WV Medicaid & CHIP

HIPAA Transaction
Standard Companion Guide

Refers to the Implementation Guides
Based on ASC X12N version 5010

837 Encounter Institutional Claims

December 2023

Preface

This Companion Guide to the 5010 standard that regulates the electronic transmission of certain health care transactions (X12) Type 3 Technical Reports (TR3) and associated errata adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with Gainwell Technologies. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

EDITOR'S NOTE
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Table of Contents

1. INTRODUCTION

This section describes how 5010 X12 Type 3 Technical Reports (TR3) adopted under the Health Insurance Portability and Accountability Act (HIPAA) will be detailed with the use of a table. The tables contain a row for each segment that Gainwell Technologies has something additional, over, and above, the information in the TR3s.

That information can:

- Limit the repeat of loops, or segments
- Limit the length of a simple data element
- Specify a sub-set of the TR3s internal code listings
- Clarify the use of loops, segments, composite, and simple data elements
- Any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Gainwell Technologies

In addition to the row for each segment, one or more additional rows are used to describe Gainwell Technologies' usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10 percent and notes or comment about the segment itself goes in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Gainwell Technologies.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and how to specify that only one code value is applicable.

SCOPE

This companion guide documents the transaction type listed below and further defines situational and required data elements that are used for processing claims for programs administered by West Virginia (WV) Medicaid. This document is not the complete Electronic Data Interchange (EDI) transaction format specifications. Refer to the ASC X12N Implementation Guides or 5010 TR3s (Technical Report Type 3) for information not supplied in this document, such as code lists, definitions, and edits.

- Health Care Claim: Institutional 005010X223 May 2006
- Health Care Claim: Institutional 005010X223A1 October 2007
- Health Care Claim: Institutional 005010X223A2 June 2010

OVERVIEW

Data elements, segments, and loops not included in this guide are not used for processing claims by WV Medicaid but will still be sent if the information is required for compliance with the ASC X12N version 5010A2 format.

REFERENCES

The ASC X12N Implementation Guides or 5010 TR3s are standards developed by the X12 committee and published by the Washington Publishing Company (WPC).

https://x12.org/index.php/products/technical-reports

ADDITIONAL INFORMATION

- Assumptions regarding the reader
  - The user is interested in reducing error, maximizing efficiency, and saving money.
  - WV Medicaid encourages all providers to receive and make use of the standard HIPAA 837 Healthcare Claim.
- Advantages / Benefits of EDI
  - The 837 Healthcare Claim allows for electronic submission of claims data sent to WV Medicaid using computer software.

2. GETTING STARTED

WORKING WITH GAINWELL TECHNOLOGIES

Visit http://www.wvmmis.com for information.

For any questions, or to begin testing, contact the Gainwell EDI Helpdesk at (888) 483-0793, select option 1 to enter the provider NPI or option 2 to enter the provider Medicaid ID then select option 6 for EDI, or email at edihelpdesk@gainwelltechnologies.com.

TRADING PARTNER REGISTRATION

A trading partner is defined as any entity with which Gainwell exchanges electronic data. The term electronic data is not limited to HIPAA X12 transactions. WV Medicaid's Healthcare Payer Administration Solution (Health PAS) system supports the following categories of trading partner:

- Provider
- Billing Agency
- Clearinghouse
- Health Plan

To obtain a trading partner ID visit http://www.wvmmis.com or contact (888)-483-0793, select option 1 to enter the provider NPI or option 2 to enter the provider Medicaid ID then select option 6 for EDI.

CERTIFICATION AND TESTING OVERVIEW

All trading partners must be authorized to submit production EDI transactions. Any trading partner may submit test EDI transactions. The Usage Indicator, element 15 of the Interchange Control Header (ISA) of an X12 file, indicates if a file is test or production. Authorization is granted on a per transaction basis. For example, a trading partner may be certified to submit 837P professional claims but not certified to submit 837I institutional claim files.

3. TESTING WITH THE PAYER

Trading partners must submit three test files of a particular transaction type, with a minimum of fifteen transactions within each file, and have no failures or rejections to become certified for production. Review the "EDI Certification Status" page of Health PAS-OnLine under the "Account Maintenance" menu option to verify when testing for a particular transaction has been completed.

The EDI Certification Status page is found by logging into the users trading partner account on the Health PAS-OnLine Website (www.wvmmis.com).

Detailed instructions for retrieving and interpreting HIPAA validation acknowledgments may be found in the Business Scenarios and Transmission Examples appendices found at the end of this companion guide.

4. CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

PROCESS FLOWS

The 837 Encounter Healthcare Claim Institutional transaction process flow is not available at this time and will be updated when mandated by Council for Affordable Quality Healthcare (CAQH) operating rules.

TRANSMISSION ADMINISTRATIVE PROCEDURES

Trading Partners and/or MCOs transmit 837 Encounter Healthcare Claim Institutional transaction files and retrieve acknowledgements and responses from their designated secured File Transfer Protocol (FTP) drop off/pickup location. Each MCO is assigned a specific day of the week/month when files will be retrieved for processing.

RE-TRANSMISSION PROCEDURE

The data element ISA13 – Interchange Control Number needs to be unique to each file and Trading Partner ID.

COMMUNICATION PROTOCOL SPECIFICATIONS

There are no mandated communication protocol specifications for 837 Encounter Healthcare Claim Institutional transactions.

PASSWORDS

Trading partners create their own password at time of registration and are required to update it every 60 days as per the Health PAS-OnLine requirements. Password must be at least eight (8) characters long, contain at least one (1) uppercase character and lowercase character, at least one (1) numeral, and at least one (1) special character such as # or * or ^ (except ,). Passwords must not start with the first three (3) characters of the Username and should not be the same as the previous 5 passwords.

5. CONTACT INFORMATION

GAINWELL EDI HELPDESK

Contact (888) 483-0793, select option 1 to enter the provider NPI or option 2 to enter the provider Medicaid ID then select option 6 for EDI, or email edihelpdesk@gainwelltechnologies.com.

EDI TECHNICAL ASSISTANCE

Contact (888) 483-0793, select option 1 to enter the provider NPI or option 2 to enter the provider Medicaid ID then select option 6 for EDI, or email edihelpdesk@gainwelltechnologies.com.

PROVIDER SERVICE NUMBER

Contact (888) 483-0793, select option 1 to enter the provider NPI or option 2 to enter the provider Medicaid ID then select the appropriate option or email wvmmis@gainwelltechnologies.com.

APPLICABLE WEBSITES/EMAIL

The following email addresses can be used in contacting WV Medicaid's EDI Support, Provider Services, and Provider Enrollment departments. These groups can provide assistance and answer questions relating to EDI file submissions, provider enrollment, and services.

Website: http://www.wvmmis.com

EDI Support: edihelpdesk@gainwelltechnologies.com

Provider Services: wvmmis@gainwelltechnologies.com

Provider Enrollment: wvproviderenrollment@gainwelltechnologies.com

6. CONTROL SEGMENTS/ENVELOPES

DELIMITERS

WV Medicaid does not require the use of specific values for the delimiters used in electronic transactions. The following suggested values are included in the specifications:

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	~	126	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

ISA-IEA

The following ISA/IEA fields are the sender and receiver specific information listed in the 837 Encounter Healthcare Claim Institutional transaction. For all other fields, refer to the transaction specific information table in section 10.

ISA06 – Interchange Sender ID will contain the Gainwell assigned trading partner ID.
ISA08 – Interchange Receiver ID will contain WV_MES_4_MMS_IG.
ISA13 – Sender generated Interchange Control Number. This number must be unique in each file submission and will match the number in IEA02.

GS-GE

The following GS/GE fields are the sender and receiver specific information listed in the 837 Encounter Healthcare Claim Institutional transaction. For all other fields, refer to the transaction specific information table in section 10.

GS02 – Interchange Sender ID will contain the Gainwell assigned trading partner ID.
GS03 – Interchange Receiver ID will contain WV_MES_4_MMS_IG.
GS06 – Sender generated Group Control Number and must match the number in GE02.

ST-SE

The following ST/SE fields are the sender and receiver specific information listed in the 837 Encounter Healthcare Claim Institutional transaction. For all other fields, see the transaction specific information table in section 10.

ST02 – Sender generated Transaction Set Control Number and must match the number in SE02.

For all other fields, refer to the transaction specific information table in section 10.

7. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

The following list is the transmission constraints associated with the submission of 837 Healthcare claim transactions:

1. Only one Interchange per transmission
2. Only one transaction type per interchange
3. Maximum of 5,000 claims per transmission
4. Single transmission file size must be less than five Megabits (Mb)

For Gainwell Technologies specific business rules and limitation in association with the ASC X12N 837 Encounter Claim transaction, refer to section 10.

8. ACKNOWLEDGEMENTS AND/OR REPORTS

The following acknowledgements and/or reports are related to the submission of EDI transactions by a trading partner. These acknowledgements and/or reports are downloaded via the Heath PAS-OnLine Web portal or through FTP for those providers that submit transactions from an FTP connection. Additional information about retrieving and interpreting acknowledgements and/or reports can be found in the Appendices.

REPORT INVENTORY

- TA1 – Interchange Acknowledgement. This acknowledgement is sent if requested by setting ISA14 to '1', or if ISA14 is set to '0' and there is an error that needs to be reported.
- 999 – Functional Acknowledgement. This acknowledgement file reports any errors found while checking compliance against TR3 specifications, or acceptance of an EDI transaction that meets the TR3 specifications for Strategic National Implementation Process (SNIP) levels 1and 2.
- 277 Claim Acknowledgement. This transaction is not mandated by HIPAA but will be used to report claims that have been accepted for adjudication as well as those that are not accepted due to compliancy errors when submitted through the 837 transaction.
- 824 Application Advice Report. This transaction is not mandated by HIPAA but will be used to report the results of data content edits of transaction sets. It is designed to report rejections based on business rules such as invalid diagnosis codes, invalid procedure codes, and invalid provider numbers. The 824 Application Advice report does not replace the 999 or TA1 transactions and will only be generated by Health PAS if there are errors within the transaction for SNIP level 3 through 7.

- BRR – Business Rejection Report. Health PAS also produces a readable version of the 824 called the Business Rejection Report (BRR). This report helps to facilitate the immediate correction and re-bill of claims rejected during HIPAA validation for SNIP levels 1 through 7.

9. TRADING PARTNER AGREEMENTS

TRADING PARTNERS

A trading partner is defined as any entity with which Gainwell exchanges electronic data. The term electronic data is not limited to HIPAA X12 transactions. WV Medicaid's Health PAS system supports the following categories of trading partner:

- Provider
- Billing Agency
- Clearinghouse
- Health Plan

Gainwell will assign trading partner IDs to support the exchange of X12 EDI transactions for providers, billing agencies and clearinghouses, and other health plans.

All trading partners must be authorized to submit production EDI transactions. Any trading partner may submit test EDI transactions. The Usage Indicator, element 15 of the ISA of an X12 file, indicates if a file is test or production. Authorization is granted on a per transaction basis. For example, a trading partner may be certified to submit 837P professional claims but not certified to submit 837I institutional claim files.

10. TRANSACTION SPECIFIC INFORMATION

Listed in the following table are the specific requirements for submitting and processing an ASC X12N 837 Encounter Institutional Claim transaction file to Gainwell Technologies.

Use these guidelines in conjunction with the official ASC X12N 837 TR3 document to submit 837 Healthcare Claim Institutional transaction files.

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
HEADER	ISA	Interchange Control Header	3	R	ISA
	ISA01	Authorization Information Qualifier	2	R	00
	ISA02	Authorization Information	10	R	Space fill
	ISA03	Security Information Qualifier	2	R	00
	ISA04	Security Information	10	R	Space fill
	ISA05	Interchange ID Qualifier	2	R	ZZ
	ISA06	Interchange Sender ID	15	R	Gainwell assigned trading partner ID + 3 spaces
	ISA07	Interchange ID Qualifier	2	R	ZZ
	ISA08	Interchange Receiver ID	15	R	WV_MES_4_MMS_IG
	ISA09	Interchange Date	6	R	YYMMDD
	ISA10	Interchange Time	4	R	HHMM
	ISA11	Interchange Control ID	1	R	^
	ISA12	Interchange Version Number	5	R	00501
	ISA13	Interchange Control Number	9	R	Must be identical to the interchange trailer IEA02 (defined by sending Trading Partner)
	ISA14	Ack. Requested	1	R	1
	ISA15	Usage Indicator	1	R	P or T
	ISA16	Component Element Separator	1	R	:
	GS	Functional Group Header	2	R	GS
	GS01	Functional Identifier Code	2	R	HC
	GS02	Application Sender's Code	2/15	R	Gainwell assigned trading partner ID

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	GS03	Application Receiver's Code	15	R	WV_MES_4_MMS_IG
	GS04	Date	8	R	CCYYMMDD
	GS05	Time	4/8	R	HHMM
	GS06	Group Control Number	1/9	R	Assigned by Sender
	GS07	Responsible Agency Code	1/2	R	X
	GS08	Version / Release Code	12	R	005010X223A2
	ST	Transaction Set Header	2	R	ST
	ST01	Transaction Set Identifier Code	3	R	837
	ST02	Transaction Set Control Number	4/9	R	Sequential number assigned by sender ST and SE must be equivalent
	ST03	Technical Report Type 3 Version Name	35	R	005010X223A2
	BHT	Beginning Hierarchical Transaction Segment	3	R	BHT
	BHT01	Hierarchical Structure Code	4	R	0019
	BHT02	Transaction Set Purpose Code	2	R	'00' Original
	BHT03	Reference identification	1/30	R	Submitter Transaction Identifier
	BHT04	Date	8	R	CCYYMMDD
	BHT05	Time	4/8	R	HHMM
	BHT06	Transaction Type Code	2	R	RP = Reporting (used for encounters)
1000A	NM1	Submitter Name	3	R	NM1
	NM101	Entity Identifier Code	2/3	R	41
	NM102	Entity Type Qualifier	1	R	1 or 2
	NM103	Name Last or Organization Name	1/60	R	
	NM104	Name First	1/35	S	Required when NM102 = 1 (person) and the person has a first name.
	NM105	Name Middle	1	S	Required when NM102 = 1 (person) and the middle name or initial of the person is needed to identify the individual.

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	NM108	Identification Code Qualifier	1/2	R	46
	NM109	Identification Code	2/80	R	Trading Partner ID ***Note:*** *This is a change from the FFS claims. Will need to put TP ID here in place of Tax-ID.*
1000A	PER	Submitter EDI Contact Information	3	R	PER
	PER01	Contact Function Code	2/2	R	IC
	PER02	Name	1/60	S	
	PER03	Communication Number Qualifier	2/2	R	TE = Telephone
	PER04	Communication Number	1/256	R	
1000B	NM1	Receiver Name	3	R	NM1
	NM101	Entity Identifier Code	2/3	R	40
	NM102	Entity Type Qualifier	1	R	2
	NM103	Name Last or Organization Name	60	R	WV_MES_4_MMS_IG
	NM108	Identification Code Qualifier	1/2	R	46
	NM109	Identification Code	80	R	WV_MES_4_MMS_IG
2000A	HL	Billing/Pay-to Provider Hierarchical Level	2	R	HL
	HL01	Hierarchical ID Number	1	R	1
	HL03	Hierarchical Level Code	1/2	R	20
	HL04	Hierarchical Child Code	1/1	R	1
2000A	PRV	Billing/Pay-to Provider Specialty Information	3	S	PRV Required when the payer's adjudication is known to be impacted by the provider taxonomy code.
	PRV01	Provider Code	1/3	R	BI = Billing
	PRV02	Reference Identification Qualifier	2/3	R	PXC
	PRV03	Reference Identification	1/50	R	Provider Taxonomy Code
2010AA	NM1	Billing Provider Name	3	R	NM1
	NM101	Entity Identifier Code	2/3	R	85

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	NM102	Entity Type Qualifier	1	R	2
	NM103	Name Last or Organization Name	1/60	R	
	NM108	Identification Code Qualifier	1/2	S	XX = National Provider ID (NPI) Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.
	NM109	Identification Code	2/80	S	NPI Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.
2010AA	N3	Billing Provider Address	2	R	N3
	N301	Address Information	1/55	R	
	N302	Address Information	1/55	S	Required when there is a second address line.
2010AA	N4	Billing Provider City/State/Zip Code	2	R	N4
	N401	City Name	2/30	R	
	N402	State or Province Code	2	S	Required when the address is in the United States of America, including its territories, or Canada
	N403	Postal Code	5/15	S	Required when the address is in the United States of America, including its territories, or Canada
2010AA	REF	Billing Provider Tax Identification	3	R	REF
	REF01	Reference Identification Qualifier	2/3	R	EI = Employer's Identification Number
	REF02	Reference Identification	1/50	R	
2000B	HL	Subscriber Hierarchical Level	2	R	HL
	HL01	Hierarchical ID Number	1	R	2
	HL02	Hierarchical Parent ID Number	1/12	R	
	HL03	Hierarchical Level Code	1/2	R	22 = Subscriber
	HL04	Hierarchical Child Code	1	R	0

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
2000B	SBR	Subscriber Information	3	R	SBR
	SBR01	Payer Responsibility Sequence Number Code	1	R	A - Payer Responsibility Four B - Payer Responsibility Five C - Payer Responsibility Six D - Payer Responsibility Seven E - Payer Responsibility Eight F - Payer Responsibility Nine G - Payer Responsibility Ten H - Payer Responsibility Eleven P - Primary S - Secondary T - Tertiary U - Unknown
	SBR02	Individual Relationship Code	2	S	18
	SBR03	Reference Identification	1/50	S	
	SBR04	Name	1/60	S	
	SBR09	Claim Filing Indicator Code	1/2	S	MC – Medicaid
2010BA	NM1	Subscriber Name	3	R	NM1
	NM101	Entity Identifier Code	2/3	R	IL
	NM102	Entity Type Qualifier	1	R	1 = Person
	NM103	Name Last or Organization Name	1/60	R	
	NM104	Name First	1/35	S	Required when NM102 = 1 (person) and the person has a first name.
	NM105	Name Middle	1/25	S	Required when NM102 = 1 (person) and the middle name or initial of the person is needed to identify the individual.
	NM107	Name Suffix	1/10	S	
	NM108	Identification Code Qualifier	1/2	R	MI **=** Member Identification Number

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	NM109	Identification Code	2/80	R	Enter the West Virginia Medicaid Identification number as it appears on the Medicaid Member's ID card (11 digits).
2010BA	N3	Subscriber Address	2	S	N3 Required when the patient is the subscriber or considered to be the subscriber
	N301	Address Information	1/55	R	
	N302	Address Information	1/55	S	Required if a second address line exists.
2010BA	N4	Subscriber City/State/Zip Code	2	R	N4
	N401	City Name	2/30	R	
	N402	State or Province Code	2	S	Required when the address is in the United States of America, including its territories, or Canada.
	N403	Postal Code	5/15	S	Required when the address is in the United States of America, including its territories, or Canada.
2010BA	DMG	Demographic Information	3	S	DMG Required when the patient is the subscriber or considered to be the subscriber.
	DMG01	Date Time Period Format Qualifier	2/3	R	D8
	DMG02	Date Time Period	1/35	R	Date of birth CCYYMMDD
	DMG03	Gender Code	1/1	R	M=Male F=Female U=Unknown
2010BB	NM1	Payer Name	3	R	NM1
	NM101	Entity Identifier Code	2/3	R	PR
	NM102	Entity Type Qualifier	1	R	2
	NM103	Name Last or Organization	1/60	R	WV_MES_4_MMS_IG
	NM108	Identification Code Qualifier	1/2	R	PI = Payer Identification
	NM109	Identification Code	2/80	R	WV_MES_4_MMS_IG
2010BB	REF	Billing Provider Secondary Identification	3	S	REF

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	REF01	Reference Identification Qualifier	2/3	R	G2
	REF02	Reference Identification	1/50	R	Provider Medicaid ID
2300	CLM	Claim Information	3	R	CLM
	CLM01	Claim Submitter's Identifier	(1/20)	R	Patient Account Number MCO to use reference number for identifying member.
	CLM02	Monetary Amount	1/18	R	Total Claim Charges
	CLM05-1	Facility Code Value	1/2	R	Facility Type Code
		Component Element Separator	1		:
	CLM05-2	Facility Code Qualifier	1/2	R	A
		Component Element Separator	1		:
	CLM05-3	Claim Frequency Type Code	1	R	Valid Codes: 0–9, A–M, O–Q, X–Z. Special instructions for frequency codes that will be used in adjustments: 7 – Replacement of prior claim. 8 – Void/Cancel of prior claim If codes 7 or 8 are used, then the original claim MUST be submitted in the 2300 – REF02. - REF*F8*12345678 * Note, frequency codes 7/8 cannot be used when the claim is originally submitted.
	CLM07	Provider Accept Assignment Code	1/1	R	
	CLM08	Yes/No Condition or Response Code	1	R	Y = YES
	CLM09	Release of Information Code	1	R	Y= YES
	CLM20	Delay Reason Code	1/2	S	
2300	DTP	Discharge Hour	3	S	DTP
	DTP01	Date/Time Qualifier	3	R	096 = Discharge (Required on all final inpatient claims)

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	DTP02	Date Time Period Format Qualifier	2/3	R	TM
	DTP03	Date Time Period	1/35	R	HHMM
2300	DTP	Statement Dates	3	R	DTP
	DTP01	Date/Time Qualifier	3	R	434 = Statement
	DTP02	Date Time Period Format Qualifier	2/3	R	RD8
	DTP03	Date Time Period	1/35	R	CCYYMMDD-CCYYMMDD *Note: Inpatient dates of service must reflect the date of admission through date of discharge unless claim is an interim bill. Acute care hospitals may not bill interim claims.*
2300	DTP	Admission Date/Hour	3	S	DTP
	DTP01	Date/Time Qualifier	3	R	435 = Admission (Required on all inpatient claims)
	DTP02	Date Time Period Format Qualifier	2/3	R	DT = CCYYMMDDHHMM
	DTP03	Date Time Period	1/35	R	Hours (HH) are expressed as "00" for midnight, "01" for 1A.M., and so on through "23" for 11 P.M. Minutes (MM) are expressed as "00" through "59". If the actual minutes are not known, use a default of "00". This is only required for original or final bills.
2300	CL1	Institutional Claim Code	3	R	CL1
	CL101	Priority (Type) of Admission or Visit	1	S	Admission Type Code Required when patient is being admitted for inpatient services
	CL102	Point of Origin for Admission or Visit	1	S	Admission Source Code Required for all inpatient and outpatient services.
	CL103	Patient Status Code	1/2	R	Patient Status Code
2300	CN1	Contract Information	3	R	

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	CN101	Contract Type Code	2/2	R	04 = Payment Indicator 05 = Capitated The value "05" (Capitated) is required on encounters when the service is provided by a sub-capitated provider.
	CN102	Monetary Amount	1/18	S	When CN101 = 4. Enter MCO paid amount. When CN101 = 5. Enter the "shadow price."
	CN104	Reference Identification	01/50	R	P = Paid R = Partially Paid D = Denied Required - Claims will reject if CN104 is missing. **Enter CN1*05*0*P to report capitated information and the payment indicator in the same segment.
2300	AMT	Patient Estimated Amount Due	3	S	Patient Co-Pay Amount *DO NOT Use for Nursing Facility Patient Liability deduction
	AMT01	Amount Qualifier Code	1/3	R	F3 = Patient Responsibility - Estimated
	AMT02	Monetary Amount	1/18	R	Patient Responsibility Amount Report any co-payment charged and collected by the MCO.
2300	REF	Original Reference Number (ICN/DCN)	3	S	REF
	REF01	Reference Identification Qualifier	2/3	R	9F = Referral
	REF02	Reference Identification	1/50	R	Original ICN
2300	REF	Prior Authorization	3	S	REF
	REF01	Reference Identification Qualifier	2/3	R	G1 = Prior Authorization Number
	REF02	Reference Identification	1/50	R	Assigned Prior Authorization Number
2300	REF	REF – Payer Claim Control Number	3	S	REF
	REF01	Reference Identification Qualifier	2/3	R	F8 = Original Reference Number
	REF02	Reference Identification	1/50	R	Payer Claim Control Number

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
					*This is the Claim number of the Original Claim ICN and is required when making adjustments.
2300	REF	Claim Identifier for Transmission Intermediaries	3	S	REF
	REF01	Reference Identification Qualifier	2/3	R	D9
	REF02	Reference Identification	1/20	R	Value Added Network Trace Number. ** This is where Gainwell is looking for the MCO Original Claim ID and it is required.
2300	REF	Medical Record Number	3	S	REF Required when the provider needs to identify for future inquiries, the actual medical record of the patient.
	REF01	Reference Identification Qualifier	2/3	R	EA = Medical Record Identification Number
	REF02	Reference Identification	1/50	R	Medical Record Number (MRN) MCOs use the Claim ID when the MRN is not available.
2300	HI	Principal Diagnosis	2	R	HI
	HI01-1	Code List Qualifier Code	1/3	R	ABK = ICD-10 Principal Diagnosis
		Component Element Separator	1		:
	HI01-2	Industry Code	1/30	R	Principal Diagnosis Code
	HI01-9	Yes/No Condition or Response Code	1	S	Present on Admission Indicator
2300	HI	Admitting Diagnosis	2	S	HI
	HI01-1	Code List Qualifier Code	1/3	S	ABJ = ICD-10 Admitting Diagnosis
		Component Element Separator	1		:
	HI01-2	Industry Code	1/30	R	Admitting Diagnosis Code
2300	HI	Patient's Reason For Visit	2	R	HI
	HI01-1	Code List Qualifier Code	1/3	S	APR = ICD-10 Patient's Reason for Visit
		Component Element Separator	1		:
	HI01-2	Industry Code	1/30	R	Patient Reason For Visit

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
2300	HI	External Cause Of Injury	2	S	HI Required when an external Cause of Injury is needed to describe an injury, poisoning, or adverse effect.
	HI01-1	Code List Qualifier Code	1/3	S	ABN = ICD-10 External Cause of Injury Code
		Component Element Separator	1		:
	HI01-2	Industry Code	1/30	R	External Cause of Injury Code
	HI01-9	Yes/No Condition or Response Code	1	S	Present on Admission Indicator
2300	HI	Diagnosis Related Group (DRG) Information	2	S	HI Required when an Inpatient Acute Care Hospital is under DRG contract with a payer and the contract requires the provider to identify the DRG to the payer.
	HI01-1	Code List Qualifier Code	2	R	DR = Diagnosis Related Group (DRG)
		Component Element Separator	1		:
	HI01-02	Industry Code	1/3	R	DRG Code
2300	HI	Other Diagnosis Information	2	S	HI Required when other condition(s) coexist or develop(s) subsequently during the patient's treatment.
	HI01-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI01-2	Industry Code	1/30	R	Other Diagnosis
	HI01-9	Yes/No Condition or Response Code	1	S	Present on Admission Indicator
		Component Element Separator	1		*
	HI02	Health Care Code Information		S	Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses.
	HI02-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	HI02-2	Industry Code	1/30	R	Other Diagnosis
	HI02-9	Yes/No Condition or Response Code	1	S	Present on Admission Indicator
		Component Element Separator	1		*
	HI03	Health Care Code Information		S	Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses.
	HI03-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI03-2	Industry Code	1/30	R	
	HI03-9	Yes/No Condition or Response Code	1	S	Present on Admission Indicator
		Component Element Separator	1		*
	HI04	Health Care Code Information		S	Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses.
	HI04-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI04-2	Industry Code	1/30	R	
	HI04-9	Yes/No Condition or Response Code	1	S	Present on Admission Indicator
		Component Element Separator	1		*
	HI05	Health Care Code Information		S	Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses.
	HI05-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI05-2	Industry Code	1/30	R	
	HI05-9	Yes/No Condition or Response Code	1	S	Present on Admission Indicator
		Component Element Separator	1		*

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	HI06	Health Care Code Information		S	Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses.
	HI06-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI06-2	Industry Code	1/30	R	
	HI06-9	Yes/No Condition or Response Code	1	S	Present on Admission Indicator
		Component Element Separator	1		*
	HI07	Health Care Code Information		S	Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses.
	HI07-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI07-2	Industry Code	1/30	R	
	HI07-9	Yes/No Condition or Response Code	1	S	Present on Admission Indicator
		Component Element Separator	1		*
	HI08	Health Care Code Information		S	Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses.
	HI08-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI08-2	Industry Code	1/30	R	
	HI08-9	Yes/No Condition or Response Code	1	S	Present on Admission Indicator
		Component Element Separator	1		*
	HI09	Health Care Code Information		S	Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses.
	HI09-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	HI09-2	Industry Code	1/30	R	
	HI09-9	Yes/No Condition or Response Code	1	S	Present on Admission Indicator
		Component Element Separator	1		*
	HI10	Health Care Code Information		S	Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses.
	HI10-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI10-2	Industry Code	1/30	R	
	HI10-9	Yes/No Condition or Response Code	1	S	Present on Admission Indicator
		Component Element Separator	1		*
	HI11	Health Care Code Information		S	Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses.
	HI11-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI11-2	Industry Code	1/30	R	
	HI11-9	Yes/No Condition or Response Code	1	S	Present on Admission Indicator
		Component Element Separator	1		*
	HI12	Health Care Code Information		S	Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses.
	HI12-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI12-2	Industry Code	1/30	R	
	HI12-9	Yes/No Condition or Response Code	1	S	Present on Admission Indicator
2300	HI	Principal Procedure Information	2	S	HI Required on inpatient claims when a procedure was performed.

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	HI01-1	Code List Qualifier Code	1/3	R	BBR = ICD-10 Principal Procedure Codes
		Component Element Separator	1		:
	HI01-2	Industry Code	1/30	R	Principal Procedure Code
		Component Element Separator	1		:
	HI01-3	Date Time Period Format Qualifier	2/3	R	D8
		Component Element Separator	1		:
	HI01-4	Date Time Period	1/35	R	Principal Procedure Date: CCYYMMDD
2300	HI	Other Procedure Information	2	S	HI Required on inpatient claims when additional procedures must be reported.
	HI01-1	Code List Qualifier Code	1/3	R	BBQ = ICD-10 Other Procedure Codes
		Component Element Separator	1		:
	HI01-2	Industry Code	1/30	R	Procedure Code
		Component Element Separator	1		:
	HI01-3	Date Time Period Format Qualifier	2/3	R	D8
		Component Element Separator	1		:
	HI01-4	Date Time Period	1/35	R	Procedure Date: CCYYMMDD
		Component Element Separator	1		*
	HI02	Health Care Code Information		S	Required when it is necessary to report an additional procedure and the preceding HI data elements have been used to report other procedures
	HI02-1	Code List Qualifier Code	1/3	R	BBQ = ICD-10 Other Procedure Codes
		Component Element Separator	1		:
	HI02-2	Industry Code	1/30	R	Procedure Code
		Component Element Separator	1		:
	HI02-3	Date Time Period Format Qualifier	2/3	R	D8
		Component Element Separator	1		:
	HI02-4	Date Time Period	1/35	R	CCYYMMDD

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
2300	HI	Occurrence Span Information	2	S	HI Required when there is an Occurrence Span Code that applies to this claim.
	HI01-1	Code List Qualifier Code	1/3	R	BI = Occurrence Span
		Component Element Separator	1		:
	HI01-2	Industry Code	1/30	R	Occurrence Span Code
		Component Element Separator	1		:
	HI01-3	Date Time Period Format Qualifier	2/3	R	RD8
		Component Element Separator	1		:
	HI01-4	Date Time Period	1/35	R	Occurrence Span Code Date: CCYYMMDD-CCYYMMDD
		Component Element Separator	1		*
	HI02	Health Care Code Information		S	Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes.
	HI02-1	Code List Qualifier Code	1/3	R	BI = Occurrence Span
		Component Element Separator	1		:
	HI02-2	Industry Code	1/30	R	Occurrence Span Code
		Component Element Separator	1		:
	HI02-3	Date Time Period Format Qualifier	2/3	R	RD8
		Component Element Separator	1		:
	HI02-4	Date Time Period	1/35	R	Occurrence Span Code Date: CCYYMMDD-CCYYMMDD
2300	HI	Occurrence Information	2	S	HI Required when there is an Occurrence Code that applies to this claim.
	HI01-1	Code List Qualifier Code	1/3	R	BH = Occurrence
		Component Element Separator	1		:

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	HI01-2	Industry Code	1/30	R	Occurrence Code
		Component Element Separator	1		:
	HI01-3	Date Time Period Format Qualifier	2/3	R	D8
		Component Element Separator	1		:
	HI01-4	Date Time Period	1/35	R	Occurrence Code Date CCYYMMDD-CCYYMMDD
		Component Element Separator	1		*
	HI02	Health Care Code Information		S	Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes
	HI02-1	Code List Qualifier Code	1/3	R	BH = Occurrence
		Component Element Separator	1		:
	HI02-2	Industry Code	1/30	R	Occurrence Code
		Component Element Separator	1		:
	HI02-3	Date Time Period Format Qualifier	2/3	R	D8
		Component Element Separator	1		:
	HI02-4	Date Time Period	1/35	R	Occurrence Code Date CCYYMMDD
2300	HI	Value Information	2	S	HI Required when there is a Value Code that applies to this claim.
	HI01-1	Code List Qualifier Code	1/3	R	BE = Value
		Component Element Separator	1		:
	HI01-2	Industry Code	1/30	R	Value Code
	HI01-5	Monetary Amount	1/18	R	Value Code Amount
		Component Element Separator	1		*

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	HI02	Health Care Code Information		S	Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes.
	HI02-1	Code List Qualifier Code	1/3	R	BE = Value
		Component Element Separator	1		:
	HI02-2	Industry Code	1/30	R	Value Code
	HI02-5	Monetary Amount	1/18	R	Value Code Amount
2300	HI	Condition Information	2	S	HI Required when there is a Condition Code that applies to this claim.
	HI01-1	Code List Qualifier Code	1/3	R	BG = Condition
		Component Element Separator	1		:
	HI01-2	Industry Code	1/30	R	Condition Code
		Component Element Separator	1		*
	HI02	Health Care Code Information		S	Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes.
	HI02-1	Code List Qualifier Code	1/3	R	BG = Condition
		Component Element Separator	1		:
	HI02-2	Industry Code	1/30	R	Condition Code
2310A	NM1	Attending Physician Name	3	S	NM1 Required when the claim contains any services other than non-scheduled transportation claims.
	NM101	Entity Identifier Code	2/3	R	71 = Attending Physician
	NM102	Entity Type Qualifier	1	R	1 = Person
	NM103	Name Last or Organization Name	1/60	R	Attending Provider Last Name
	NM104	Name First	1/35	S	Required when the person has a first name.
	NM105	Name Middle	1/25	S	
	NM107	Name Suffix	1/10	S	

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	NM108	Identification Code Qualifier	1/2	S	XX = National Provider ID (NPI) Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI
	NM109	Identification Code	2/80	S	NPI Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.
2310A	PRV	Attending Physician Specialty Information	3	S	PRV
	PRV01	Provider Code	1/3	R	AT = Attending
	PRV02	Reference Identification Qualifier	2/3	R	PXC = Health Care Provider Taxonomy Code
	PRV03	Reference Identification	1/50	R	Provider Taxonomy Code
2310B	NM1	Operating Physician Name	3	S	NM1 Required when a surgical procedure code is listed on this claim.
	NM101	Entity Identifier Code	2/3	R	72 = Operating Physician
	NM102	Entity Type Qualifier	1	R	1 = person
	NM103	Name Last or Organization Name	1/60	R	Operating Physician Last Name
	NM104	Name First	1/35	S	Required when the person has a first name.
	NM105	Name Middle	1/25	S	Required when the middle name or initial of the person is needed to identify the individual.
	NM107	Name Suffix	1/10	S	
	NM108	Identification Code Qualifier	2	S	XX = National Provider ID (NPI) Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.
	NM109	Identification Code	2/80	S	NPI

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
					Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI
2310C	NM1	Other Operating Physician Name	3	S	NM1 Required when another Operating Physician is involved.
	NM101	Entity Identifier Code	2/3	R	ZZ
	NM102	Entity Type Qualifier	1	R	1 = person
	NM103	Name Last or Organization Name	1/60	R	Other Operating Physician Last Name
	NM104	Name First	1/35	S	Required when the person has a first name.
	NM105	Name Middle	1/25	S	Required when the middle name or initial of the person is needed to identify the individual.
	NM107	Name Suffix	1/10	S	
	NM108	Identification Code Qualifier	1/2	S	XX=National Provider ID (NPI) Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.
	NM109	Identification Code	2/80	S	NPI Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.
2310E	NM1	Service Facility Location Name	3	S	NM1 Required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider).
	NM101	Entity Identifier Code	2/3	R	77 = Service Location
	NM102	Entity Type Qualifier	1	R	2 = Non-Person Entity
	NM103	Name Last or Organization Name	1/60	R	Laboratory or Facility Name

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	NM108	Identification Code Qualifier	1/2	S	XX=National Provider ID (NPI) Required when the service location to be identified has an NPI and is not a component or subpart of the Billing Provider entity
	NM109	Identification Code	2/80	S	NPI Required when the service location to be identified has an NPI and is not a component or subpart of the Billing Provider entity
2310E	N3	Service Facility Location Address		R	N3
	N301	Address Information	1/55	R	
	N302	Address Information	1/55	S	Required if a second address line exists.
2310E	N4	Service Facility City/State/Zip	2	R	N4
	N401	City	2/30	R	
	N402	State	2	S	Required when the address is in the United States of America, including its territories, or Canada.
	N403	Zip Code	3/15	S	ZIP Code must be the full 9 digits Required when the address is in the United States of America, including its territories, or Canada.
2310E	REF	Service Facility Secondary Identification	3	R	REF
	REF01	Reference Identification Qualifier	2/3	R	G2 = Facility ID Number Nursing Home based Hospice claim use only
	REF02	Reference Identification	1/50	R	Nursing Facility Provider Number
2320	SBR	Other Subscriber Information	3	S	SBR
	SBR01	Payer Responsibility Sequence Number Code	1	R	U = This is where Gainwell is looking for the MCO's payer sequence.
	SBR02	Individual Relationship Code	2	R	18
	SBR03	Reference Identification	1/50	S	Insured Group or Policy Number
	SBR04	Name	1/60	S	
	SBR09	Claim Filing Indicator Code	1/2	S	HM = Encounter Claims for MCO.

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
					** Note: This value can be used in any 2320 occurrence where SBR01 = 'U", and 2330B NM103 = MCO payer. Refer to 2330B for expected NM103 values.
2320	CAS	Claim Level Adjustments	3	S	CAS Required when the claim has been adjudicated by the payer identified in this loop, and the claim has claim level adjustment information.
	CAS01	Claim Adjustment Group Code	1/2	R	CO = Contractual Obligations CR = Correction and Reversals OA = Other Adjustments PI = Payor Initiated Reductions PR = Patient Responsibility
	CAS02	Claim Adjustment Reason Code	1/5	R	Use Valid Values, 1 = Deductible
	CAS03	Monetary Amount	1/18	R	Deductible Amount
	CAS04	Quantity	1/15	S	
	CAS05	Claim Adjustment Reason Code	1/5	S	Use Valid Values, 2 = Coinsurance
	CAS06	Monetary Amount	1/18	S	Coinsurance Amount
	CAS07	Quantity	1/15	S	
	CAS08	Claim Adjustment Reason Code	1/5	S	Use Valid Values, 122 = Psychiatric Reduction
	CAS09	Monetary Amount	1/18	S	Reduction Amount
	CAS10	Quantity	1/15	S	
2320	AMT	Coordination of Benefits (COB) Allowed Amount	3	S	AMT Required when the claim has been adjudicated by the payer identified in Loop ID-2330B of this loop
	AMT01	Amount Qualifier Code	1/3	R	D = Payor Amount Paid
	AMT02	Monetary Amount	1/18	R	Paid Amount ***Note:*** *If claim is denied, the AMT02 must be '0'.*
2320	AMT	Remaining Patient Liability	3	S	AMT
	AMT01	Amount Qualifier Code	1/3	R	EAF = Amount Owed

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	AMT02	Monetary Amount	1/18	R	Amount
2320	AMT	Coordination of Benefits (COB) Total Non-Covered Amount	3	S	AMT
	AMT01	Amount Qualifier Code	1/3	R	A8 = Non-covered Charges – Actual
	AMT02	Monetary Amount	1/18	R	Amount
2320	OI	Other Insurance Coverage Information	2	R	OI
	OI03	Yes/No Condition or Response Code	1	R	Y
	OI06	Release of Information Code	1	R	Y
2330A	NM1	Other Subscriber Name	3	R	NM1
	NM101	Entity Identifier Code	2/3	R	IL
	NM102	Entity Type Qualifier	1	R	1 = Person
	NM103	Name Last or Organization Name	1/60	R	Other Insured Last Name
	NM104	Name First	1/35	S	Required when NM102 = 1 (person) and the person has a first name.
	NM105	Name Middle	1/25	S	Required when NM102 = 1 (person) and the middle name or initial of the person is needed to identify the individual.
	NM108	Identification Code Qualifier	1/2	R	MI
	NM109	Identification Code	2/80	R	Member ID
2330B	NM1	Other Payer Name	3	R	NM1
	NM101	Entity Identifier Code	2/3	R	PR = Payer
	NM102	Entity Type Qualifier	1	R	2 = Non-Person Entity
	NM103	Name Last or Organization Name	1/60	R	MCO – Other Payer ** Note: Assigned Other Payer value MUST be used when reporting Other Payer. Carelink = 'Carelink' Unicare = 'Unicare5010' THP = 'The Health Plan' HHO = 'HHO'

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	NM108	Identification Code Qualifier	1/2	R	Payor Identification
	NM109	Identification Code ** Update ** In order to ensure that the MCO's other payers are recognized as the true 'MCO – Other payer' we needed to add a unique value to the NM109 to be used with the unique value in NM103	2/80	R	MCO – Other Payer ID ** Note: Assigned Other Payer ID MUST be used with the assigned NM103 value when reporting Other Payer information. Carelink = 'CARELINK5010' Unicare = 'UNICARE5010' THP = 'THP-7255334485' HHO = 'HHOWV
2330B	DTP	Claim Check or Remittance Date	3	S	DTP
	DTP01	Date/Time Qualifier	3	R	573 = Date Claim Paid
	DTP02	Date Time Period Format Qualifier	2/3	R	D8
	DTP03	Date Time Period	1/35	R	Other Insurance Paid Date CCYYMMDD
2400	LX	Service Line Number	2	R	LX
	LX01	Assigned Number	1/6	R	Service Line Counter
2400	SV2	Institutional Service Line	3	R	SV2
	SV201	Product/Service ID	1/48	R	Revenue Code
	SV202-1	Product/Service ID Qualifier	2	R	HC
		Component Element Separator	1		:
	SV202-2	Product/Service ID	1/48	R	Procedure Code
		Component Element Separator	1		:
	SV202-3	Procedure Modifier	2	S	Modifier
		Component Element Separator	1		:
	SV202-4	Procedure Modifier	2	S	Modifier
		Component Element Separator	1		:
	SV202-5	Procedure Modifier	2	S	Modifier
		Component Element Separator	1		:

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	SV202-6	Procedure Modifier	2	S	Modifier
	SV203	Monetary Amount	1/18	R	Line Item Charge Amount
	SV204	Unit or Basis for Measurement Code	2	R	DA = Days, UN = Unit
	SV205	Quantity	1/15	R	Service Unit Count
	SV207	Monetary Amount	1/18	S	Line Item Denied or Non-Covered Charge Amount
2400	DTP	Service Line Date	3	S	DTP Required on outpatient service lines where a drug is not being billed and the Statement Covers Period is greater than one day. OR Required on service lines where a drug is being billed and the payer's adjudication is known to be impacted by the drug duration or the date the prescription was written.
	DTP01	Date/Time Qualifier	3	R	472 = Service
	DTP02	Date Time Period Format Qualifier	2/3	R	D8 or RD8
	DTP03	Date Time Period	1/35	R	Service Date: CCYYMMDD or CCYYMMDD-CCYYMMDD
2410	LIN	Drug Identification	3	S	When billing a prescribed drug procedure code in Loop 2400, this Loop is required.
	LIN02	Product/Service ID Qualifier	2	R	N4 = National Drug Code in 5-4-2 Format
	LIN03	Product/Service ID	1/48	R	National Drug Code
2410	CTP	Drug Quantity	3	R	CTP
	CTP04	Quality	1/15	R	Drug Unit Count
	CTP05-1	Unit or Basis from Measure Code	2	R	Unit of Measure Code
2430	SVD	Line Adjudication Information	3	S	SVD
	SVD01	Identification Code	2/80	R	Other Payer Primary Identifier
	SVD02	Monetary Amount	1/18	R	Service Line Paid Amount ***Note****: If Claim is denied, the SVD02 must be '0'.*
	SVD03	Composite Medical Procedure Identifier		R	This element contains the procedure code that was used to pay this service line.

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
	SVD03-1	Product/Service ID Qualifier	2	R	HC
		Component Element Separator	1		:
	SVD03-2	Product/Service ID	1/48	R	Procedure Code
		Component Element Separator	1		:
	SVD03-3	Procedure Modifier	2	S	Modifier
		Component Element Separator	1		:
	SVD03-4	Procedure Modifier	2	S	Modifier
		Component Element Separator	1		:
	SVD03-5	Procedure Modifier	2	S	Modifier
		Component Element Separator	1		:
	SVD03-6	Procedure Modifier	2	S	Modifier
		Component Element Separator	1		:
	SVD03-7	Description	1/80	S	Procedure Code Description
	SVD05	Quantity	1/15	R	Paid Service Unit Count
2430	CAS	Line Adjustment	3	S	CAS
	CAS01	Claim Adjustment Group Code	1/2	R	CR = Correction and Reversals CO = Contractual Obligations OA = Other Adjustments PI = Payor Initiated Reductions PR = Patient Responsibility
	CAS02	Claim Adjustment Reason Code	1/5	R	1 – Deductible Amount 2 – Co-Insurance Amount 3 – Co-Payment 96 – Carrier Non-Covered Charges 122 – Psychiatric Reduction Enter value "1" to indicate Deductible Amount. Enter value "2" to indicate Co-Insurance Amount. Enter value "3" to indicate Co-Payment.

Loop	Segment	Segment Name/Data Element Name	Length	Req	Value
					Enter value "96" to indicate Carrier Non-Covered Charges. Enter value "122" to indicate Psychiatric Reduction.
	CAS03	Monetary Amount	1/18	R	Amount
	CAS04	Quantity	1/15	S	
	CAS05	Claim Adjustment Reason Code	1/5	S	
	CAS06	Monetary Amount	1/18	S	Amount
	CAS07	Quantity	1/15	S	
	CAS08	Claim Adjustment Reason Code	1/5	S	
	CAS09	Monetary Amount	1/18	S	
	CAS10	Quantity	1/15	S	
2430	DPT	Line Adjudication Date	3	R	DTP
	DPT01	Date/Time Qualifier	3/3	R	573 = Date Claim Paid
	DPT02	Date Format Qualifier	2/3	R	D8
	DPT03	Payment Date	35	R	Medicare Payment Date CCYYMMDD
TRAILER	SE	Transaction Set Trailer	2	R	SE
	SE01	Number of Included Segments	1/10	R	Transaction Segment Count
	SE02	Transaction Set Control Number	4/9	R	Must be identical to the value in ST02
	GE	Functional Group Trailer	2	R	GE
	GE01	Number of Transaction Sets Included	1/6	R	
	GE02	Group Control Number	1/9	R	Must be identical to the value in GS06
	IEA	Interchange Control Number	3	R	IEA
	IEA01	Number of Included Functional Groups	1/5	R	
	IEA02	Interchange Control Number	9	R	Must be identical to the value in ISA13

APPENDICES

1. Implementation Checklist

The Health PAS-Online Web portal user guides contain all necessary steps for going live with Gainwell Technologies in submitting specified EDI transactions, and receiving EDI responses, including the 5010 837. It also covers the following categories:

- Register for a Trading Partner ID
- Test with Gainwell Technologies

The user guides can be found at https://www.wvmmis.com/SitePages/User-Guides.aspx.

2. File Name Convention

Refer to the 5010 Technical Report Type 3 (TR3) for information not supplied in this document, such as code lists, definitions, and edits.

The naming standards for Medical/Institutional Files are as follows:

- MCO Submitter ID - Date - Transaction - Sequence Number
- Examples:
  - UNICARE5010-05102019-837I-001.edi
  - CARELINK5010-05102019-837I-001.edi
  - THP5010-05102019-837I-001.edi
  - HHO5010-05102019-837I-001.edi

The naming standards for Historical Files are as follows:

- MCO Submitter ID - Date - Transaction - Sequence Number - H(Historical)
- Examples:
  - UNICARE5010-05102019-837I-001-H.edi
  - CARELINK5010-05102019-837I-001-H.edi
  - THP5010-05102019-837I-001-H.edi
  - HHO5010-05102019-837I-001-H.edi

The naming standards for Pharmacy Files are listed here.

- MCO Name - Date – Point of Sale (POS) - Transaction - Paid/Denied - Sequence Number
- Examples:
  - UNICARE5010–POS-05102019-B1-Paid-001.edi
  - UNICARE5010-POS-05102019-B1-Denied-001.edi
  - CARELINK5010–POS-05102019-B1-Paid-001.edi
  - CARELINK5010-POS-05102019-B1-Denied-001.edi
  - THP5010–POS-05102019-B1-Paid-001.edi
  - THP5010-POS-05102019-B1-Denied-001.edi
  - HHO5010–POS-05102019-B1-Paid-001.edi
  - HHO5010-POS-01012015-B1-Denied-001.edi

Below are examples of how the Interchange Control Header/Functional Group Header (ISA/GS) lines should be reported in the files:

- ISA*00* *00* *ZZ*UNICARE5010 *ZZ*WV_MES_4_MMS_IG*190510*0929*<*0050 1*000000002*0*P*>
  GS*HC*UNICARE5010*WV_MES_4_MMS_IG*20190510*0928*2*X*005010X223A2~
- ISA*00* *00* *ZZ*CARELINK5010 *ZZ*WV_MES_4_MMS_IG*190510*0929*<*0050 1*000000002*0*P*>

GS*HC*CARELINK5010*WV_MES_4_MMS_IG*20190510*0928*2*X*005010X223A2~

- ISA*00* *00* *ZZ*THP5010 *ZZ*WV_MES_4_MMS_IG*190510*0929*<*00501*000000002*0*P*>
  GS*HC*THP5010*WV_MES_4_MMS_IG*20190510*0928*2*X*005010X223A2~
- ISA*00* *00* *ZZ*HHO5010 *ZZ*WV_MES_4_MMS_IG*190510*0929*<*00501*000000002*0*P*>
  GS*HC*HHO5010*WV_MES_4_MMS_IG*20190510*0928*2*X*005010X2232A2~

3. Business Scenarios

Retrieving Acknowledgements for X12 transactions submitted via secured FTP submission

Trading Partners who have submitted X12 transactions via Secured FTP may retrieve acknowledgements and responses from their designated secured FTP Pickup location. Any validation responses to the original submission (TA1, 999, 824, and BRR) will be based on the Gainwell internal file naming convention. The naming convention is as follows:

<Input Class>-<Sender ID>-<Receiver ID>-<Date: CCYYMMDD>-<Time: HHMMSS>-<File ID>-<Transaction Type>-<Usage: T for Test, P for Production>.edi

For example:

An inbound 837 Encounter Healthcare Claim Institutional file from Trading Partner ID *****5010, would be assigned an internal name of:

Encounter-*****5010-WV_MES_4_MMS_IG-20190510-112750-1367-005010X223A2-P.edi

The HIPAA validation acknowledgements would appear in this trading partner's FTP pickup location named:

Encounter-*****5010-WV_MES_4_MMS_IG-20190510-112750-1367-005010X223A2-P.edi-1367-TA1.edi

Encounter-*****5010-WV_MES_4_MMS_IG-20190510-112750-1367-005010X223A2-P.edi-1367-999.edi

Encounter-*****5010-WV_MES_4_MMS_IG-20190510-112750-1367-005010X223A2-P.edi-1367-824.edi

Encounter-*****5010-WV_MES_4_MMS_IG-20190510-112750-1367-005010X223A2-P.edi-1367-BRR.edi

4. Transmission Examples

TA1 Interchange Acknowledgement

The TA1 interchange acknowledgement is used to verify the syntactical accuracy of the envelope of the X12 interchange. The TA1 interchange will indicate that the file was successfully received; as well as indicate what errors existed within the envelope segments of the received X12 file.

The structure of a TA1 interchange acknowledgement depends on the structure of the envelope of the original EDI document. When the envelope of the EDI document does not contain an error then the interchange acknowledgement will contain the ISA, TA1, and IEA segments. The TA1 segment will have an Interchange Acknowledgement Code of 'A' (Accepted) followed by a three-digit code of '000' which indicates that there were not any errors.

If the EDI document contains an error at the interchange level, such as in the Interchange Control Header (ISA) segment or the Interchange control trailer (IEA), then the interchange acknowledgement will also only contain the ISA, TA1, and IEA segments. The TA1 segment will have an Interchange Acknowledgement Code of 'R' (Rejected) which will be followed by a three-digit number that corresponds to one of the following codes:

Code	Description
000	No error
001	The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment
002	This Standard as Noted in the Control Standards Identifier is Not Supported
003	This Version of the Controls is Not Supported
005	Invalid Interchange ID Qualifier for Sender
006	Invalid Interchange Sender ID
009	Unknown Interchange Receiver ID
010	Invalid Authorization Information Qualifier Value (ISA01 is not '00' or '03')
012	Invalid Security Information Qualifier Value
013	Invalid Security Information Value
018	Invalid Interchange Control Number Value
019	Invalid Acknowledgment Requested Value
020	Invalid Test Indicator Value
021	Invalid Number of Included Groups Value
023	Improper (Premature) End-of-File (Transmission)
024	Invalid Interchange Content (e.g., Invalid GS Segment)
025	Duplicate Interchange Control Number

999 Implementation Acknowledgement for Health Care Insurance

The ASC X12 999 transaction set is designed to report only on conformance against a Technical Report Type 3 line (TR3).

The 999 is not limited to only Implementation Guide (TR3) errors. It can report standard syntax errors, as well as Implementation Guide (TR3) errors.

The 999 cannot be used for any application level validations.

The ASC X12 999 transaction set is designed to respond to one and only one functional group e.g., GS/GE but will respond to all transaction sets e.g., ST/SE within that functional group.

This ASC X12 999 Implementation Acknowledgement cannot be used to respond to any management transaction sets intended for acknowledgements, e.g., TS 997 and 999, or interchange control segments related to acknowledgments, e.g., TA1 and TA3.

Each segment in a 999 functional acknowledgement plays a specific role in the transaction. For example, the AK1 segment starts the acknowledgement of a functional group. Each AKx segment has a separate set of associated error codes.

The 999 functional acknowledgements include but are not limited to, the following required segments:

- ST segment—Transaction Set Header
- AK1 - Functional Group Response Header
- AK2 - Transaction Set Response Header
- IK3 – Error Identification
- CTX – Segment Context
- CTX – Business Unit Identifier

- IK4 – Implementation Data Element Note
- CXT – Element Context
- IK5 – Transaction set response trailer
- AK9 - Functional Group Response Trailer
- SE -Transaction Set Trailer

For additional information regarding the 999 transaction, refer to the Implementation Acknowledgement Section of the ASC X12 Standards for EDI Technical Report Type 3 Technical Report Type 3 line for the transaction to submit.

824 Application Advice

This transaction is not mandated by HIPAA but will be used to report the results of data content edits of transaction sets. It is designed to report rejections based on business rules such as: invalid diagnosis codes, invalid procedure codes, and invalid provider numbers. The 824 Application Advice does not replace the 999 or TA1 transactions and will only be generated by Health PAS if there are errors within the transaction set.

The 824 acknowledgment is divided into two levels of segments: header and detail.

- The header level contains general information, such as the transaction set control reference number of the previously sent transaction, date, time, submitter, and receiver.
- The detail level reports the results of an application system's data content edits.

The 824 Application Advice includes, but is not limited to following segments and their roles:

Header Segments:

- ST segment—Transaction Set Header
- BGN segment—Beginning Segment
- N1 segment—Submitter Name
- N1 segment—Receiver Name

Detail Segments:

- OTI segment—Original Transaction Identification
- TED segment—Error or Informational Message Location
- RED segment—Error or Informational Message
- SE segment—Transaction Set Trailer

The Health PAS application outputs the following errors in the TED segment of the 824 Application Advice:

Code **TED01**	**Description** **TED02**
O	Missing or Invalid Issuer Identification
P	Missing or Invalid Item Quantity
Q	Missing or Invalid Item Identification
U	Missing or Unauthorized Transaction Type Code
006	Duplicate
007	Missing Data
008	Out of Range
009	Invalid Date
010	Total Out of Balance
011	Not Matching

Code TED01	Description TED02
012	Invalid Combination
024	Other Unlisted Reason
027	Customer Identification Number Does not Exist
815	Duplicate Batch
848	Incorrect Data
DTE	Incorrect Date
DUP	Duplicate Transaction
ICA	Invalid Claim Amount
IID	Invalid Identification Code
NAU	Not Authorized
UCN	Unknown Claim Number

Business Rejection Report

Health PAS also produces a readable version of the 824 called the Business Rejection Report. This report helps to facilitate the immediate correction and re-bill of claims rejected during HIPAA validation.

Claim File Submission Error Report

File Information:

Sender ID:	TradingPart5010	**Transaction Type:**	005010X222
Receiver ID:	TriZetto	**Usage Indicator:**	T
Date / Time:	031010 / 1647	**Transaction Control Number:**	001110933

Claim Information:

Billing Provider:	THE FINLEY HOSPITAL	**Claim Number:**	19824
Billing Provider Qualifier, ID:	XX, 1972601953	**Service Date:**	n/a
Billing Provider Secondary Qualifier, ID:	n/a	**Claim Charges:**	100
Subscriber:	JOHN, LAWRENCE	**Transaction Set:**	10093
Subscriber Qualifier, ID:	, QCSIQA000101634		

Transaction Error(s):

Error Number:	1
Error ID:	0x3939310
Error Summary:	Same value of Name should not be sent.
Error Message:	Element PER02 is used. It should not be used when name is the same as in segment NM1, loop 1000A. Segment PER is defined in the guideline at position 0450.
Data in Error:	jai
Error Location:	This error was detected at: Segment Count: 4 Element Count: 2 Character: 269 through 272

Error Number:	2
Error ID:	0x81004e
Error Summary:	A data element with 'Mandatory' status is missing.
Error Message:	Element CUR02 (Currency Code) is missing. This Element's standard option is 'Mandatory'. Segment CUR is defined in the guideline at position 0100.This Element was expected in: Segment Count: 7 Element Count: 2 Character: 337

5. Frequently Asked Questions

This appendix contains a compilation of questions and answers relative to Gainwell Technologies and its providers. Typical questions would involve a discussion about code sets and their effective dates. Refer to https://www.wvmmis.com/FAQs/Forms/AllPages.aspx for answers to frequently asked questions.

6. Change Summary

Version	Date	Author	Action/Summary of Changes
0.1	05/01/2014	Molina	Initial document
0.2	06/27/2014	Susan Savage-McGuckin	QA review of document
0.3	07/16/2014	Jeff Ruby	Added Most Common Rejections
0.4	08/05/2014	Jeff Ruby	Added Denied Claim logic 2320 & 2430 Loops.
0.5	10/08/2014	Susan Savage-McGuckin	QA review of document
0.6	11/01/2014	Jeff Ruby	Corrected SBR09 values in Loop 2000B and 2320.
0.7	01/22/2015	Stacy Zuber	Added file naming convention and updated claim adjustment information.
0.8	01/22/2015	Tawanda Warren	QA review of document
0.9	02/12/2015	Stacy Zuber	Added notes to REF segments in Loop 2300. REF – Payer Claim Control Number REF – Claim Identifier for Transmission Intermediaries
0.10	04/02/2015	Stacy Zuber	Updated requirements for 2320 SBR and 2330B REF segments.
0.11	04/16/2015	Stacy Zuber	Updated value for Unicare in 2330B from 'Unicare WV' to 'Unicare5010'
0.12	05/04/2015	Stacy Zuber	Updated requirements for 2330B NM109 – other payer ID values.
0.13	05/18/2015	Stacy Zuber	Corrected file naming standards in 1.4 Additional Information
0.14	09/15/2015	Jenny Jacobson	QA review of document
0.15	01/07/2016	Joseph White	Modified for CAQH formatting compliance and responded to State comments
0.16	01/07/2016	Lori Hoppe	QA review of document
0.17	01/15/2016	Joseph White	Updated document per State's comments.
0.18	01/15/2016	Jenny Jacobson	QA review of updates.
1.0	01/17/2016	Lori Hoppe	Updated to the approved version after BMS approval
1.1	07/07/2017	Katie Banks	Updated phone contacts, email addresses and changed formatting to match other Companion Guides.
1.2	07/25/2017	Kim Stoudenmire	QA review of document after updates
1.3	11/14/2018	Katie Banik	DXC Rebranding
1.4	11/15/2018	Tisjauna Palmer	QA review of rebranding updates
1.5	04/01/2019	Katie Banik	Per CR 26776, Updated Receiver ID from WV_MMIS_4MOLINA to WV_MMIS_4_DXCMS Updated table in section 10.

Version	Date	Author	Action/Summary of Changes
1.6	05/09/2019	Kim Stoudenmire	QA review of updates for CR 26776
1.7	07/20/2020	Katie Banik	Updated email address from @molinahealthcare.com to @dxc.com in section 2 & 5
1.8	07/29/2020	Tisjauna Palmer	QA review of updates due to CR 33538
1.9	10/07/2020	Katie Banik	Added note to Section 10 - 2300 REF EA: MCOs use the Claim ID when the MRN is not available per CR 27284
1.10	10/07/2020	Tisjauna Palmer	QA review of updates due to CR 27284
1.11	12/21/2020	Katie Banik	CR 34960 – Gainwell Rebranding Content Update Section 10– Added 2300 HI DRG and 2430 CAS02 Reason Codes
1.12	04/16/2021	Kim Stoudenmire	QA review for Gainwell Rebranding
1.13	05/21/2021	Katie Banik	Update Section 10 Require and Situational Indicators and field data, EDI contact option 6 and password requirements. Rebranded the filename.
1.14	05/26/2021	Kim Stoudenmire	QA review for updates in Section 10
1.15	06/11/2021	Katie Banik	Updated Section 10 - CL1 situational requirement notes and REF01 = D9 then REF02 is limited to 20 characters
1.16	02/07/2022	Kim Stoudenmire	QA of Gainwell rebranding and updated email address from @dxc.com to @gainwelltechnologies.com
1.17	03/23/2022	Katie Banik	Updated: TR3 Guide hyperlink Updated Section 10: Added: 2300 CN1 per CR 40383.
1.18	04/20/2022	Kim Stoudenmire	QA of updates for CR 40383
1.19	05/04/2022	Amy Kristic	CR 40468 Updated Receiver ID to WV_MES_4_MMS_IG from WV_MMIS_4_DXCMS.
1.20	05/09/2022	Kim Stoudenmire	QA of updates for CR 40468
1.21	12/15/2023	Katie Banik	CR 45955 Add CN104 Payment Indicator
1.22	12/15/2023	Kim Stoudenmire	QA of updates for CR 45955
1.23	01/16/2024	Armando Gurrola	WVDHHR to WVDoHS Rebranding (CR 46681)
1.24	01/31/2024	Kim Stoudenmire	QA of WVDHHR to WVDoHS Rebranding (CR 46681)
1.25	02/07/2024	Katie Banik	CR 49091 Add new MCO (HHO) Update CN1 segment
1.26	02/13/2024	Tisjauna Palmer	QA of updates for CR 49091