WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR
MEDICAL SERVICES

WV Medicaid & CHIP

HIPAA Transaction Standard Companion Guide

Refers to the Implementation Guides Based on ASC X12N version 5010

837 Encounter Professional Claims

April 2019

DXC.technology

Preface

This Companion Guide to the 5010 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 DXC Technology. 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 HIPAA will be detailed with the use of a table. The tables contain a row for each segment that DXC Technology 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 DXC Technology

In addition to the row for each segment, one or more additional rows are used to describe DXC Technology's 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% and notes or comments about the segment itself go 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 DXC Technology.
			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			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
231	2110C	EB13-1	Product/ Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also 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 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: Professional 005010X222 May 2006
- Health Care Claim: Professional 005010X222A1 October 2007
- Health Care Claim: Professional 005010X222A2 June 2010

OVERVIEW

Data elements, segments, and loops not included in this guide are not used for processing claims by West Virginia 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).

http://store.x12.org/store/healthcare-5010-consolidated-guides

ADDITIONAL INFORMATION

- Assumptions regarding the reader:
  - You are interested in reducing error, maximizing efficiency, and saving money.
  - West Virginia 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 West Virginia Medicaid using computer software.

2. GETTING STARTED

WORKING WITH DXC TECHNOLOGY

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

For any questions, or to begin testing, contact the DXC 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 4 for EDI, or email at edihelpdesk@molinahealthcare.com.

TRADING PARTNER REGISTRATION

A trading partner is defined as any entity with which DXC exchanges electronic data. The term electronic data is not limited to HIPAA X12 transactions. West Virginia Medicaid's 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 4 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 15 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 your 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 Appendices found at the end of this companion guide.

4. CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

PROCESS FLOWS

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

TRANSMISSION ADMINISTRATIVE PROCEDURES

Trading Partners and/or MCOs transmit 837 Encounter Healthcare Claim Professional transaction files may 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 the 837 Encounter Healthcare Claim Professional transactions.

PASSWORDS

Trading Partners create their own password at the time of registration and are required to update it every 60 days as per the Health PAS-OnLine requirements. Password must be at least seven (7) characters long, contain at least one (1) uppercase character, at least one (1) number, and at least one (1) special character.

5. CONTACT INFORMATION

DXC EDI HELP DESK

Contact (888) 483-0793, select option 1 to enter the provider NPI or option 2 to enter the provider Medicaid ID then select option 4 for EDI, or email edihelpdesk@molinahealthcare.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 4 for EDI, or email edihelpdesk@molinahealthcare.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@molinahealthcare.com

APPLICABLE WEBSITES/E-MAIL

The email addresses below can be used in contacting West Virginia Medicaid's EDI Support, Provider Services, and Provider Enrollment department. 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@molinahealthcare.com

Provider Services – wvmmis@molinahealthcare.com

Provider Enrollment – wvproviderenrollment@molinahealthcare.com

6. CONTROL SEGMENTS AND ENVELOPES

DELIMITERS

West Virginia Medicaid does not require the use of specific values for the delimiters used in electronic transactions. The suggested values are included in the specifications below.

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 Professional transaction. For all other fields, see the transaction specific information table in section 10.

ISA06 – Interchange Sender ID will contain the DXC assigned trading partner ID.
ISA08 – Interchange Receiver ID will contain WV_MMIS_4_DXCMS.
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 Professional transaction. For all other fields, see the transaction specific information table in section 10.

GS02 – Interchange Sender ID will contain the DXC assigned trading partner ID.
GS03 – Interchange Receiver ID will contain WV_MMIS_4_DXCMS.
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, see the transaction specific information table in section 10.

7. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

Listed below are the transmission constraints associated with the submission of the 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 5 MB

For DXC Technology specific business rules and limitation in association with the ASC X12N 837 Healthcare Claim transaction, refer to section 10.

8. ACKNOWLEDGEMENTS AND/OR REPORTS

The acknowledgements and/or reports listed below are related to the submission of EDI transactions by a trading partner. These acknowledgements and/or reports are downloaded via the Health 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 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 Strategic National Implementation Process (SNIP) levels 1 through 7.

9. TRADING PARTNER AGREEMENTS

TRADING PARTNERS

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

- Provider
- Billing Agency
- Clearinghouse
- Health Plan

DXC 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 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.

10. TRANSACTION SPECIFIC INFORMATION

Listed in the following table are the specific requirements for submitting and processing an ASC X12N 837 Encounter Healthcare Claim Professional transaction file to DXC Technology.

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

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	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	DXC assigned trading partner ID + 3 spaces
	ISA07	Interchange ID Qualifier	2	R	ZZ
	ISA08	Interchange Receiver ID	15	R	WV_MMIS_4_DXCMS
	ISA09	Interchange Date	6	R	YYMMDD
	ISA10	Interchange Time	4	R	HHMM
	ISA11	Repetition Separator	1	R	^
	ISA12	Interchange Version Number	5	R	00501
	ISA13	Interchange Control Number	9	R	Must be identical to the interchange trailer IEA02
	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

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
	GS01	Functional Identifier Code	2/15	R	HC
	GS02	Application Sender's Code	15	R	DXC assigned trading partner ID
	GS03	Application Receiver's Code	8	R	WV_MMIS_4_DXCMS
	GS04	Date	4/8	R	CCYYMMDD
	GS05	Time	1/9	R	HHMM
	GS06	Group Control Number	1/2	R	Assigned by Sender
	GS07	Responsible Agency Code	1/2	R	X
	GS08	Version / Release Code	2/15	R	005010X222A1
	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	Implementation Convention Reference	35	R	005010X222A1
	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 Transaction Set Creation Date
	BHT05	Time	4/8	R	HHMM Transaction Set Creation Time
	BHT06	Transaction Type Code	2	R	RP = Reporting (use for encounters)
1000A	NM1	Submitter Name	3	R	
	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	1/2	R	

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
	NM105	Name Middle	15	R	
	NM108	Identification Code Qualifier	1	R	46
	NM109	Identification Code	1/60	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	
	NM101	Entity Identifier Code	2/3	R	40
	NM102	Entity Type Qualifier	1	R	2
	NM103	Name Last or Organization Name	1/60	R	WV_MMIS_4_DXCMS
	NM104	Name First	1/2	R	
	NM105	Name Middle	15	R	
	NM108	Identification Code Qualifier	1	R	46
	NM109	Identification Code	1/60	R	WV_MMIS_4_DXCMS
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	N	PRV
	PRV01	Provider Code	1/3	N	BI = Billing
	PRV02	Reference Identification Qualifier	2/3	N	PXC
	PRV03	Reference Identification	1/50	N	Provider Taxonomy Code
2010AA	NM1	Billing Provider Name	3	R	NM1

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
	NM101	Entity Identifier Code	2/3	R	85
	NM102	Entity Type Qualifier	1/1	R	1 or 2
	NM103	Name Last or Organization Name	1/60	R	
	NM104	Name First	1/35	S	
	NM105	Middle Name	1/25	S	
	NM107	Name Suffix	1/10	S	
	NM108	Identification Code Qualifier	1/2	S	XX = National Provider ID (NPI)
	NM109	Identification Code	2/80	S	NPI
2010AA	N3	Billing Provider Address	2	R	N3
	N301	Address Information	1/55	R	
	N302	Address Information	1/55	S	Required if a second address line exists.
2010AA	N4	Billing Provider City/State/Zip Code	2	R	N4
	N401	City Name	2/30	R	
	N402	State or Province Code	2/2	R	
	N403	Postal Code	9	R	
2010AA	REF	Billing Provider Secondary Identification	3	R	
	REF01	Reference Identification Qualifier	2/3	R	EI = Employer's Identification Number
	REF02	Reference Identification	1/50	R	EIN
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
	HL04	Hierarchical Child Code	1/1	R	0
2000B	SBR	Subscriber Information	3	R	SBR
	SBR01	Payer Responsibility Sequence Number Code	1/1	R	A - Payer Responsibility Four B - Payer Responsibility Five C - Payer Responsibility Six

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
					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	2/2	S	
	SBR03	Reference Identification	1/50	S	
	SBR04	Name	1/60	S	
	SBR05	Insurance Type Code	1/3	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
	NM103	Name Last Organization	1/60	R	
	NM104	Name First	1/35	R	
	NM105	Name Middle	1/25	S	
	NM107	Name Suffix	1/10	S	
	NM108	Identification Code Qualifier	1/2	R	MI
	NM109	Identification Code	2/80	R	Enter the West Virginia Members Medicaid Identification number as it appears on their ID card. (11 digits).
2010BA	N3	Subscriber Address	2	R	N3
	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	S	N4

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
	N401	City Name	2/30	R	
	N402	State or Province Code	2/2	R	
	N403	Postal Code	5/9	R	
2010BA	DMG	Subscriber Demographic Information	3	R	DMG
	DMG01	Date Time Period Format Qualifier	2/3	R	D8
	DMG02	Date Time Period	1/35	R	CCYYMMDD Date of Birth
	DMG03	Gender Code	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_MMIS_4_DXCMS
	NM108	Identification Code Qualifier	1/2	R	PI = Payer Identification
	NM109	Identification Code	2/80	R	WV_MMIS_4_DXCMS
	REF	Billing Provider Secondary Identification	3	S	REF
	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	1/38	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	
		Component Element Separator	1		:
	CLM05-2	Facility Code Qualifier	1/2	R	B
		Component Element Separator	1		:

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
	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.
	CLM06	Yes/No Condition or Response Code	1	R	Y = Yes
	CLM07	Provider Accept Assignment Code	1	R	
	CLM08	Yes/No Condition or Response Code	1	R	Y = Yes
	CLM09	Release of Information Code	1	R	
	CLM10	Patient Signature Source Code	1	S	P
	CLM11	Related Causes Information		S	
	CLM11-1	Related Causes Code	2/3	R	AA = Auto Accident OA = Other Accident EM = Employment
		Component Element Separator	1		:
	CLM11-2	Related Causes Code	2/3	S	
		Component Element Separator	1		:
	CLM11-4	State or Province Code	2	S	Required if CLM11-1, CLM11-2, or CLM11-3 = AA to identify the state in which the automobile accident occurred. Use state code.
		Component Element Separator	1	S	:
	CLM11-5	Country Code	2/3	S	Required if the auto accident outside the U.S. to identify the country in which the accident occurred.
	CLM12	Special Program Code	2/3	S	

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
	CLM20	Delay Reason Code	1/2	S	
2300	DTP	Date – Onset of Current Illness/Symptom	3	S	DTP
	DTP01	Date/Time Qualifier	3	R	431
	DTP02	Date Time Period Format Qualifier	2/3	R	D8
	DTP03	Date Time Period	1/35	R	CCYYMMDD
2300	DTP	Date – Accident	3	S	DTP Required if CLM11-1 or CLM11-2 = AA or OA
	DTP01	Date/Time Qualifier	3	R	439
	DTP02	Date Time Period Format Qualifier	2/3	R	D8
	DTP03	Date Time Period	1/35	R	CCYYMMDD
2300	AMT	Patient Amount Paid	3	S	AMT
	AMT01	Amount Qualifier Code	1/3	R	F5
	AMT02	Monetary Amount	1/18	R	
2300	REF	Prior Authorization or Referral Number	3	S	REF
	REF01	Reference Identification Qualifier	2/3	R	9F = Referral Number
	REF02	Reference Identification	1/50	R	Assigned Referral Number
2300	REF	Prior Authorization or Referral Number	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 *This is the Claim number of the Original Claim ICN and is required when making adjustments.
2300	REF	REF – Claim Identifier for Transmission Intermediaries	3	S	REF
	REF01	Reference Identification Qualifier	2/3	R	D9

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
	REF02	Reference Identification	1/50	R	Value Added Network Trace Number. ** This is where DXC is looking for the MCO Original Claim ID and it is required.
2300	REF01	Reference Identification Qualifier	2/3	R	EA
	REF02	Reference Identification	1/50	R	Medical Record Identification Number. Not required for DXC
2300	HI	Health Care Diagnosis Code	2	S	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	Diagnosis Code Required on all claims. Transportation claims use 799.0 when unknown.
	HI02-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI02-2	Industry Code	1/30	R	Diagnosis Code
	HI03-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI03-2	Industry Code	1/30	R	Diagnosis Code
	HI04-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI04-2	Industry Code	1/30	R	Diagnosis Code
	HI05-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI05-2	Industry Code	1/30	R	Diagnosis Code
	HI06-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI06-2	Industry Code	1/30	R	Diagnosis Code
	HI07-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
		Component Element Separator	1		:
	HI07-2	Industry Code	1/30	R	Diagnosis Code
	HI08-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI08-2	Industry Code	1/30	R	Diagnosis Code
	HI09-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI09-2	Industry Code	1/30	R	Diagnosis Code
	HI10-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI10-2	Industry Code	1/30	R	Diagnosis Code
	HI11-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI11-2	Industry Code	1/30	R	Diagnosis Code
	HI12-1	Code List Qualifier Code	1/3	R	ABF = ICD-10 Diagnosis
		Component Element Separator	1		:
	HI12-2	Industry Code	1/30	R	Diagnosis Code
2310A	NM1	Referring Provider Name	3	S	NM1
	NM101	Entity Identifier Code	2/3	R	DN = Referring Provider
	NM102	Entity Type Qualifier	1	R	1
	NM103	Name Last or Organization Name	1/60	R	
	NM104	Name First	1/35	S	
	NM105	Middle Name	1/25	S	
	NM108	Identification Code Qualifier	1/2	S	XX = National Provider ID (NPI)
	NM109	Identification Code	2/80	S	NPI
2310A	REF	Referring Provider Secondary Identification	3	S	REF
	REF01	Reference Identification Qualifier	2/3	R	G2 = Provider Medicaid ID

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
	REF02	Reference Identification	1/50	R	Provider Medicaid ID
2310B	NM1	Rendering Provider Name	3	S	NM1
	NM101	Entity Identifier Code	2/3	R	82
	NM102	Entity Type Qualifier	1	R	1 or 2
	NM103	Name Last or Organization Name	1/60	R	
	NM104	Name First	1/35	S	
	NM105	Middle Name	1/25	S	
	NM108	Identification Code Qualifier	1/2	S	XX = National Provider ID (NPI)
	NM109	Identification Code	2/80	S	NPI
2310B	PRV	Rendering Provider Specialty Information	3	S	PRV
	PRV01	Provider Code	1/3	R	PE = Performing
	PRV02	Reference Identification Qualifier	2/3	R	PXC
	PRV03	Reference Identification	1/30	R	Provider Taxonomy Code
2310B	REF	Rendering Provider Secondary Identification	3	S	REF
	REF01	Reference Identification Qualifier	2/3	R	G2
	REF02	Reference Identification	1/30	R	Provider Medicaid ID
2310C	NM1	Service Facility Location	3	S	NM1
	NM101	Entity Identifier Code	2/3	R	77
	NM102	Entity Type Qualifier	1	R	2
	NM103	Name Last or Organization Name	1/60	S	
	NM108	Identification Code Qualifier	1/2	S	XX = National Provider Identifier
	NM109	Service Facility Location	2/80	S	NPI
2310C	N3	Service Facility Location Address	2	R	N3
	N301	Address Information	1/55	R	
	N302	Address Information	1/55		
2310C	N4	Service Location City/State/Zip	2	R	N4
	N401	City	2/30	R	

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
	N402	State	2	R	
	N403	Zip Code	3/15	R	
2310C	REF	Service Facility Secondary Identification	3	S	REF
	REF01	Reference Identification Qualifier	2/3	R	LU = Location Number
	REF02	Reference Identification	1/50	R	Service Location Identifier
2320	SBR	Other Subscriber Information	3	S	SBR
	SBR01	Payer Responsibility Sequence Number Code	1	R	U = This is where DXC is looking for the MCO.
	SBR02	Individual Relationship Code	2	R	18
	SBR03	Reference Identification	1/50	S	Insured Group or Policy Number
	SBR04	Name	1/60	S	
	SBR05	Insurance Type Code	1/3	S	
	SBR09	Claim Filing Indicator Code	1/2	S	HM = Encounter Claims for MCO. ** Note: This value can be used in any 2320 occurrence where SBR01 = 'U", and 2330B NM103 = MCO payer. See 2330B for expected NM103 values.
2320	CAS	Claim Level Adjustments	3	S	CAS
	CAS01	Claim Adjustment Group Code	1/5	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
	CAS03	Monetary Amount	1/18	R	Deductible Amount
	CAS04	Quantity	1/15	S	
	CAS05	Claim Adjustment Reason Code	1/5	S	2 = Coinsurance
	CAS06	Monetary Amount	1/18	S	Coinsurance Amount
	CAS07	Quantity	1/15	S	
	CAS08	Claim Adjustment Reason Code	1/5	S	

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
2320	AMT	Coordination of Benefits (COB) Allowed Amount	3	R	AMT
	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	OI	Other Insurance Coverage Information	2	S	OI
	OI03	Yes/No Condition or Response Code	1	R	Y
	OI04	Patient Signature Source Code	1	S	P
	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 or 2
	NM103	Name Last or Organization Name	1/60	R	
	NM104	Name First	1/35	S	
	NM105	Name Middle	1/25	S	
	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
	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' WVFHP = 'Health Plan WV'
	NM108	Identification Code Qualifier	1/2	R	PI

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
	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' WVFHP= 'FHP-OT01'
2330B	DTP	Claim Check or Remittance Date	3	S	DTP
	DTP01	Date/Time Qualifier	3	R	573 = Claim Paid Date
	DTP02	Date Time Period Format Qualifier	2/3	R	D8
	DTP03	Date Time Period	1/35	R	Paid Date CCYYMMDD
2400	LX	Service Line	2	R	
	LX01	Assigned Number	1/6	R	
2400	SV1	Professional Service	3	R	SV1
	SV101-1	Product/Service ID Qualifier	2	R	HC
		Component Element Separator	1		:
	SV101-2	Product/Service ID	1/48	R	Procedure Code
		Component Element Separator	1		:
	SV101-3	Procedure Modifier	2	S	Modifier
		Component Element Separator	1		:
	SV101-4	Procedure Modifier	2	S	Modifier
		Component Element Separator	1		:
	SV101-5	Procedure Modifier	2	S	Modifier
		Component Element Separator	1		:
	SV101-6	Procedure Modifier	2	S	Modifier
	SV101-7	Description	1/80	S	

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
	SV102	Monetary Amount	1/18	R	
	SV103	Unit or Base for Measurement Code	2	R	
	SV104	Quantity	1/15	R	
	SV105	Facility Code Value	1/2	R	
	SV107-1	Diagnosis Code Pointer	1/2	R	
		Component Element Separator	1		:
	SV107-2	Diagnosis Code Pointer	1/2	S	
		Component Element Separator	1		:
	SV107-3	Diagnosis Code Pointer	1/2	S	
		Component Element Separator	1		:
	SV107-4	Diagnosis Code Pointer	1/2	S	
	SV109	Yes/No Condition Response Code	1	S	Emergency Indicator
	SV111	Yes/No Condition Response Code	1	S	EPSDT Indicator
	SV112	Yes/No Condition Response Code	1	S	Family Planning Indicator
	SV115	Copay Status Code	1	S	
2400	CRC	Condition Indicator/Durable Medical Equipment	3	S	CRC
	CRC01	Code Category	2/2	R	09 = Durable Medical Equipment Certification
	CRC02	Certification Condition Code Applies Indicator	1	R	N or Y
	CRC03	Condition Indicator	2/2	R	38 = Certification signed by the physician is on file at the supplier's office ZV = Replacement Item
	CRC04	Condition Indicator	2/2	S	
2400	DTP	Date – Service Date	3	R	DTP
	DTP01	Date/Time Qualifier	3	R	472 = Service Date
	DTP02	Date Time Period Format Qualifier	2/3	R	D8 or RD8
	DTP03	Date Time Period	1/35	R	CCYYMMDD or CCYYMMDD-CCYYMMDD
2400	DTP	Date – Last Certification Date	3	S	DTP

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
	DTP01	Date/Time Qualifier	3	R	461
	DTP02	Date Time Period Format Qualifier	2/3	R	D8
	DTP03	Date Time Period	1/35	R	CCYYMMDD
2410	LIN	Drug Identification	3	S	LIN When billing a prescribed drug procedure code in Loop 2400, this Loop is required.
	LIN02	Product/Service ID Qualifier	2	R	N4
	LIN03	Product/Service ID	1/48	R	National Drug Code Only need a valid NDC code. ***Note:*** *There will not be any NDC/J-Code crosswalk enforcement.*
2410	CTP	Drug Pricing	3	R	CTP
	CTP04	Quantity	1/15	R	Drug Unit Count
	CTP05-1	Unit or Basis for Measurement Code	2	R	Unit of Measure Code
2420A	NM1	Rendering Provider Name	3	S	NM1
	NM101	Entity Identifier Code	2/3	R	82 = Rendering Provider
	NM102	Entity Type Qualifier	1	R	1 or 2
	NM103	Name Last or Organization Name	1/60	R	
	NM104	Name First	1/35	S	
	NM105	Name Middle	1/25	S	
	NM108	Identification Code Qualifier	1/2	R	XX = NPI
	NM109	Identification Code	2/80	R	NPI
2420A	PRV	Rendering Provider Specialty Information	3	S	PRV
	PRV01	Provider Code	1/3	R	PE = Performing
	PRV02	Reference Identification Qualifier	2/3	R	PXC
	PRV03	Reference Identification	1/30	R	Provider Taxonomy Code
2420A	REF	Rendering Provider Secondary Identification	3	S	REF
	REF01	Reference Identification Qualifier	2/3	R	G2
	REF02	Reference Identification	1/30	R	Provider Medicaid ID
2430	SVD	Line Adjudication Information	3	S	SVD

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
	SVD01	Identification Code	2/80	R	Valid Value
	SVD02	Monetary Amount	1/18	R	Service Line Paid Amount ***Note:*** *If Claim is denied, the SVD02 must be '0'.*
	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	
	SVD05	Quantity	1/15	R	Quantity/Units
2430	CAS	Line Adjustment	3	S	C Valid Value
	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
	CAS03	Monetary Amount	1/18	R	Deductible Amount
	CAS04	Quantity	1/15	S	
	CAS05	Claim Adjustment Reason Code	1/5	S	
	CAS06	Monetary Amount	1/18	S	Amount

Loop	Segment ID	Segment Name/Data Element Name	Length	Req Des.	Value
	CAS07	Quantity	1/15	S	
	CAS08	Claim Adjustment Reason Code	1/5	S	
	CAS09	Monetary Amount	1/18	S	
2430	DTP	Line Adjudication Date		R	DTP
	DTP01	Date/Time Qualifier	3/3	R	573 = Claim Paid Date
	DTP02	Date Format Qualifier	2/3	R	D8
	DTP03	Payment Date	8	R	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, contains all necessary steps for going live with DXC Technology 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 DXC Technology

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/Professional Files are as follows:

- MCO Submitter ID - Date - Transaction - Sequence Number
- Examples:
    - LGTC5010-05102019-837P-001.edi
    - UNICARE5010-05102019-837P-001.edi
    - CARELINK5010-05102019-837P-001.edi
    - THP5010-05102019-837P-001.edi
    - WVFHP5010-05102019-837P-001.edi

The naming standards for Historical Files are as follows:

- MCO Submitter ID - Date - Transaction - Sequence Number - H(Historical)
- Examples:
    - LGTC5010-05102019-837P-001-H.edi
    - UNICARE5010-05102019-837P-001-H.edi
    - CARELINK5010-05102019-837P-001-H.edi
    - THP5010-05102019-837P-001-H.edi
    - WVFHP5010-05102019-837P-001-H.edi

The naming standards for Pharmacy Files are as follows:

- MCO Name - Date - 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-0510201901012015-B1-Denied-001.edi
    - THP5010–POS-05102019-B1-Paid-001.edi
    - THP5010-POS-05102019-B1-Denied-001.edi
    - WVFHP5010–POS-05102019-B1-Paid-001.edi
    - WVFHP5010-POS-05102019-B1-Denied-001.edi

3. ISA/GS Segment Examples

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*LGTC5010 *ZZ*WV_MMIS_4_DXCMS*190510*0929*<*00501*000000002*0*P*>
  GS*GS*HC*LGTC5010*WV_MMIS_4_DXCMS*20190510*0928*2*X*005010X222A1~
- ISA*00* *00* *ZZ*UNICARE5010 *ZZ*WV_MMIS_4_DXCMS*190510*0929*<*00501*000000002*0*P*>
  GS*GS*HC*UNICARE5010*WV_MMIS_4_DXCMS*20190510*0928*2*X*005010X222A1~
- ISA*00* *00* *ZZ*CARELINK5010 *ZZ*WV_MMIS_4_DXCMS*190510*0929*<*00501*000000002*0*P*>
  GS*HC*CARELINK5010*WV_MMIS_4_DXCMS*20190510*0928*2*X*005010X222A1~
- ISA*00* *00* *ZZ*THP5010 *ZZ*WV_MMIS_4_DXCMS*190510*0929*<*00501*000000002*0*P*>
  GS*HC*THP5010*WV_MMIS_4_DXCMS*20150113*0928*2*X*005010X222A1~
- ISA*00* *00* *ZZ*WVFHP5010 *ZZ*WV_MMIS_4_DXCMS*190510*0929*<*00501*000000002*0*P*>
  GS*HC*WVFHP5010*WV_MMIS_4_DXCMS*20190510*0928*2*X*005010X222A1~

4. Business Scenarios

Retrieving Acknowledgements for X12 Transactions Submitted via Secured FTP submission

Trading Partners who have submitted X12 transactions via Secured File Transfer Protocol (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 DXC internal file naming convention. This 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 Professional file from Trading Partner ID *****5010, would be assigned an internal name of:

Encounter-*****5010-WV_MMIS_4_DXCMS-20190510-112750-1367-005010X222A1-P.edi

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

Encounter-*****5010-WV_MMIS_4_DXCMS-20190510-112750-1367-005010X222A1-P.edi-1367-TA1.edi

Encounter-*****5010-WV_MMIS_4_DXCMS-20190510-112750-1367-005010X222A1-P.edi-1367-999.edi

Encounter-*****5010-WV_MMIS_4_DXCMS-20190510-112750-1367-005010X222A1-P.edi-1367-824.edi

Encounter-*****5010-WV_MMIS_4_DXCMS-20190510-112750-1367-005010X222A1-P.edi-1367-BRR.edi

5. 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 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

Code	Description
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 3line (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 (i.e. GS/GE), but will respond to all transaction sets (i.e. 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, i.e. TS 997 and 999, or interchange control segments related to acknowledgments, i.e. 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, see the Implementation Acknowledgement Section of the ASC X12 Standards for EDI Technical Report Type 3 Technical Report Type 3 line for the transaction you are submitting.

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 output 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
012	Invalid Combination
024	Other Unlisted Reason
027	Customer Identification Number Does not Exist

Code TED01	Description TED02
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 (BRR). This report helps to facilitate the immediate correction and re-bill of claims rejected during HIPAA validation. See Sample Business Rejection Report (BRR) shown below.

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

6. Frequently Asked Questions

This appendix contains a compilation of questions and answers relative to DXC Technology and its providers. Typical questions would involve a discussion about code sets and their effective

dates. See https://www.wvmmis.com/FAQs/Forms/AllPages.aspx for answers to frequently asked questions.

7. 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	01/23/2015	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	01/06/2016	Joe White	Modified for CAQH formatting compliance and responded to State comments
0.16	01/08/2016	Jenny Jacobson	QA review of document
1.0	01/17/2016	Lori Hoppe	Updated to the approved version after BMS approval
1.1	11/14/2018	Katie Banik	DXC Rebranding
1.2	11/15/2018	Tisjauna Palmer	QA review of rebranding updates
1.3	05/01/2019	Katie Banik	Per CR 26776, Updated Receiver ID from WV_MMIS_4MOLINA to WV_MMIS_4_DXCMS. Updated table in section 10. Updated Contact Info
1.4	05/09/2019	Kim Stoudenmire	QA review of updates for CR26776