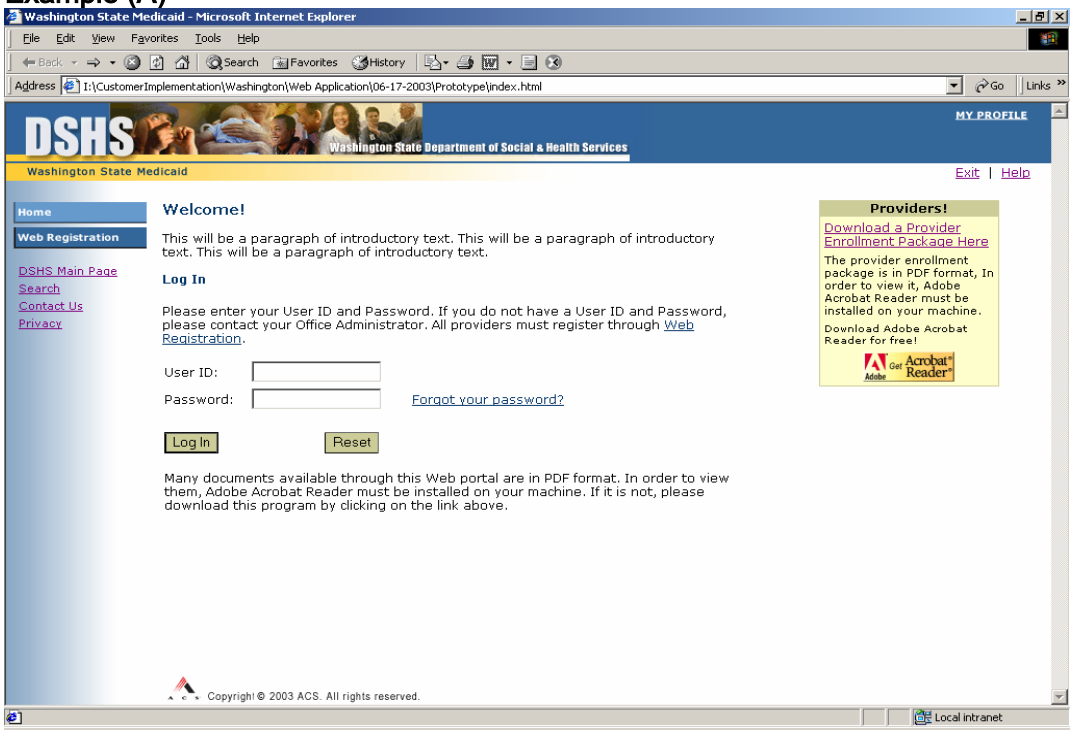
Web Portal

The web portal method allows a trading partner to initiate the submission of a batch file for processing. The trading partner must be an authenticated portal user who is a provider. Only active Washington State Medicaid clients and providers are authorized to access files via the web. The provider accesses the web portal via a web browser and is prompted for login and password assigned to them during the EDI Enrollment process. The provider may select files from their PC or work environment using the Browse function in conjunction with the Add and Remove functions. To transmit the selected files for processing, the trading partner must click the Submit link. All files submitted must meet the ANSI ASC X12N 837 standard.

Site Access

The web address to access data from ACS EDI Gateway is http://wamedweb.acs-inc.com.
Web browsers must be able to support 128-bit encryption to enter the Data Exchange area of the site. We recommend using Internet Explorer 5.5 or above for best results. Upon reaching the site, enter a valid User ID and Password (issued by ACS EDI Gateway). Click on the "Login" button to request access to the secure Data Exchange area.

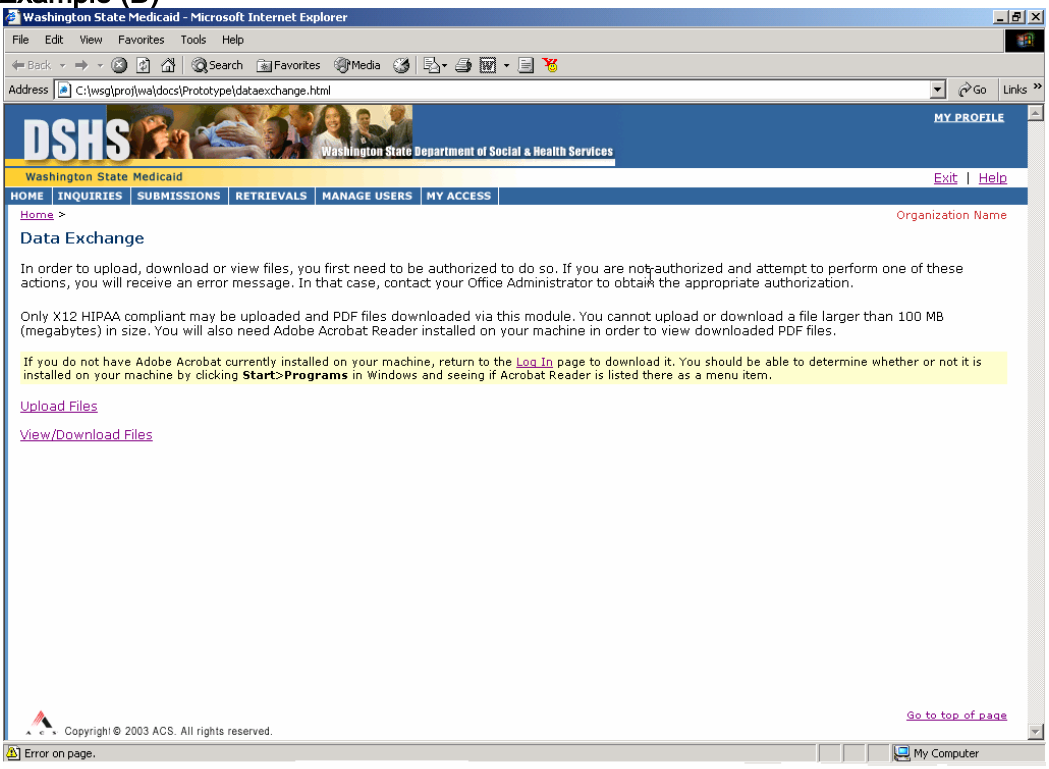
Example (A)



Entering an invalid User ID or Password will cause an error screen to show and entry will not be allowed. Enter access information exactly as it is specified, including case and spaces, if any. If the correct User ID and Password have been entered to access to the Web Portal area and a failure occurs, please contact the ACS EDI Support Unit at **1(800) 833-2051** for assistance.

Upload Files

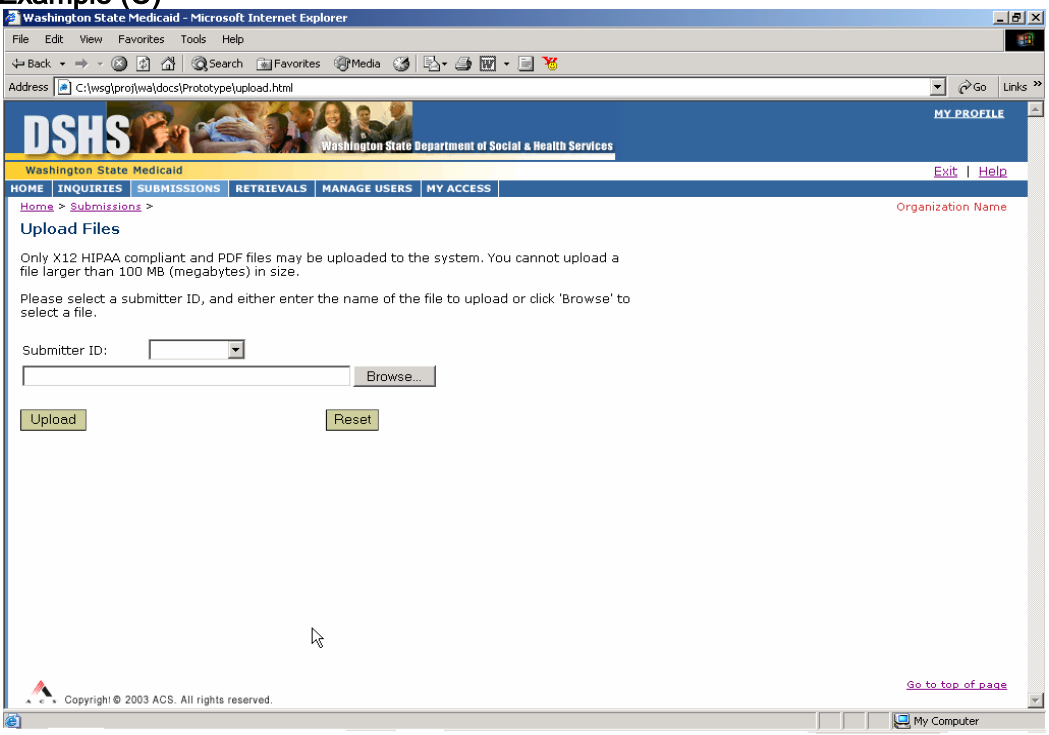
Example (B)



Select the Upload Files link to retrieve files from the ACS SHCH.

File Submission

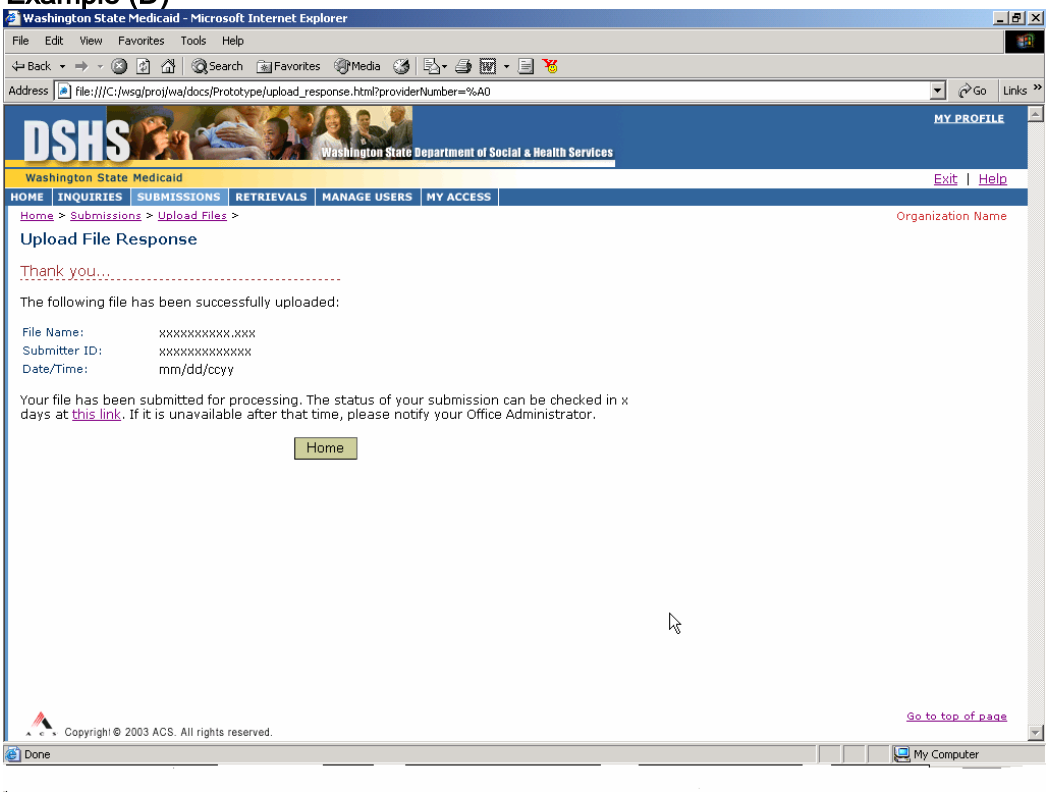
Example (C)



Enter the Submitter ID. Then click on the Browse button and select the file for upload. Then click on the Upload button for submission. If the file was selected in error, click on the Reset button.

Confirmation screen

Example (D)



This will show the File name, Submitter ID, and Date/Time that the file was submitted.

ADDITIONAL TRANSMISSION METHODS FOR DATA SUBMISSION

Important Note

Please note that some options for data receipt and delivery may involve connectivity issues and have additional cost factors that will need to be resolved prior to implementation. The modes shown below are best implemented for large submitter transaction volumes (switch vendors and intermediaries). The technology will incur additional expense for the requesting provider community.

Please contact the ACS EDI Support Unit for more information. The ACS EDI Support Unit is available to all Washington State Medicaid clients and providers Monday through Friday from 8:00 a.m. to 5:00 p.m. PST at 1(800)833-2051.

SNA

Please note that ACS EDI Gateway does not currently support SNA connectivity.

DATA RETRIEVAL

This section describes the available data retrieval modes from ACS EDI Gateway. The ANSI ASC X12N 837 Professional, Institutional and Dental is an inbound (to ACS EDI) claim transaction. The response to the 837 Professional, Institutional and Dental transaction is the ANSI ASC X12N 835 Remittance Advice transaction. This transaction is available on the Host Data Exchange (HDE), Web Portal, and through other modes of transmission discussed in the following sections.

Chapter 3,Transmission Responses, also contains a section on the ANSI ASC X12N 835 Remittance Advice transaction that will be available to providers currently receiving paper responses.

Providers will have an option to select an appropriate transmission mode for delivery.

Error Reports

The 997 and 824 transactions will be posted to Host Data Exchange (HDE), Web Portal, or sent via another agreed upon transmission mode. The TA1s are sent to the EDI Business Analysts for resolution because TA1s denote an unknown sender or invalid trading partner. The Business Analyst must research the transmission to identify and notify the sender.

The functions of the acceptance/rejection reports (TA1, 997 and 824) are discussed in: *Chapter 3,Transmission Responses.*

Asynchronous Dial-Up

ACS EDI Gateway provides an interactive, menu-driven Host Data Exchange System (HDE) that allows you to upload your transaction files and receive immediate confirmation of the status of your transfer. This Host Data Exchange System can be accessed using a standard modem and supports modem speeds of up to 56,000 bps. Transaction transmission is available twenty-four hours a day, seven days a week. This availability is subject to scheduled and unscheduled host downtime. It is operational policy to schedule preventative maintenance periods on weekends whenever possible.

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Transmission Protocol	ZMODEM uses 128 byte to 1024 byte variable packets and a 16-bit or 32-bit Cyclical Redundancy Check (CRC).

	XMODEM uses 128 byte blocks and a 16-bit CRC. YMODEM uses 1024 byte blocks and a 16-bit CRC. KERMIT can be accepted if X, Y, or ZMODEM capabilities are not available with your communication software.

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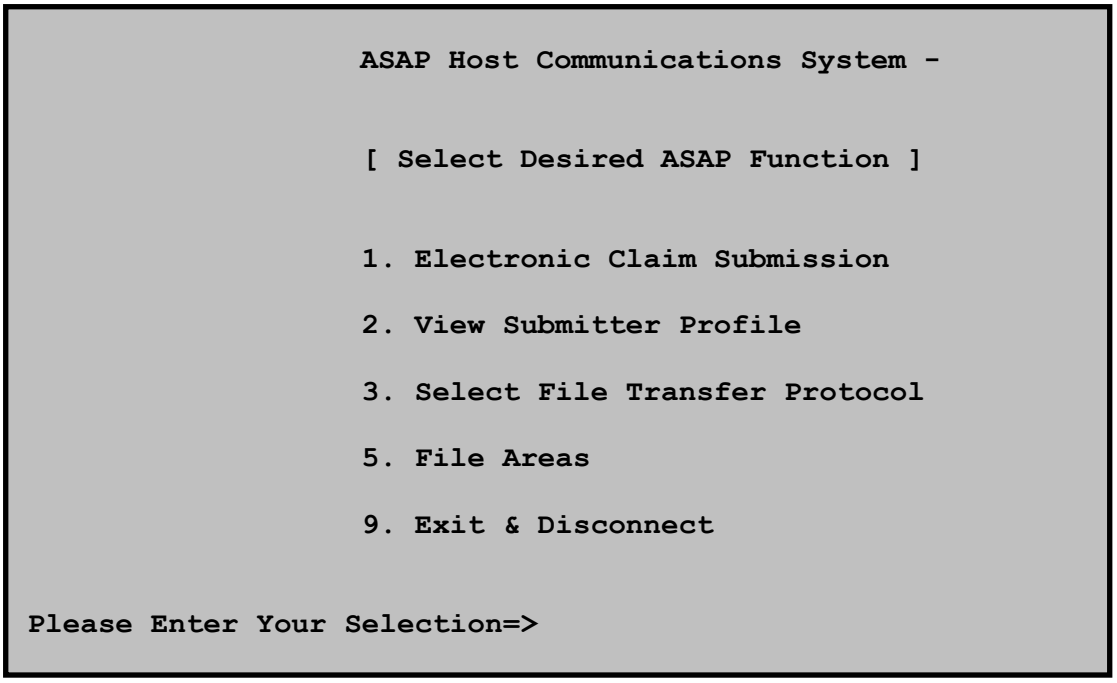
Terminal Emulation	VT100 or Auto.

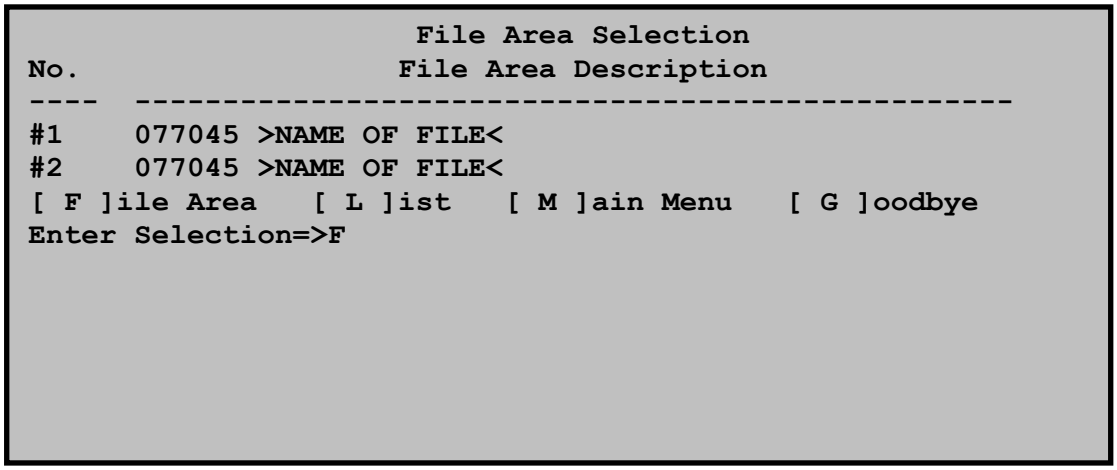
Transmission Procedures

```
LAPM/V42BIS

Welcome to ASAP HOST Communication System!

Please Enter your User name =>77045

Checking user file..

Please Enter your password =>770451111
```

SUBMITTER	HOST SYSTEM
1. Dials ACS Host	Answers call, negotiates a common baud rate, and sends to the trading partner: **"Please enter your User Name=>"**
2. Enter Logon Name <CR>	Receives User Name (Logon Name) and sends to the trading partner: **"Please enter your password=>"**
3. Enter Password <CR>	Receives Logon and verifies if trading partner is an authorized user. Sends HOST selection menu followed by a user prompt:



	"Please Select from the Menu Options Below=>"
4. Enter "5" to send file <CR>	#5. Files Area: Retrieves the response to the Files that were previously submitted.



5. Enters Desired Selection <CR>

#F. File Area: Retrieves the Response Files

#L. List: Lists the Response File to Retrieve.

#M. Main Menu: Returns to the Main Menu.

#G. Goodbye: Terminates connection.

Web Portal

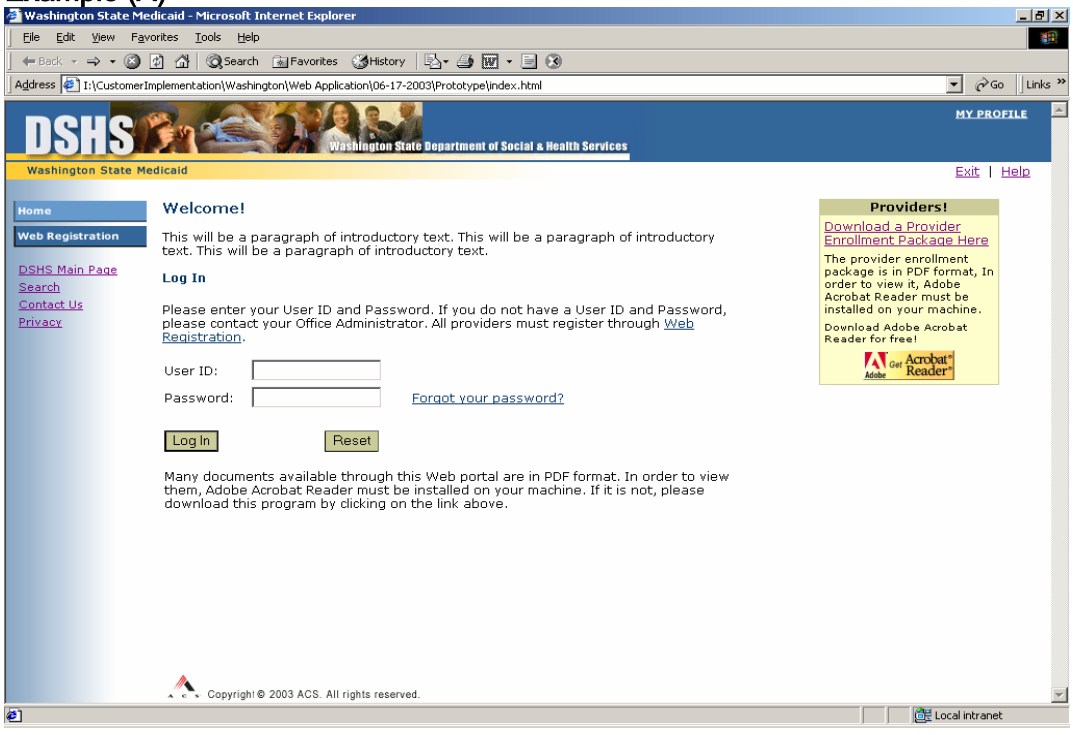
The Web Portal allows all trading partners to retrieve data via the Internet 24 hours a day, seven days a week. Each individual provider has the option of retrieving the transaction responses and reports themselves and/or of allowing billing agents and clearinghouses the option of retrieval on their behalf. The trading partner will access the Web Portal system using the User ID and Password provided during the enrollment process.

Please contact the ACS EDI Support Unit for more information about web data delivery transmissions. The ACS EDI Support Unit is available to all Washington State Medicaid clients and providers Monday through Friday from 8:00 a.m. to 5:00 p.m. PST at **1(800) 833-2051**.

Site Access

The web address to access data from ACS EDI Gateway is http://www.acs-gcro.com/Medicaid_Accounts/Washington_Medicaid/washington_medicaid.htm http://wamedweb.acs-inc.com.
Click on the Login button to request access to the secure Data Exchange area.

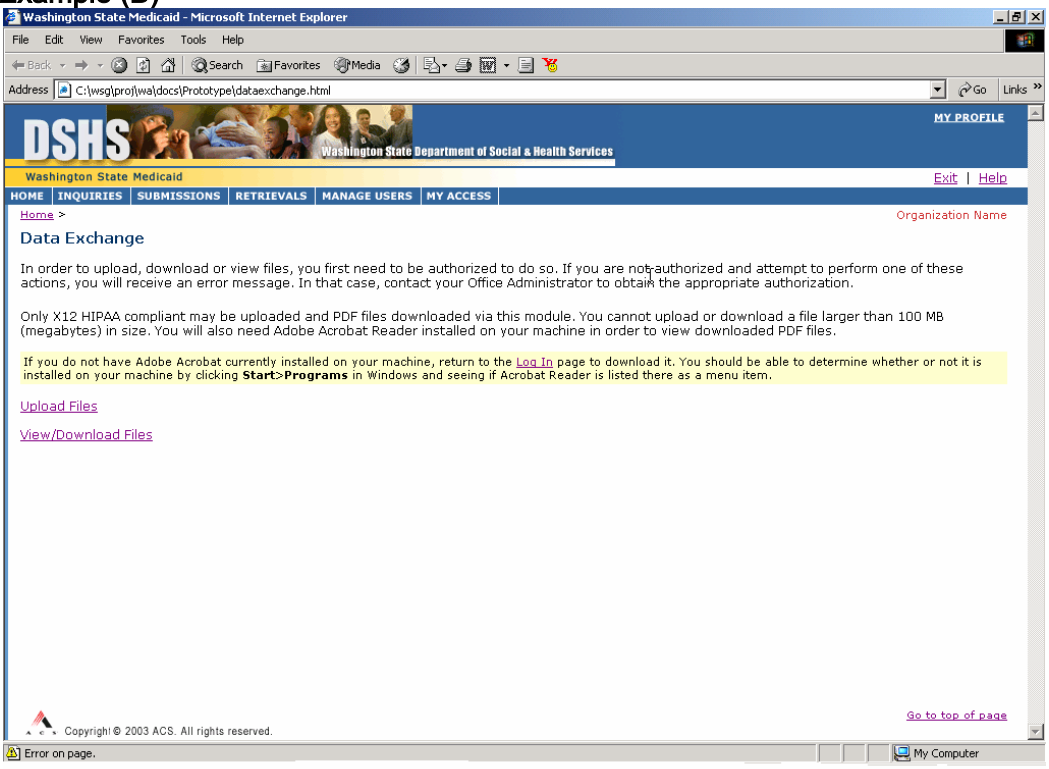
Example (A)



Entering an invalid User ID or Password will cause an error screen to show and entry will not be allowed. Enter access information exactly as it is specified, including case and spaces, if any. If the correct User ID and Password have been entered to access to the Web Portal area and a failure occurs, please contact our ACS EDI Support Unit for assistance.

Download Files

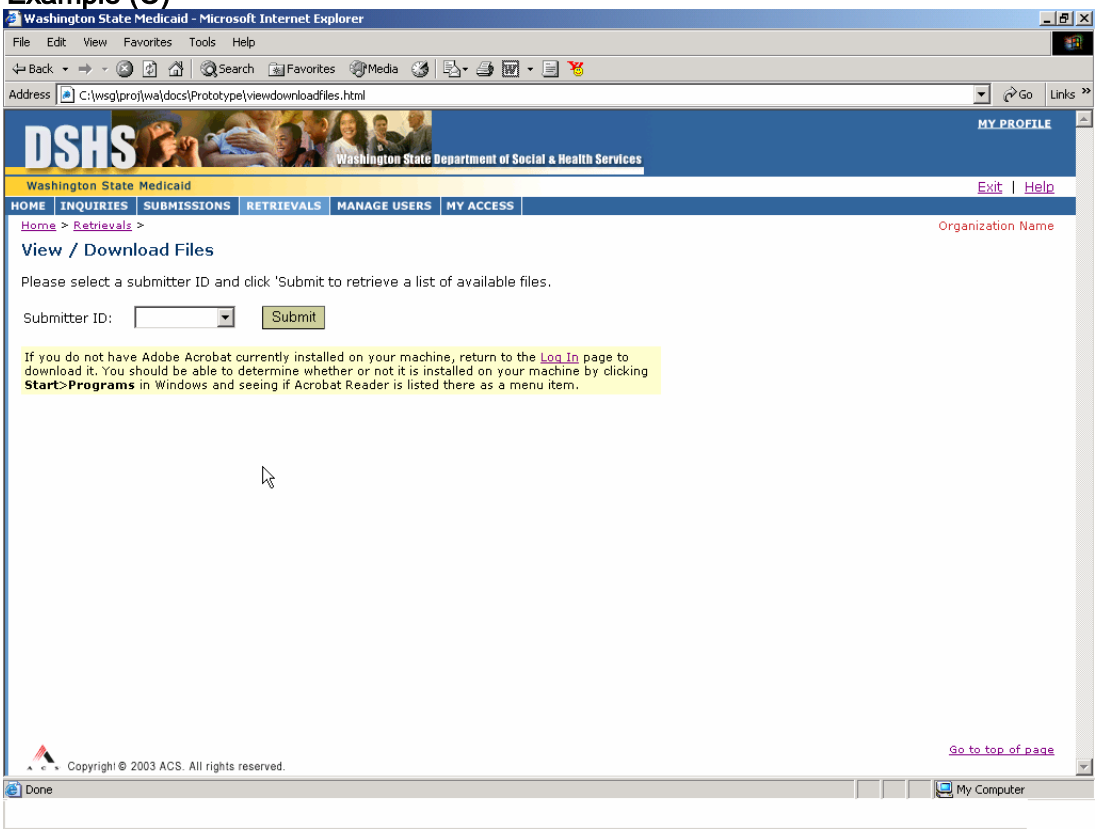
Example (B)



Select the View/Download Files Link to retrieve files from the ACS SHCH.

Retrieve Files

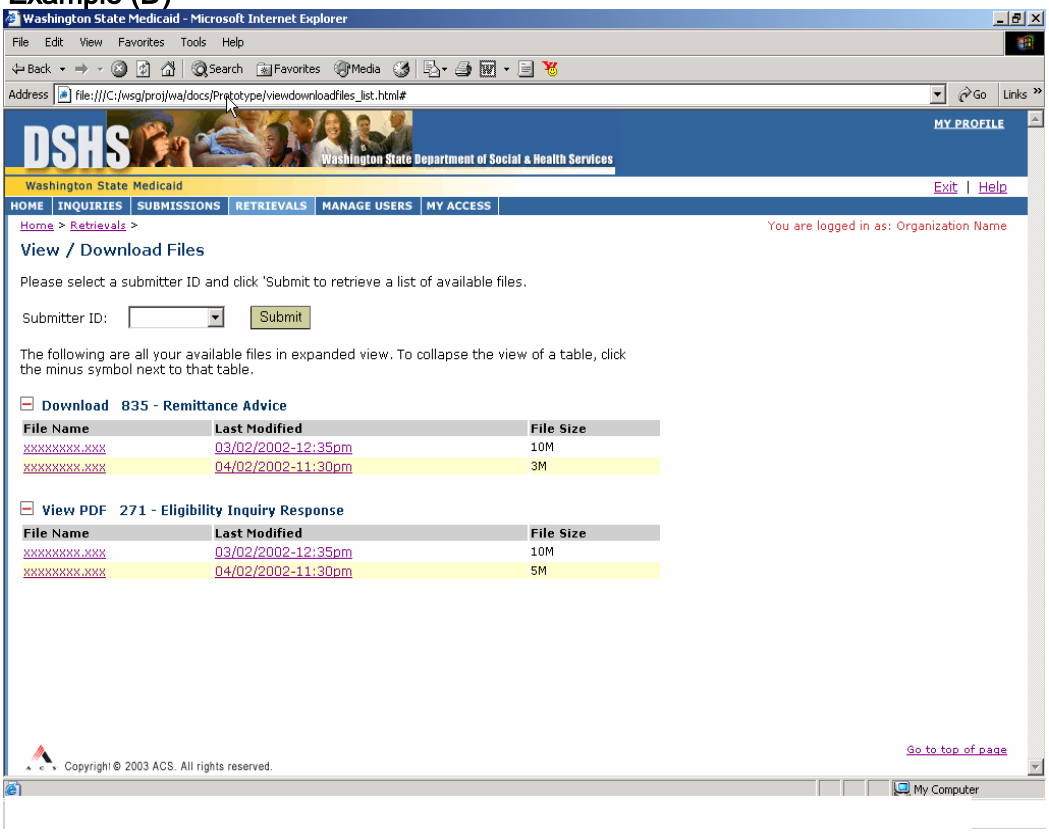
Example (C)



Enter the Submitter ID. Then click on the Submit button to view all files that can be viewed or downloaded.

File Display

Example (D)



Once the files are retrieved, click on the hyperlink file name. This will open the file in Adobe Acrobat.

ADDITIONAL TRANSMISSION METHODS FOR DATA RETRIEVAL

Important Note:

Please note that some options for data delivery may involve connectivity issues and have additional cost factors that will need to be resolved prior to implementation. The modes shown below are best implemented for large transaction volumes (switch vendors and intermediaries). The technology will incur additional expense for the requesting provider community.

Please contact the ACS EDI Support Unit for more information. The ACS EDI Support Unit is available to all Washington State Medicaid clients and providers Monday through Friday from 8:00 a.m. to 5:00 p.m. PST at **1(800) 833-2051**.

CHAPTER 3 TRANSMISSION RESPONSES

HIPAA not only gave the healthcare community the ability to standardize transactions, but also the ability to standardize front-end edits and the acceptance/rejection reports associated with the edits. The acceptance/rejection reports indicate errors within EDI transaction format syntax. When a report is generated, the type of report returned is dependent on the edit level that is invalid.

Each transaction contains three levels where edits (data validation processes) are present. Rejection of an entire batch or a single claim is designated by the edit level in which the error occurs. The three levels are:

- Interchange Level Errors
- Transaction Set Level Syntax Results
- Implementation Guide Level Results

In the description below, the three levels and their affiliated acceptance/rejection reports are discussed.

INTERCHANGE LEVEL ERRORS AND THE TA1 REJECTION REPORT

This edit is enforced by interchange level problems. It checks the **ISA**, **GS**, **GE** and **IEA** level segments and the data content within these segments, which consist of the header and footer batch information. Any X12N syntax error that occurs at this level will result in the entire transaction being rejected. These rejections are reported on a TA1.

TA1-Interchange Acknowledgement

A TA1 is an ANSI ASC X12N Interchange Acknowledgement segment used to report receipt of individual interchange envelopes. An interchange envelope contains the sender, receiver, and data type information within the header. The TA1 reports the syntactical analysis of the interchange header and trailer. If invalid (e.g. the data is corrupt or the trading partner relationship does not exist within the ACS system) the interchange will reject and a TA1, along with the data, will be forwarded to the ACS EDI Gateway call center. **The TA1 writes to an error log and the entire transaction is rejected at the header level.** The TA1's error logs are sent to the ACS EDI Support Unit for resolution because TA1s denote an unknown sender or an invalid Trading Partner. The ACS EDI Support Unit must research the transmission to identify and notify the sender.

EXAMPLE:
The transaction was built with incorrect sender information or incorrect total of groups at the end of the transaction. The items shown in bold text show the section where the error would occur.

ISA (contains sender information)

GS

ST

Detailed Segment Information-1

SE

ST

Detailed Segment Information-2

SE

ST

Detailed Segment Information-3

SE

GE

IEA (contains a number total of all functional groups within the batch)

For an additional example of this report, please see the ANSI ASC X12N 837 Professional, Institutional or Dental Implementation Guide.

TRANSACTION SET LEVEL SYNTAX RESULTS AND THE 997 REJECTION REPORT

This edit is enforced by transaction set level syntax problems for all transactions within each functional group. These edits check the ST and SE level segments and the data content within these segments. These segments consist of the entire detailed information within a transaction. Any X12N syntax error that occurs at this level will result in the entire transaction being rejected. However, if the functional group consists of additional transactions without errors, these will be processed. The rejections are reported on the ANSI ASC X12N 997.

ANSI ASC X12N 997-Functional Acknowledgement

ACS SHCH validates submission of ANSI ASC X12N format(s). An ANSI ASC X12N 997, or Functional Acknowledgement, is generated when an EDI file, e.g. an ANSI ASC X12N file that has passed the header and trailer check, passes through the clearinghouse. The ANSI ASC 997 contains **ACCEPT** or **REJECT** information; if the file contained syntactical errors, the segment(s) and element(s) where the error(s) occurred will be reported. For an example of this report, please see the ANSI ASC X12N 837 Professional, Institutional or Dental Implementation Guide. This method of acknowledgement is required by Trading Partner Agreement between ACS EDI Gateway and the Trading Partners.

EXAMPLE:

The batch was built with incorrect segment data. The items shown in bold text show the section where the error would occur.

ISA

GS

ST

Detailed Segment Information-1

SE (contains detailed information within a transaction)

ST

Detailed Segment Information-2

SE (contains detailed information within a transaction)

ST

Detailed Segment Information-3

SE (contains detailed information within a transaction)

GE

IEA

IMPLEMENTATION GUIDE LEVEL RESULTS AND THE REJECTION REPORT

This edit is enforced by the implementation guide rules for the particular transaction. These edits will vary depending on the rules set by the implementation guide, code sets, and looping structures. Any errors that occur at this level will result in the data content within that claim being rejected. However, if the batch consists of additional claims without errors, these will be processed. The rejection reports are not mandated to be in a specific format. The ANSI ASC X12N 824 may be used during these instances as a replacement for the report.

ANSI ASC X12 824-Application Advice

If a business edit fails during the translation of the ANSI ASC X12N 837 Professional, Institutional or Dental transaction, an ANSI ASC X12 824 application advice will be returned to the submitter, electronically or paper-based, indicating that the error(s) encountered during the claim processing. This is used to report errors outside of the scope of the 997.

The 824 Application Advice details what errors are present, and if necessary, what action the submitter should take. The use of the ANSI ASC X12N 824 transaction is not required by HIPAA. For an example of this report, please see the ANSI ASC X12 824 Implementation Guide.

EXAMPLE:

The batch was built with incorrect transaction “required field” data. The items shown in bold text show the section where the error would occur.

ISA

GS

ST

Detailed Segment Information-1 (contains HIPAA required field data)

SE

ST

Detailed Segment Information-2 (contains HIPAA required field data)

SE

ST

Detailed Segment Information-3 (contains HIPAA required field data)

SE

GE

IEA

For further explanation, please see Chapter 1, “Editing and Validation Flow Diagram” for a visual depiction of the error process/responses.

ANSI ASC X12N 835-Remittance Advice

An ANSI ASC X12N 835 Remittance Advice may be requested as a replacement for or in addition to a paper remittance advice. After claim adjudication and payment, an ANSI ASC X12N 835 Remittance Advice will be delivered to the ACS Host Data Exchange (HDE), Web Portal system also available through other modes of transmission. Providers/submitters will have the option, during the enrollment process, to select appropriate transmission method(s) for receiving 835 transactions (e.g., HDE and Web Portal etc.). For further information, please see Chapter 2, Transmission Methods.

The ANSI ASC X12N 835 contains information related to payees, payers, dollar amounts and payments. Please see the ANSI ASC X12N 835 Implementation Guide for details on the ANSI ASC X12N 835 transaction.

CHAPTER 4 TESTING

Completion of the testing process must occur prior to electronic submission to ACS EDI Gateway. Assistance from the ACS EDI Support Unit is available throughout this process. Each test transmission is inspected thoroughly to ensure no format errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, we request that you send real transmission data. The number of test transmissions required depends on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to the Washington State MMIS system. Also, changes to the X12N formats may require additional testing.

TRADING PARTNER TESTING PROCEDURES

- ACS EDI Gateway provides companion guides and enrollment packages for download via the web at: http://www.acs-gcro.com.
- The trading partner completes enrollment package and submits to ACS EDI Gateway.
- The trading partner is assigned Logon Name and Logon User ID.
- The trading partner contacts the ACS EDI Support Unit at 1(800) 833-2051 to arrange a testing schedule and complete their EDIFECS enrollment.
- The trading partner has access to the EDIFECS website in order to submit X12N test files for analysis. Each test file is analyzed based on the seven levels of testing defined by WEDI SNIP. At this time, the submitter is required to address any errors discovered by EDIFECS during the compliance analysis prior to moving on to the next stage of testing with ACS EDI Gateway.
- The trading partner executes test files and data is sent to ACS EDI Gateway.
- The ACS EDI Support Unit representative evaluates the flow of test data through the ACS SHCH.
- If the test files are completed successfully, the ACS EDI Support Unit contacts the trading partner that the trading partner is approved for placement into production environment when available. If the testing entity is a software vendor, they will be required to provide a list of submitters using the approved software package.
- If the test files are unsuccessful, the ACS EDI Support Unit will contact the trading partner. The trading partner will remain in the testing environment until test files are completed successfully.

EDIFECS – HIPAADESK ONLINE TESTING APPLICATION

EDIFECS – HIPAADesk is an online HIPAA testing application available to the Washington State Medicaid clients and providers. HIPAADesk offers the following types of testing against the base HIPAA implementation guidelines for free.

- **Test all 7 WEDI/SNIP Types.** HIPAADesk provides all 7 Types of WEDI/SNIP testing for HIPAA including integrity testing, requirement testing, balancing testing, situational testing, code set testing, product or services testing, and guide-specific testing.

- **Test the HIPAA Code Sets.** Validate over 40 of industry code tables and databases.

- **Get your Answers Fast.** With HIPAADesk, the results of your free compliance testing are typically available within seconds for small files and within minutes for files up to 10 megabytes and larger.

The Washington State Medicaid client and provider community can access the EDIFECS – HIPAADesk online application at: https://www.hipaadesk.com/?acs. Submitters will test claims submissions through the EDIFECS - HIPAADesk utility and will receive a file status report. Once these files test with no errors, a submitter may then submit test claims submissions to ACS SHCH for Client Integration testing.

CHAPTER 5 PAYER SPECIFIC DATA

EDI SUPPORT

The ACS EDI Support Unit assists users with questions about electronic submission. The ACS EDI Support Unit is available to all Washington State Medicaid clients and providers Monday through Friday from 8:00 a.m. to 5:00 p.m. PST at 1(800) 833-2051. The ACS EDI Support Unit:

- Provides information on available services
- Enrolls users for claims submission
- Verifies receipt of electronic transmissions
- Provides technical assistance to users who are experiencing transmission difficulties

ENROLLMENT INFORMATION

Any entity sending electronic claims to ACS EDI Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package. This package provides ACS EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic claims. You may obtain an enrollment package by contacting the ACS EDI Support Unit or by downloading it from our website at http://acs-gcro.com.

TRANSMISSION TELEPHONE NUMBER

ACS EDI Gateway provides availability for transmission 24 hours a day, 7 days a week. There are no restrictions on the number or frequency of transmissions. The transmission telephone numbers are **1(800) 334-4650** or **1(800) 334-2832**.

TRACKING TRANSMISSION/PRODUCTION PROBLEMS

Please have the following information available when calling the ACS EDI Support Unit regarding transmission and production issues.

Trading Partner ID: Your Trading Partner ID is our key to accessing your trading partner information. Please have this number available each time you contact the ACS EDI Support Unit.

Logon Name and Logon User ID: These allow asynchronous trading partners access to the host system for claims submission. The ACS EDI Support Unit uses this information to reference your submitted data.

HIGHLIGHTS

- Each new user is assigned a seven-digit Trading Partner ID.
- It you are a current submitter you will continue to use your current Submitter ID.
- Login User IDs (passwords) are nine characters.
- All dates are in the CCYYMMDD format unless using date ranges CCYYMMDD-CCYYMMDD
- All date/times are in the CCYYMMDDHHMM format.
- The same phone number will be used for transmitting test and production data.
- The Receiver ID and Payer ID for Washington State MAA is **77045**. Transmissions without this value in the appropriate fields will not be processed.
- Your Trading Partner Agreement determines where reports and responses will be delivered.
- Unless indicated otherwise for Professional, Institutional or Dental claims, use the HIPAA-defined values for data fields.
- All responses are retained for pickup for a period of 60 days.
- When a credit (void) or adjustment is submitted electronically, the pay-to provider ID, recipient ID, and claim type must match the claim being adjusted. Otherwise, the claim is treated as an original claim.

CHAPTER 6 TRANSACTION DESCRIPTION - V4010.A

This section contains data clarifications. The clarifications include:

- Identifiers used when a national standard has not been adopted (and),
- Parameters in the implementation guide that provide options.

Many of the data elements included in the Companion Guides are business requirements and are not standardization-required elements. Inclusion of a "business-required" data field, as defined by this Companion Guide, may aid in the delivery of a positive response.

There are submission rules that will result in the rejection of a claim if not followed:

- Amounts fields must not exceed $9,999,999.99
- Medicaid Provider ID must be submitted.
- Unit of service fields must not exceed 5 digits.
- Fractional unit(s) of service submitted will be rounded to the next highest whole number.

When a credit (void) or adjustment is submitted electronically, the pay-to provider ID, recipient ID, and claim type must match the claim being adjusted. Otherwise, the claim is treated as an original claim.

This companion guide for the ANSI ASC X12N 837 Professional, Institutional, or Dental Healthcare Claim transaction has been created for use in conjunction with the standard Implementation Guide. It should not be considered a replacement for the Implementation Guide, but rather used as an additional source of information.

**Please note the page numbers listed below in each of the tables represent the corresponding page number in the ANSI ASC X12N Implementation Guide for this transaction. Please refer to the Implementation Guide for any questions concerning standard data requirements for this transaction.*

837 PROFESSIONAL

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
Interchange Control Header (ISA)				
Appendix B	Envelope	ISA	01	Please use '**00**'.
	Envelope	ISA	02	Please use **10 spaces**.
	Envelope	ISA	03	Please use '**00**'.
	Envelope	ISA	04	Please use **10 spaces**.
	Envelope	ISA	05	Please use '**ZZ**'.
	Envelope	ISA	06	Please use the **7-digit Trading Partner ID** provided during the enrollment process, followed by spaces.
	Envelope	ISA	07	Please use '**ZZ**'.
	Envelope	ISA	08	Please use **'100000'** followed by spaces.
	Envelope	ISA	15	Please use '**T**' when submitting a **Test file**. Please use '**P**' when submitting a **Production file**.
Functional Group Header (GS)				
Appendix B	Envelope	GS	02	Please use the **7-digit Trading Partner ID** provided during the enrollment process.
	Envelope	GS	03	Please use '**77045'.**

Beginning of Hierarchical Transaction				
65	Header	BHT	06	Transaction Type Code Please use **'CH'** for Fee for Service claims (ECC, adjustments, or reversals) or **'RP'** for encounters.
66	Header	REF	02	When this draft is used to **pilot** the transaction set, this value is **'004010X098DA1'**. When this draft is used to send the transaction set in a **production** mode, this value is **'004010X098A1'**.
Submitter Name (Loop 1000A)				
69	1000A	NM1	09	Please use the **7-digit Trading Partner ID** provided during the enrollment process.
Receiver Name (Loop 1000B)				
75	1000B	NM1	09	Please use **'77045'**.
Billing/Pay-to Provider Hierarchical Level (Loop 2000A)				
80	2000A	PRV	03	If the Billing or Pay-to Provider is also the Rendering Provider and loop 2310B is not used, use this field to indicate which entity (Billing or Pay-to) is the Rendering Physician.
Patient Information (Loop 2000C)				
154	2000C	PAT	01	This loop and PAT segments to be used only when billing for baby using parent's PIC.
Billing Provider Name (Loop 2010AA)				
92	2010AA	REF	01	The Medicaid Provider Number is necessary to adjudicate the claim if the loop is applicable. Please use the qualifier **'1D'** to identify the Medicaid Provider Number.
92	2010AA	REF	02	The Billing Provider Medicaid Number is necessary to adjudicate the claim if the loop is applicable.

Pay-To Provider's Name (Loop 2010AB)				
106	2010AB	REF	01	The Medicaid Provider Number is necessary to adjudicate the claim if the loop is applicable. Please use the qualifier '**1D**' to identify the Medicaid Provider Number.
107	2010AB	REF	02	The Pay-to Provider Medicaid ID is required by the adjudication system. If missing from both the 2010AB and 2010AA loops, all claims in the 837 will be returned to the submitter.
Subscriber Name (Loop 2010BA)				
119	2010BA	NM1	09	For Medicaid purposes the subscriber is equal to the patient. The format for the Medicaid recipient ID is 14 characters. **First initial, Middle Initial**, *(if no middle initial use a dash)*, **birth date as MMDDYY**, **first five letters of last name** *(if last name less than five letters, space fill; if last name is a hyphenated last name the hyphen is included as one of the five characters, if last name includes an apostrophe, the apostrophe is included as one of the five characters;* **with a tiebreaker** (either alpha or numeric) as the final character. EXAMPLES: JD010301DOE A - Last name less than five characters N-020310CLINEA - No middle initial DL020301RUS-KA - Hyphenated last name NN020310O'LEA2 - Apostrophe last name AB010203EMANS1 - Numeric tiebreaker
Payer Name (Loop 2010BB)				
130	2010BB	NM1	08	Please use the qualifier '**PI**' to identify the Payer Identification Number.

130	2010BB	NM1	09	Please populate with Payer Identification Number. **77045**
Patient Demographic Information (Loop 2010CA)				
165	2010CA	DMG	02	Patient Date of Birth
Claim Information (Loop 2300)				
173	2300	CLM	05-3	Claim Frequency Type Code This is a required data element. Please submit a valid code from the National Uniform Billing Data Element Specifications for Type of Bill, position 3. **1**=Original **7**=Replacement **8**=Void To cancel or adjust a previously submitted claim, submit "**7**" for Replacement of Prior Claim or "**8**" for Void/Cancel of Prior Claim. See also 2300/REF02.
216	2300	PWK	06	**If PWK02 is "BM", "EL", "EM" or "FX".** Attachment Control Number Providers may submit the claim electronically and send the attachment separately. To facilitate the matching of the attachment to the claim, the pay-to provider id, recipient id, and date of service should be used as the attachment control number in the paperwork segment of the 837 transaction. To expedite the claim's adjudication, use this same control number on the Attachment Control Document.
229	2300	REF	01	Reference Identification Qualifier **'F8'**
229	2300	REF	02	Claim Original Reference Number To cancel or adjust a previously submitted claim, please submit the 17-digit transaction control number (TCN), assigned by the adjudication system and printed on the remittance advice, for the previously submitted claim that is being replaced or voided by this claim.

246	2300	NTE	02	This field can be used at the provider's discretion. To facilitate the successful outcome of your claim, we will be reading this field for information required in various billing instructions and/or where state regulations mandate information that is not reported elsewhere within the claim data set. Please refer to your billing instructions and memorandums. An example would be the "I" indicator for Involuntary Treatment Act (ITA)
Ambulance Transport Information (Loop 2300)				
249	2300	CR	102	Used if needed to justify extra attendant.
249	2300	CR	103	**"I"** Initial, **"R"** Return, **"T"** Transfer, **"X"** Roundtrip.
Referring Provider Name (Loop 2310A)				
288	2310A	REF	01	The Medicaid Provider Number is necessary to adjudicate the claim if the loop is applicable. Please use the qualifier '**1D**' to identify the Medicaid Provider Number.
289	2310A	REF	02	Please populate with Referring Provider's Medicaid Number. Checking for 7 bytes or will reject.
Rendering Provider Name (Loop 2310B)				
296	2310B	REF	01	The Medicaid Provider Number is necessary to adjudicate the claim if the loop is applicable. Please use the qualifier '**1D**' to identify the Medicaid Provider Number.
297	2310B	REF	02	The Rendering Provider's Medicaid Number is necessary to adjudicate the claim if the loop is applicable. If missing from both the 2310A and 2310B loops, all claims in the 837 will be returned to the submitter.
Other Subscriber Information (Loop 2320)				

321	2320	SBR	05	Use Qualifier **"MB"** when submitting Medicare Crossover Claims.
327	2320	CAS	03	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the submitter.
327	2320	CAS	06	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the submitter.
339	2320	AMT	02	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the submitter.
Claim Level Adjustments (Loop 2320)				
327	2320	CAS	03	Coinsurance/Deductible
327	2320	CAS	05	Adjustment Reason Code
Coordination of Benefits (COB) Payer Paid Amount (Loop 2320)				
332	2320	AMT	02	Amount Paid by Medicare or Third Party Payment Amount
Coordination of Benefits (COB) Approved Amount (Loop 2320)				
333	2320	AMT	02	Medicare Allowed Amount or Third Party Approved Amount
Coordination of Benefits Allowed Amount (Loop 2320)				
334	2320	AMT	02	Medicare Allowed Amount or Third Party Allowed Amount
Coordination of Benefits (COB) Covered Amount (Loop 2320)				
336	2320	AMT	02	Amount covered by other payer
Other Payer Name (Loop 2330B)				
359	2330B	NM1	03	Do not indicate "Medicaid" here. Only report information on other payers if known
Claim Adjudication Date (Loop 2330B)				
367	2330B	DTP	03	Date Paid by Medicare or Third Party
Line Counter (Loop 2400)				

402	2400	SV1	02	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the submitter.
403	2400	SV1	03	If decimal units of service are submitted, the system will round to a whole number. Claims submitted with units greater than 99,999 (i.e. larger than 5 digits) will be returned to the submitter.
470	2400	REF	02	Please submit a nine digit Prior Authorization Number when applicable, using qualifier "**G1**" for Prior Authorization Number in REF01.
Approved Amount (Loop 2400)				
485	2400	AMT	02	Medicare Allowed Amount
Drug Identification (Loop 2410)				
480	2410	LIN	03	Must report NDC corresponding to the HCPCS or CPT code in Loop 2400 Professional Service Data Segment SV101-1 and SV101-2 when billing for injectable drugs dispensed by the provider's office. Please refer to your billing instructions and/or memos.
Rendering Provider Name (2420A)				
507	2420A	REF	01	The Medicaid Provider Number is necessary to adjudicate the claim if the loop is applicable. Please use the qualifier '**1D**' to identify the Medicaid Provider Number.
Transaction Set Trailer (SE)				
572	Trailer	SE	01	Number of Included Segments.
572	Trailer	SE	02	Transaction Set Control Number.

837 INSTITUTIONAL

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
Interchange Control Header (ISA)				
Appendix B	Envelope	ISA	01	Please use '**00**'.
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	Envelope	ISA	03	Please use '**00**'.
	Envelope	ISA	04	Please use **10 spaces**.
	Envelope	ISA	05	Please use '**ZZ**'.
	Envelope	ISA	06	Please use the **7-digit Trading Partner ID** provided during the enrollment process, followed by spaces.
	Envelope	ISA	07	Please use '**ZZ**'.
	Envelope	ISA	08	Please use **'100000'** followed by spaces.
	Envelope	ISA	15	Please use '**T**' when submitting a **Test File**. Please use '**P**' when submitting a **Production File**.
Functional Group Header (GS)				
Appendix B	Envelope	GS	02	Please use the **7-digit Trading Partner ID** provided during the enrollment process.
	Envelope	GS	03	Please use '**77045'.**
Beginning of Hierarchical Transaction				
59	Header	BHT	06	Transaction Type Code Please use '**CH**' for Fee for Service claims (ECC, adjustments, or reversals) or '**RP**' for encounters.

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
60	Header	REF	02	When this draft is used to **pilot** the transaction set, this value is '**004010X096DA1'**. When this draft is used to send the transaction set in a **production** mode, this value is '**004010X096A1'**.
Submitter Name (Loop 1000A)				
63	1000A	NM1	09	Please use the **7-digit Trading Partner ID** provided during the enrollment process.
Billing Provider Name (Loop 2010AA)				
83	2010AA	REF	01	The Medicaid Provider Number is necessary to adjudicate the claim if the loop is applicable. Please use the qualifier '**1D**' to identify the Medicaid Provider Number**.**
84	2010AA	REF	02	The Billing Provider Medicaid ID Number is necessary to adjudicate the claim if the loop **is applicable**.
Pay-to Provider Name (Loop 2010AB)				
97	2010AB	REF	01	The Medicaid Provider Number is necessary to adjudicate the claim if the loop is applicable. Please use the qualifier '**1D**' to identify the Medicaid Provider Number**.**
98	2010AB	REF	02	The Pay-to Provider Medicaid ID is required by the adjudication system. If missing from both the 2010AB and 2010AA loops, all claims in the 837 will be returned to the submitter.
Subscriber Name (Loop 2010BA)				

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
110	2010BA	NM1	09	The format for the recipient ID is 14 characters. **First initial, Middle Initial**, *(if no middle initial use a dash)*, **birth date as MMDDYY**, **first five letters of last name** *(if last name less than five letters, space fill; if last name is a hyphenated last name the hyphen is included as a letter, if last name includes an apostrophe, the apostrophe is included as one of the five characters;* **with a tiebreaker** (either alpha or numeric) as the final character. EXAMPLES: JD010301DOE A - Last name less than five characters N-020310CLINEA - No middle initial DL020301RUS-KA - Hyphenated last name NN020310O'LEA2 - Apostrophe last name AB010203EMANS1 - Numeric tiebreaker
Payer Name (Loop 2010BB)				
123	2010BB	NM1	08	Please use the qualifier '**PI**' to identify the Payer Identification Number.
123	2010BB	NM1	09	Please populate with Payer Identification Number. **77045**
Discharge Hour (Loop 2300)				
165	2300	DTP	01	Discharge Hour
Claim Information (Loop 2300)				

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
159	2300	CLM	05-3	Claim Frequency Type Code This is a required data element. Please submit a valid code from the National Uniform Billing Data Element Specifications for Type of Bill, position 3. **1**=Original **7**=Replacement **8**=Void To correct or void a previously submitted claim, submit "**7**" for Replacement of Prior Claim or "**8**" for Void/Cancel of Prior Claim. See also 2300/REF02.
175	2300	PWK	06	Attachment Control Number To facilitate the matching of the attachment to the claim, the pay-to provider id, recipient id, and date of service should be used as the attachment control number in the paperwork segment of the 837 transaction. To expedite the claim's adjudication, use this same control number on the Attachment Control Document.
191	2300	REF	02	Original Reference Number To cancel or adjust a previously submitted claim, please submit the **17-digit transaction control number (TCN)**, assigned by the adjudication system and printed on the remittance advice, for the previously submitted claim that is being replaced or voided by this claim.
208	2300	NTE	02	This field can be used at the provider's discretion. To facilitate the successful outcome of your claim, we will be reading this field for information required in various billing instructions and/or where state regulations mandate information that is not reported elsewhere within the claim data set. An example would be the "I" indicator for Involuntary Treatment Act (ITA) Please refer to your billing instructions or memorandums

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
233	2300	HI	XX-2	1. PRINCIPAL, ADMITTING, E-CODE AND PATIENT REASON FOR VISIT DIAGNOSIS INFORMATION 2. DIAGNOSIS RELATED GROUP (DRG) INFORMATION 3. OTHER DIAGNOSIS INFORMATION 4. PRINCIPAL PROCEDURE INFORMATION 5. OTHER PROCEDURE INFORMATION 6. OCCURRENCE SPAN INFORMATION 7. OCCURRENCE INFORMATION 8. VALUE INFORMATION 9. CONDITION INFORMATION 10. TREATMENT CODE INFORMATION The adjudication system can receive one admitting diagnosis, one E-code, one principal diagnosis and up to 11 "other" diagnosis codes. Only 3 diagnosis codes (the principal and the first 2 other codes) are used to price the claim.
281	2300	HI	01-2	The adjudication system can receive 6 procedure codes (including the principal procedure). Only the first two are considered for adjudication.
281	2300	HI	XX-2 and XX-5	Value Codes and Amounts For a live birth claim, submit '**54**' in HIXX-2 for Newborn Birth Weight in Grams, and submit the infant's weight at birth in HIXX-5.
Claim Quantity (Loop 2300)				
306	2300	QTY	01	**"CA"** Days
307	2300	QTY	02	Number of days
Attending Physician Name (Loop 2310A)				
326	2310A	REF	01	The Medicaid Provider Number is necessary to adjudicate the claim if the loop is applicable. Please use the qualifier '**1D**' to identify the Medicaid Provider Number.
327	2310A	REF	02	Submit the attending physician's Medicaid provider number.

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
Other Provider Secondary Identifier (Loop 2310C)				
341	2310C	REF	02	Other Provider Secondary Identifier-Medicaid Assigned ID
Other Subscriber Information (Loop 2320)				
363	2320	SBR	03	Group Policy
363	2320	SBR	04	Group Policy Name
363	2320	SBR	09	**"MA"** or **"MB"** for Medicare Crossover Claims
367	2320	CAS	03	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the submitter.
368	2320	CAS	06	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the submitter.
373	2320	AMT	02	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the submitter.
Claim Level Adjustments (Loop 2320)				
367	2320	CAS	01-03	Claim Adjustment Reason Code and Amounts
369	2320	CAS	12	Medicare Coinsurance Amount
370	2320	CAS	15	Medicare Deductible Amount
Payer Prior Payment (Loop 2320)				
371	2320	AMT	02	Third Party Payment Amount
Coordination of Benefits (COB) Total Allowed Amount (Loop 2320)				
372	2320	AMT	02	Allowed Amount
Coordination of Benefits (COB) Totals Submitted Charges (Loop 2320)				
373	2320	AMT	02	COB Total Submitted Charge
Diagnostic Related Group (DRG) Outlier Amount (Loop 2320)				
375	2320	AMT	02	Claim DRG Outlier Amount

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
Coordination of Benefits (COB) Total Medicare Paid Amount (Loop 2320)				
377	2320	AMT	02	Medicare Paid Amount
Coordination of Benefits (COB) Total Non-covered Amount (Loop 2320)				
386	2320	AMT	02	Claim total Denied Charges
Medicare Inpatient Adjudication Information (Loop 2320)				
393	2320	MIA	04	Claim DRG Amount
Medicare Outpatient Adjudication Information (Loop 2320)				
397	2320	MOA	01	Reimbursement Rate
398	2320	MOA	02	Claim HCPCS Payable Amount
398	2320	MOA	03	Remark Code
398	2320	MOA	04	Remark Code
398	2320	MOA	05	Remark Code
399	2320	MOA	06	Remark Code
Other Subscriber Secondary Information (Loop 2330A)				
409	2330A	REF	02	Other Insured Additional Identifier
Other Payer Name (Loop 2330B)				
410	2330B	NM1	03	Do not indicate “Medicaid” here. Only report information on other payers if known
Claim Adjudication Date (Loop 2330B)				
415	2330B	DTP	03	Date Paid by Medicare or Date Claim Paid by Other Insurance
Service Line Number (Loop 2400)				
446	2400	SV2	01	Four-digit revenue code.
448	2400	SV2	03	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the submitter.

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
449	2400	SV2	05	If decimal or fractional units of service are submitted, the system will round to a whole number. Claims submitted with units that are greater than 99,999 (i.e. larger than 5 digits) will be returned to the submitter.
449	2400	SV2	07	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the submitter.
Drug Identification (Loop 2410)				
459	2410	LIN	03	Must report NDC corresponding to the HCPCS or CPT code in Loop 2400 Professional Service Data Segment SV101-1 and SV101-2 when billing for injectable drugs dispensed by the provider's office or **for Kidney Centers only**. Please refer to your billing instructions and/or memos.
Service Line Adjudication Information (Loop 2430)				
491	2430	SVD	02	Amount Paid by Other Insurance
Service Adjudication Date (Loop 2430)				
502	2430	DTP	03	Date Paid by Medicare
Transaction Set Trailer (SE)				
503	Trailer	SE	01	Number of Included Segments.
503	Trailer	SE	02	Transaction Set Control Number.

837 DENTAL

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
Interchange Control Header (ISA)				
Appendix B	Envelope	ISA	01	Please use '**00**'.
	Envelope	ISA	02	Please use **10 spaces**.
	Envelope	ISA	03	Please use '**00**'.
	Envelope	ISA	04	Please use **10 spaces**.
	Envelope	ISA	05	Please use '**ZZ**'.
	Envelope	ISA	06	Please use the **7-digit Trading Partner ID** provided during the enrollment process, followed by spaces.
	Envelope	ISA	07	Please use **'ZZ'**.
	Envelope	ISA	08	Please use **'100000'** followed by spaces.
	Envelope	ISA	15	Please use '**T**' when submitting a **Test File**. Please use '**P**' when submitting a **Production File**.
Functional Group Header (GS)				
Appendix B	Envelope	GS	02	Please use the **7-digit Trading Partner ID** provided during the enrollment process.
	Envelope	GS	03	Please use '**77045**'.
Beginning of Hierarchical Transaction				
59	Header	BHT	06	Transaction Type Code Please use '**CH**' for Fee for Service claims (ECC, adjustments, or reversal, or '**RP**' for encounters).

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
60	Header	REF	02	When this draft is used to **pilot** the transaction set, this value is '**004010X097DA1'**. When this draft is used to send the transaction set in a **production** mode, this value is '**004010X097A1'**.
Submitter Name (Loop 1000A)				
63	1000A	NM1	09	Please use the **7-digit Trading Partner ID** provided during the enrollment process.
Receiver Name (Loop 1000B)				
67	1000B	NM1	09	Please use **'77045'**.
Billing/Pay-To Provider Hierarchical Level (Loop 2000A)				
72	2000A	PRV	03	If the Billing or Pay-to Provider is also the Rendering Provider and loop 2310B is not used, use this field to indicate which entity (Billing or Pay-to) is the Rendering Provider.
Billing Provider Name (Loop 2010AA)				
84	2010AA	REF	01	The Medicaid Provider Number is necessary to adjudicate the claim if the loop is applicable. Please use the qualifier **'1D'** to identify the Medicaid Provider Number.
84	2010AA	REF	02	The Billing Provider's Medicaid Identification Number is necessary to adjudicate the claim if the loop is applicable.
Pay-To Provider's Name (Loop 2010AB)				
95	2010AB	REF	01	The Medicaid Provider Number is necessary to adjudicate the claim if the loop is applicable. Please use the qualifier '**1D**' to identify the Medicaid Provider Number.

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
95	2010AB	REF	02	The Pay to Provider's Medicaid ID is necessary to adjudicate the claim if the loop is applicable.
Subscriber Name (Loop 2010BA)				
106	2010BA	NM1	09	For Medicaid purposes the subscriber is equal to the patient. The format for the Medicaid recipient ID is 14 characters. **First initial, Middle Initial**, *(if no middle initial use a dash)*, **birth date as MMDDYY**, **first five letters of last name** *(if last name less than five letters, space fill; if last name is a hyphenated last name the hyphen is included as one of the five characters, if last name includes an apostrophe, the apostrophe is included as one of the five characters;* **with a tiebreaker** (either alpha or numeric) as the as the final character. EXAMPLES: JD010301DOE A - Last name less than five characters N-020310CLINEA - No middle initial DL020301RUS-KA - Hyphenated last name NN020310O'LEA2 - Apostrophe last name AB010203EMANS1 - Numeric tiebreaker
Payer Name (Loop 2010BB)				
118	2010BB	NM1	08	Please use the qualifier '**PI**' to identify the Payer Identification Number.
118	2010BB	NM1	09	Please populate with Payer Identification Number. **77045**
Claim Information (Loop 2300)				
151	2300	CLM	01	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the provider.

*PAGE	LOOP	SEGMENT	DATA ELEMENT	COMMENTS
172	2300	PWK	06	Attachment Control Number Currently, all claims requiring attachments are submitted on paper. With the HIPAA implementation, the provider may submit the claim electronically and send the attachment separately. To facilitate the matching of the attachment to the claim, the pay-to provider ID, recipient ID, and date of service should be used as the attachment control number in the paperwork segment of the 837 transaction. To expedite the claim's adjudication, use this same control number on the Attachment Control Document.
185	2300	NTE	02	This field can be used at the provider's discretion. To facilitate the successful outcome of your claim, we will be reading this field for information required in various billing instructions and/or where state regulations mandate information that is not reported elsewhere within the claim data set. Please refer to your billing instructions and/or memorandums.
Referring Provider Name (Loop 2310A)				
326	2310A	REF	01	The Medicaid Provider Number is necessary to adjudicate the claim if the loop is applicable. Please use the qualifier **'1D'** to identify the Medicaid Provider Number.
327	2310A	REF	02	The Referring Provider's Medicaid ID Number is necessary to adjudicate the claim if the loop is applicable.

Rendering Provider Name (Loop 2310B)				
201	2310B	REF	01	The Medicaid Provider Number is necessary to adjudicate the claim if the loop is applicable. Please use the qualifier **'1D'** to identify the Medicaid Provider Number.
202	2310B	REF	02	The Rendering Provider Medicaid ID Number is necessary to adjudicate the claim if the loop is applicable.
Other Subscriber Information (Loop 2320)				
211	2320	SBR	09	Use Qualifier **CI** for Commercial Insurance
220 – 226	2320	AMT	02	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the provider.
Claim Level Adjustments (Loop 2320)				
216	2320	CAS	03-05	Adjustment Amount and Adjustment Reason Code
Coordination of Benefits (COB) Payer Paid Amount (Loop 2320)				
220	2320	AMT	02	Amount Paid by Third Party
Coordination of Benefits Approved Amount (Loop 2320)				
221	2320	AMT	02	Third Party Approved Amount
Coordination of Benefits Allowed Amount (Loop 2320)				
222	2320	AMT	02	Third Party Allowed Amount
Other Payer Name (Loop 2330B)				
240	2330B	NM1	03	Do not indicate "Medicaid" here. Only report information on other payers if known
Claim Adjudication Date (Loop 2330B)				
246	2330B	DTP	03	Date Paid by Third Party Payer

Line Counter (Loop 2400)				
268	2400	SV3	02	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the provider.
270	2400	SV3	06	If decimal or fractional units of service are submitted, the system will round the fraction. Claims submitted with units greater than 99,999 (i.e. larger than 5 digits) will be returned to the submitter
272	2400	TOO	02	32 teeth per line may be submitted. Units of service must reflect the correct number of procedures. Tooth characters and tooth numbers are submitted in the same field.
Date Appliance Placement (Loop 2400)				
277	2400	DTP	01	Appliance Placement Date
Line Adjudication Information (Loop 2430)				
302	2430	SVD	02	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the provider.
307	2430	CAS	03	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the provider.
308	2430	CAS	06	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the provider
309	2430	CAS	09	Claims submitted with amounts that are more than $9,999,999.99 will be returned to the provider.
Transaction Set Trailer (SE)				
503	Trailer	SE	01	Number of Included Segments.
503	Trailer	SE	02	Transaction Set Control Number.