STATE of HAWAII
DEPARTMENT of HUMAN SERVICES
MED-QUEST DIVISION

Standard Companion Guide Transaction Information

Instructions related to the 837 Health Care Claim: Professional based on ASC X12 Technical Report Type 3 (TR3) Implementation Guide, version 005010A1 – Encounter Reporting

Instructions related to the 837 Health Care Claim: Institutional based on ASC X12 Technical Report Type 3 (TR3) Implementation Guide, version 005010A2 – Encounter Reporting

Companion Guide Version Number: 1.4
November 2015

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

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Transaction Instruction (TI)

1. TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carry provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

ASC X12 TR3 Implementation Guides can be obtained by visiting http://store.x12.org/store/.

2. Included ASC X12 Implementation Guides

Unique ID	Name
005010X222	Health Care Claim: Professional (837)
005010X223	Health Care Claim: Institutional (837)

3. Instruction Tables

3.1 837 Health Care Claim: Professional – Encounters

Loop ID	Reference	Name	Codes/Notes/Comments
			Glossary: **NOT USED BY MQD** - MQD does not use the segment or element for processing or updating of the adjudication system. The field may still be required by a Validator. - Follow TR3 guidelines.
			Blue = Header segments
			Light Blue = Billing Provider Detail Segments
			Green = Subscriber Detail Segments
			Yellow = Claim Level Segments
			Orange = Line Level Segments
			Bright Green = Specific guidance or use provided to Trading Partner (TP); included in Instruction Table of the Companion Guide (CG)
			Unless otherwise noted, these Notes apply to Paid and Denied encounter files as applicable.
___	**ISA**	**INTERCHANGE CONTROL HEADER**	
	ISA06	Interchange Sender ID	Expect HP Tax ID+6 spaces
	ISA08	Interchange Receiver ID	Expect MQD996001089
___	**GS**	**FUNCTIONAL GROUP HEADER**	
	GS02	Application Sender Code	Expect 6-character HP ID

Loop ID	Reference	Name	Codes/Notes/Comments
	GS03	Application Receiver Code	Expect MQD996001089 or MQDDENIED "MQD996001089"=Use for new day encounters (approved, replaced, voids) "MQDDENIED"=Use for Denied encounter files (.deny; input mode 6)
	GS08	Version Identifier Code	Expect 005010X222A1
___	**ST**	**TRANSACTION SET HEADER**	
	ST03	Implementation Convention Reference	Expect 005010X222A1
___	**BHT**	**BEGINNING OF HIERARCHICAL TRANSACTION**	
	BHT06	Claim or Encounter ID	Expect 'RP' Reporting
1000A	**NM1**	**SUBMITTER NAME**	
1000A	NM109	Submitter Identifier	Expect 6-character HP ID + 3-character TSN + Input Mode Input Mode: 2=Adjudicated/New Day Encounter 6=Denied (for use with .deny files) MQD notified plans of assigned TSNs to use Example: PLANID###2 For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01
1000A	**PER**	**SUBMITTER EDI CONTACT INFORMATION**	**2nd occurrence of PER segment is for BBA attestation**
1000A	PER01	Contact Function Code	Expect 'IC' Information Contact
1000A	PER02	Submitter Contact Name	NOT USED BY MQD
1000A	PER03	Communication Number Qualifier	Expect 'EM' Email
1000A	PER04	Communication Number	**BBA Attestation:** TOMYKNOWLEDGEINFORMATIONANDBELIEF THEDATAINTHISFILEISACCURATECOMPLETE ANDTRUE.CERTIFIER@PLAN.COM
1000A	PER05	Communication Number Qualifier	Expect 'FX' Fax
1000A	PER06	Communication Number	Expect Fax number
1000A	PER07	Communication Number Qualifier	Expect 'TE' Telephone
1000A	PER08	Communication Number	Expect Telephone number
1000B	**NM1**	**RECEIVER NAME**	
1000B	NM103	Receiver Name	Expect 'MED-QUEST'
1000B	NM109	Receiver Primary Identifier	Expect '996001089'
2000A	PRV03	Provider Taxonomy Code	Expect Billing Provider Taxonomy code
2010AA	**NM1**	**Billing Provider Name**	
2010AA	N403	Billing Provider Postal Zone or ZIP Code	Expect Billing Provider 9-digit Zip code Health plans are encouraged to submit the full 9-digit zip code; however, a value of '0000' or '9999' is acceptable until the actual zip+4 code is identified and reported on future encounter submissions.
2000B	**SBR**	**SUBSCRIBER INFORMATION**	
	SBR09	**Claim Filing Indicator Code**	**Expect 'MC' Medicaid**

Loop ID	Reference	Name	Codes/Notes/Comments
2010BA	**NM1**	**SUBSCRIBER NAME**	
2010BA	NM109	Subscriber Primary Identifier	Expect HAWI ID (10-digits)
2010BB	**NM1**	**PAYER NAME**	
2010BB	NM103	Payer Name	Expect 'MED-QUEST'
2010BB	NM108	Identification Code Qualifier	Expect PI
2010BB	NM109	Payer Identifier	Expect 996001089
2010BB	**REF**	**BILLING PROVIDER SECONDARY IDENTIFICATION**	This segment will only be used when the provider does not have an NPI - Atypical Provider.
2010BB	REF01	Reference Identification Qualifier	Expect "G2"
2010BB	REF02	Payer Additional Identifier	Expect 6-digit MQD Provider Registration ID + 2-digit location code when provider is not eligible for NPI
2300	**CLM**	**CLAIM INFORMATION**	
2300	CLM01	Patient Account Number	Expect Patient Account Number This value is not returned in the 277CA This value is returned in the 277U 2200D/TRN02 1st and 2nd occurrence
2300	CLM05-3	Claim Frequency Code	Expect Claim Frequency Code (1=Original, 7=Replacement, or 8=Void) *If value is '7' (Replacement of prior claim) or '8' (Void/Cancel prior claim) - Include Original MQD CRN in Claim Original Reference Number (element 2300-REF02) of segment Payer Claim Control Number
2300	**REF**	**PAYER CLAIM CONTROL NUMBER**	
2300	REF01	Reference Identification Qualifier	Expect 'F8'
2300	REF02	Claim Original Reference Number	Expect the first 12 digits of the CRN for Void/Replacement If submitting a void transaction, the MQD CRN of the encounter to be adjusted must be included in this field. MQD only accepts professional (837P) replacements or voids at the header, which replaces or voids all previously submitted lines associated with the first 12 digits of the CRN. When replacing or voiding at the header only the first 12 digits of the CRN (no line number) should be submitted. For replacements the encounter must reflect the plan's final disposition of all claim lines.
2300	**REF**	**CLAIM IDENTIFIER FOR TRANSMISSION INTERMEDIARIES**	Not required by MQD but can be used if the Health Plan chooses to send a secondary identifier to track the claim in the 277CA.
2300	REF01	Reference Identification Qualifier	Expect 'D9'
2300	REF02	Clearinghouse Trace Number	The value carried in this element is limited to a maximum of 20 positions. This value is returned in the 277CA 2200D/REF01*D9/REF02 Clearinghouse Trace number if the Health plan chooses to send a secondary identifier to track the claim in the 277CA.
2300	**REF**	**MEDICAL RECORD NUMBER**	

Loop ID	Reference	Name	Codes/Notes/Comments
2300	REF01	Reference Identification Qualifier	Expect 'EA'
2300	REF02	Medical Record Number	2300/REF*EA Medical Record number reported in 277U 2200D/REF*EA
2300	**CR1**	**AMBULANCE TRANSPORT INFORMATION**	
2300	CR105	Unit or Basis for Measurement Code	Expect 'DH' Or Default to 'DH' when CR104 is not known
2300	CR106	Transport Distance 9(4)	Expect Transport Distance Or Default to '0' when not known
2300	CR109	Round Trip Purpose Description	MQD Transportation services are separate legs and are not tracked for "round trip". Will leave open for usage as determined by the HP.
2300	**CRC**	**AMBULANCE CERTIFICATION**	Used when 2300/CR1 segment is sent and 2300/CLM05-1 = 41 or 42
2300	CRC01	Code Category	Default value '07' when not known
2300	CRC02	Certification Condition Indicator	Default value 'N' when not known
2300	CRC03	Condition Code	Default value '09' when not known
2310A	**REF**	**REFERRING PROVIDER SECONDARY IDENTIFICATION**	This segment will only be used when the provider does not have an NPI - Atypical Provider.
2310A	REF01	Reference Identification Qualifier	Expect "G2"
2310A	REF02	Referring Provider Secondary Identifier	Expect 6-digit MQD Provider Registration ID + 2-digit location code
2310B	**REF**	**RENDERING PROVIDER SECONDARY IDENTIFICATION**	This segment will only be used when the provider does not have an NPI - Atypical Provider.
2310B	REF01	Reference Identification Qualifier	Expect 'G2'
2310B	REF02	Rendering Provider Secondary Identifier	Expect 6-digit MQD Provider Registration ID + 2-digit location code
2310C	**N3**	**SERVICE FACILITY LOCATION ADDRESS**	**PO Box or Lock Box not allowed for the Service Facility Address** **Must supply the physical address information**
2310C	N301	Laboratory or Facility Address Line	Expect Laboratory or Facility Address Line **PO Box or Lock Box not allowed by MQD**
2310C	N403	Laboratory or Facility Postal Zone ZIP Code	Expect Laboratory or Facility 9-digit Zip code Health plans are encouraged to submit the full 9-digit zip code; however, a value of '0000' or '9999' is acceptable until the actual zip+4 code is identified and reported on future encounter submissions.
2310C	**REF**	**SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION**	This segment will only be used when the provider does not have an NPI - Atypical Provider.
2310C	REF01	Reference Identification Qualifier	Expect 'G2'
2310C	REF02	Laboratory or Facility Secondary Identifier	Expect 6-digit MQD Provider Registration ID + 2-digit location code
2310D	**REF**	**SUPERVISING PROVIDER SECONDARY IDENTIFIER**	This segment will only be used when the provider does not have an NPI - Atypical Provider.
2310D	REF01	Reference Identification Qualifier	Expect 'G2'

Loop ID	Reference	Name	Codes/Notes/Comments
2310D	REF02	Supervising Provider Secondary Identifier	Expect 6-digit MQD Provider Registration ID + 2-digit location code
2310E	**N3**	**AMBULANCE PICK UP LOCATION ADDRESS**	If the ambulance pickup location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, “crossroad of State Road 34 and 45” or “Exit near Mile marker 265 on Interstate 80”.)
2310E	N301	Ambulance Pick Up Address Line	PO Box address should not be used. Use physical pick up address.
2320	**SBR**	**OTHER SUBSCRIBER INFORMATION**	
2320	SBR09	Claim Filing Indicator Code	Expect 'CI', 'MA', 'MB', or 'MC'
2320	**AMT**	**COB PAYER PAID AMOUNT**	
2320	AMT02	Payer Paid Amount S9(7)V99	If 2320/SBR09 = ‘MC’, expect Health Plan Paid Amount
2330A	**NM1**	**OTHER SUBSCRIBER NAME**	
2330A	NM109	Other Insured Identifier	Expect Other Insured Identifier or HAWI ID
2330B	**NM1**	**OTHER PAYER NAME**	
2330B	NM108	Identification Code Qualifier	Expect 'PI'
2330B	NM109	Other Payer Primary Identifier	For Health plans, expect 6-character HP ID + 3-character TSN + 1-digit Input Mode For Medicare, expect 'MA' or 'MB' For TPL/Other Insurance, expect 'OI' For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01 Other Payer Primary Identifier cannot be more than 9 bytes and must be unique between payers
2330B	**REF**	**OTHER PAYER CLAIM CONTROL NUMBER**	
2330B	REF01	Reference Identification Qualifier	Expect 'F8'
2330B	REF02	Other Payer Claim Control Number	Expect Health Plan Claim ID When the Payer is the Health plan limited to 30 bytes This value is returned in the 277U 2200D/REF*1K 2nd occurrence This value is not returned in the 277CA
2400	**SV1**	**PROFESSIONAL SERVICE**	
2400	SV104	Service Unit Count	Expect Quantity MQD does not use decimals, only whole numbers
2400	SV107	COMPOSITE DIAGNOSIS CODE POINTER	Expect to have the alpha letters A-L from the CMS1500 form cross-walked to a numeric equivalent for use in the 837 Encounter. Per the TR3, the only acceptable values that can be used for a Diagnosis code pointer is 1-12.
2400	**CN1**	**CONTRACT INFORMATION**	
2400	CN102	Contract Amount	Expect Health plan Allowed amount Allowed Amount: What would have paid under FFS before other payer

Loop ID	Reference	Name	Codes/Notes/Comments
2410	**CTP**	**DRUG QUANTITY**	Part of Drug Rebate project
2410	CTP04	National Drug Unit Count	The maximum length allowed for a whole number is eight digits (99999999). When a decimal is used, the maximum number of digits allowed to the right of the decimal is three (99999999.999).
2430	**SVD**	**LINE ADJUDICATION INFORMATION**	MQD currently allows for one 2430 Loop per payer, per line.
2430	SVD01	Other Payer Primary Identifier	For Health plan, expect 6-character HP ID + 3-character TSN + Input Mode For Medicare, expect 'MA' or 'MB' For TPL/Other Insurance, expect 'OI' For Health Plans: 1000A/NM109=2330B/NM109=2430/SVD01
2430	**CAS**	**LINE ADJUSTMENT**	
2430	CAS03	Adjustment Amount	Net Allowed Amount (Approved Amount): Final value of the encounter if paid as FFS after all other payments have been considered Capitated = Amount Paid $0, use CAS*CO*24 segment FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported

3.2 837 Health Care Claim: Institutional - Encounters

Loop ID	Reference	Name	Codes/Notes/Comments
			Glossary: NOT USED BY MQD - MQD does not use the segment or element for processing or updating of the adjudication system. The field may still be required by a Validator. - Follow TR3 guidelines.
			Blue = Header segments
			Light Blue = Billing Provider & Pay To Segments
			Green = Subscriber & Payer Segments
			Yellow = Claim Level Segments
			Purple = Other Subscriber & Other Payer Segments
			Orange = Line Level Segments
			Bright Green = Specific guidance or use provided to Trading Partner (TP); included in Instruction Table of the Companion Guide (CG)
			Unless otherwise noted, these Notes apply to Paid and Denied encounter files as applicable.
___	**ISA**	**INTERCHANGE CONTROL HEADER**	
	ISA06	Interchange Sender ID	Expect HP Tax ID+6 spaces
	ISA08	Interchange Receiver ID	Expect MQD996001089
___	**GS**	**FUNCTIONAL GROUP HEADER**	
	GS02	Application Sender Code	Expect 6-character HP ID
	GS03	Application Receiver Code	Expect MQD996001089 or MQDDENIED "MQDDENIED"=Use for Denied encounter files (.deny; input mode 6) "MQD996001089"=Use for new day encounters (approved, replaced, voids)
	GS08	Version Identifier Code	Expect 005010X223A2
___	**ST**	**TRANSACTION SET HEADER**	
	ST03	Implementation Convention Reference	Expect 005010X223A2
___	**BHT**	**BEGINNING OF HIERARCHICAL TRANSACTION**	
	BHT06	Claim or Encounter ID	Expect 'RP' Reporting
1000A	**NM1**	**SUBMITTER NAME**	
1000A	NM109	Submitter Identifier	Expect 6-character HP ID + 3-character TSN + Input Mode Input Mode: 2=Adjudicated/New Day Encounter 6=Denied (for use with .deny files) MQD notified plans of assigned TSNs to use Example: PLANID###2 For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01

Loop ID	Reference	Name	Codes/Notes/Comments
1000A	**PER**	**SUBMITTER EDI CONTACT INFORMATION**	**2nd occurrence of PER segment is for BBA attestation**
1000A	PER03	Communication Number Qualifier	Expect 'EM' Email
1000A	PER04	Communication Number	**BBA Attestation:** TOMYKNOWLEDGEINFORMATIONANDBELIEF THEDATAINTHISFILEISACCURATECOMPLETE ANDTRUE.CERTIFIER@PLAN.COM
1000A	PER05	Communication Number Qualifier	Expect 'FX' Fax
1000A	PER06	Communication Number	Expect Fax number
1000A	PER07	Communication Number Qualifier	Expect 'TE' Telephone
1000A	PER08	Communication Number	Expect Telephone number
1000B	**NM1**	**RECEIVER NAME**	
1000B	NM103	Receiver Name	Expect 'MED-QUEST'
1000B	NM109	Receiver Primary Identifier	Expect '996001089'
2000B	**SBR**	**SUBSCRIBER INFORMATION**	
2000B	SBR09	Claim Filing Indicator Code	Expect 'MC' Medicaid
2010BA	**NM1**	**SUBSCRIBER NAME**	
2010BA	NM109	Subscriber Primary Identifier	Expect HAWI ID (10-digits)
2010BB	**NM1**	**PAYER NAME**	
2010BB	NM103	Payer Name	Expect 'MED-QUEST'
2010BB	NM108	Identification Code Qualifier	Expect "PI"
2010BB	NM109	Payer Identifier	Expect "996001089"
2010BB	**REF**	**BILLING PROVIDER SECONDARY IDENTIFICATION**	This segment will only be used when the provider does not have an NPI - Atypical Provider.
2010BB	REF01	Reference Identification Qualifier	Expect "G2"
2010BB	REF02	Payer Additional Identifier	Expect 6-digit MQD Provider Registration ID + 2-digit location code when provider is not eligible for NPI
2300	**CLM**	**CLAIM INFORMATION**	
2300	CLM01	Patient Control Number	Expect Patient Account Number This value is returned in the 277CA 2200D/TRN02 Patient Control number. This value is returned in the 277U 2200D/TRN02 1st and 2nd occurrence
2300	CLM05-1	Facility Type Code	The first and second positions of the Uniform Bill Type Code for Institutional Services
2300	CLM05-2	Facility Code Qualifier	Expect A
2300	CLM05-3	Claim Frequency Code	Expect Claim Frequency Code This is the third position of the Uniform Billing Claim Form Bill Type *If value is '7' (Replacement of prior claim) or '8' (Void/Cancel prior claim) - Include Original MQD CRN in Claim Original Reference Number (element 2300-REF02) of segment Payer Claim Control Number
2300	**CN1**	**CONTRACT INFORMATION**	
2300	CN102	Contract Amount	Expect Health plan approved amount

Loop ID	Reference	Name	Codes/Notes/Comments
2300	**REF**	**PAYER CLAIM CONTROL NUMBER**	Required when CLM05-3 (Claim Frequency Code) indicates this claim is a replacement or void to a previously adjudicated claim. Same for Header and Detail
2300	REF01	Reference Identification Qualifier	Expect 'F8'
2300	REF02	Claim Original Reference Number	Expect Original 12-digit CRN for Voids and Replacements
2300	**REF**	**CLAIM IDENTIFIER FOR TRANSMISSION INTERMEDIARIES**	Not required by MQD but can be used if the Health Plan chooses to send a secondary identifier to track the claim in the 277CA.
2300	REF01	Reference Identification Qualifier	Expect 'D9'
2300	REF02	Clearinghouse Trace Number	The value carried in this element is limited to a maximum of 20 positions. This value is returned in the 277CA 2200D/REF01*D9/REF02 Clearinghouse Trace number if the Health plan chooses to send a secondary identifier to track the claim in the 277CA.
2300	**REF**	**MEDICAL RECORD NUMBER**	
2300	REF01	Reference Identification Qualifier	Expect 'EA'
2300	REF02	Medical Record Number	2300/REF*EA Medical Record number reported in 277U 2200D/REF*EA
2300	**HI**	**VALUE INFORMATION**	2300/QTY*CD Coinsurance days (C3.COIN-DAY (MDC COIN DAY)) discontinued with v5010 and will be sent as Value code 82 per the UB04 manual. 2300/QTY*LA Lifetime Reserve days (C3.LTR-DAY) discontinued with v5010 and will be sent as a Value code 83 per the UB04 manual. 4/27/12 : Begin capturing value code '80' Covered Days (per the UB04 manual) from the 2300/HI Value information segment instead of the 2320/MIA segment that was previously determined.
2310A	**REF**	**ATTENDING PROVIDER SECONDARY IDENTIFICATION**	This segment will only be used when the provider does not have an NPI - Atypical Provider.
2310A	REF01	Reference Identification Qualifier	Expect "G2"
2310A	REF02	Secondary Identifier	Expect 6-digit MQD Provider Registration ID + 2-digit location code when provider is not eligible for NPI
2310D	**REF**	**RENDERING PHYSICIAN SECONDARY IDENTIFICATION**	This segment will only be used when the provider does not have an NPI - Atypical Provider.
2310D	REF01	Reference Identification Qualifier	Expect "G2"
2310D	REF02	Rendering Provider Secondary Identifier	Expect 6-digit MQD Provider Registration ID + 2-digit location code when provider is not eligible for NPI
2310E	**N3**	**SERVICE FACILITY LOCATION ADDRESS**	**PO Box or Lock Box not allowed for the Service Facility Address** **Must supply the physical address information**
2310E	N301	Laboratory or Facility Address Line	Expect Laboratory or Facility Address Line "PO Box" or "Lock Box" is not allowed
2320	**CAS**	**CLAIM LEVEL ADJUSTMENTS**	***CAS Adjustment Trios***

Loop ID	Reference	Name	Codes/Notes/Comments
2320	CAS03	Adjustment Amount	Expect Adjustment Amount CAS02='3' Copay (NO COPAY FOR MQD; COPAY-AMT=0) Net Allowed Amount (Approved Amount): Final value of the encounter if paid as FFS after all other payments have been considered Capitated = Amount Paid $0, use CAS*CO*24 segment FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported
2320	**SBR**	**OTHER SUBSCRIBER INFORMATION**	
2320	SBR09	Claim Filing Indicator Code	Expect 'CI', 'MA', 'MB', or 'MC'
2320	**AMT**	**COB PAYER PAID AMOUNT**	
2320	AMT02	Payer Paid Amount S9(7)V99	If 2320/SBR09 = 'MC', expect Health Plan Paid Amount
2330B	**NM1**	**OTHER PAYER NAME**	
2330B	NM108	Identification Code Qualifier	Expect PI
2330B	NM109	Other Payer Primary Identifier	For Health plans, expect 6-character HP ID + 3-character TSN + Input Mode For Medicare, expect 'MA' or 'MB' For TPL/Other Insurance, expect 'OI' For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01 Other Payer Primary Identifier cannot be more than 9 bytes and must be unique between payers
2330B	**REF**	**OTHER PAYER CLAIM CONTROL NUMBER**	
2330B	REF01	Reference Identification Qualifier	Expect 'F8'
2330B	REF02	Other Payer Claim Control Number	Expect Health Plan Claim ID When the Payer is the Health plan limited to 30 bytes This value is returned in the 277U 2200D/REF*1K 2nd occurrence This value is not returned in the 277CA
2400	**LX**	**SERVICE LINE**	**Currently only allows for 99 lines until a solution is identified to accept 999 lines. Claims with more than 99 lines must manually be split prior to submission.**
2410	**CTP**	**DRUG QUANTITY**	
2410	CTP04	National Drug Unit Count	The maximum length allowed for a whole number is eight digits (99999999). When a decimal is used, the maximum number of digits allowed to the right of the decimal is three (99999999.999).
2430	**SVD**	**LINE ADJUDICATION INFORMATION**	Currently only allow for one 2430 Loop per payer, per line.

Loop ID	Reference	Name	Codes/Notes/Comments
2430	SVD01	Other Payer Primary Identifier	For Health plan, expect 6-character HP ID + 3-character TSN + Input Mode For Medicare, expect 'MA' or 'MB' For TPL/Other Insurance, expect 'OI' For Health plans: 1000A/NM109=2330B/NM109=2430/SVD01

4. TI Additional Information

4.1 Acknowledgement Transactions

Each acknowledgement file has a specific purpose. Depending on the transaction and type of error, one or more of the following acknowledgements may be received. For example, an 837 submission would produce a 999 and a 277CA. It is also possible to receive an 824, 277CA as well as a TA1.

When an error is reported in any of these acknowledgement files, Trading Partners are expected to make the necessary corrections, re-increment the ISA Control Number (ISA13), re-validate using their organization's validation tool, and resubmit.

TA1 Interchange Acknowledgement Transactions
The TA1 Transaction is used to acknowledge receipt of file transmissions or interchanges of X12 Transactions and to notify the sender of problems in the ISA/IEA Interchange Envelope. This includes Trifecta errors (Invalid Test/Prod indicator, Invalid Sender, Duplicate ISA). **A TA1 acknowledgement file indicates that the submitted file was not forwarded to the mainframe for processing.**

999 Functional Acknowledgement Transactions
The 999 Transaction is used to acknowledge the GS/GE Functional Group within the interchange or to report on some types of syntactical errors (HIPAA Type 1 and 2 errors).

824 Implementation Guide Reporting Transactions
For transmissions that are valid on the interchange level, the translator edits transactions and uses 824 Implementation Guide Reporting Transactions to report problems (HIPAA Type 3-7 errors).

In addition to carrying error codes, the 824 Transaction shows the relative location of erroneous data structures with error position designators. For a large transaction, each of the generic edit code values can be repeated in many code to element combinations.

277CA Claims Acknowledgement
The 277CA is an acknowledgement to an 837 transaction at the pre-adjudication stage. This transaction identifies claims that are accepted or rejected for adjudication. A summary level as well as an individual claim level pre-adjudication status is included in the 277CA.

277U Unsolicited Claim Status Transactions
The 277U is used to inform the health plans of the statuses of the encounters that have been submitted to MQD, passed validation and were adjudicated in our mainframe.

Encounters that have been approved or pended as well as encounters denied by the health plan are included.

4.2 Other Resources

The following Websites provide information for where to obtain documentation for Medicare adopted EDI transactions, code sets and additional resources.

Resource	Web Address
ASC X12 TR3 Implementation Guides	http://store.x12.org
Washington Publishing Company Health Care Code Sets	http://www.wpc-edi.com/content/view/711/401/
To request changes to HIPAA adopted standards	http://www.hipaa-dsmo.org/

5. TI Change Summary

#	Location & Section	Revision
1.0	3 & 4	Final - Removed Transaction Notes per standard - Formatted Instruction Table per standard
1.1	3.1 & 3.2	2330B/NM109 Clarification – Other Payer Primary must be unique between payers
1.2	3.1 & 3.2	2410/CTP04 Clarification – format limited to 99999999.999 (8 whole numbers and 3 decimal) 2300/REF02 (‘F8’) Clarification – Expect Original 12-digit CRN for Voids and Replacements
1.3	4.1 & 4.2	Rename 4.1 to 4.2 Other Resources. Insert 4.1 Acknowledgement Transactions
1.4	3.1 & 3.2	Added 2000B/SBR09 to clarify that MQD always expects “MC” in this element. Added 2320/SBR to list the values that MQD expects. Added 2320/AMT02 to clarify that MQD expects the HP Paid Amt in this element when 2320/SBR = “MC”.