Arkansas Medicaid Enterprise

MMIS Core System and Services

835_Companion_Guide.docx

835 Health Care Claim: Payment/Advice

Companion Guide

X005010221A1

Version 2.0

Change History

Version #	Date of release	Author	Description of change
1.0	MM/DD/YYYY	EDI Technical Team	Initial document
2.0	10/4/2018	EDI Technical Team	Inserted sections Preface, Getting Started, Testing with the Payer, Connectivity with Payer Communications, Payer Specific Business Rules and Limitations and Transaction Specific Information

Preface

This companion guide to the Health Care Claim Payment/Advise ASC X12N/005010X221 and associated errata ASC X12N/005010X221 adopted under HIPAA clarifies and specifies the data content for electronic exchanges with Arkansas Medicaid. Transmissions based on this companion guide used in tandem with the Health Care Claim Payment/Advise ASC X12N/005010X221 are compliant with both ASC X12 syntax and the corresponding guides. This Companion Guide is intended to convey information that falls within the framework of the ASC X12N Technical Report Type 3 (TR3) adopted for use under HIPAA. This guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

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1 Introduction

This companion guide instructs users in registering and setting up compatible systems for Arkansas Medicaid claim status. Contact information and resources for the DXC EDI help desk are provided. The steps to register and prepare for testing software solutions and connectivity specifications are outlined in the following sections.

1.1 Scope

This document is a companion guide to the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Payment/Advice, ASC X12N 835 (005010X221A1). It is intended for vendors who design software or systems for receiving health care transactions electronically from Arkansas Medicaid. This document supplements, but does not supersede, requirements outlined in the ASC X12N Technical Report Type 3 (TR3).

The Health Insurance Portability and Accountability Act (HIPAA) requires Arkansas Medicaid and other covered entities to comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services. The ASC X12N TR3 was established as the standards of compliance. This companion guide provides the supplemental requirements specific to Arkansas Medicaid, as permitted within the 835 transaction set.

To develop and test a system for Arkansas Medicaid 835 transactions, follow both the 835 TR3 and this companion guide.

Arkansas currently supports 835 version 005010X221A1.

1.2 Overview

This section of the companion guide provides guidance for establishing a relationship with Arkansas Medicaid for the business purpose of submitting and receiving health care claim status inquiries and responses.

1.3 Updates

Changes to this guide are published on the Arkansas Medicaid website: https://medicaid.mmis.arkansas.gov/Provider/hipaa/compan.aspx.

1.4 Contact

See the Arkansas Medicaid website for contact information: https://medicaid.mmis.arkansas.gov/Provider/Provider.aspx.

1.5 Links

- HIPAA Implementation Guides: www.wpc-edi.com
- Federal Register Final Rules: https://federalregister.gov/a/2011-16834
- CAQH CORE: http://www.caqh.org/benefits.php
- New Submitter Registration: https://portal.mmis.arkansas.gov/armedicaid/provider/Home/tabid/135/Default.aspx
- Vendor Resources: https://medicaid.mmis.arkansas.gov/Provider/hipaa/compan.aspx
- Other Arkansas Medicaid companion guides: https://medicaid.mmis.arkansas.gov/Provider/hipaa/compan.aspx

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1.6 Conventions

Most of the companion guide is in table format (see example below). Only loops, elements, or segments with clarifications or comments are listed. For further information, please see the TR3 for each transaction.

Table 1: Conventions Sample

Loop ID – Loop Name	SEG	Element	Comments	Page
1000B – Payee Identification	N1	N102	Length = 35	73
		NM104	N103 = FI Length = 9	73

Table 2: Conventions Fields

Column Name	Description
Loop ID – Loop Name	Loop, header, or trailer.
SEG	Segment ID.
Element	Element ID. Always incorporates the segment ID.
Comments	Comments or clarifications for Arkansas Medicaid. Values, data length, and repeats are also listed here. Clarifications in field length only indicate what Arkansas Medicaid uses or returns to process the transaction. Arkansas Medicaid will still accept~~s~~ the minimum and maximum field lengths required by the Technical Report Type 3 (TR3) for each element.
Page	Page of the TR3 on which the loop, segment, or element is listed.

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2 Getting Started

2.1 Working with Arkansas Medicaid

Contact the DXC Electronic Data Interchange (EDI) help desk assistance with electronic file submission and retrieval.

DXC EDI help desk:
In-State Toll Free: 1-800-457-4454
Local and Out-of-State: 501-376-2211
Email: ARKEDI@dxc.com

2.2 Trading Partner Registration

Vendors and providers must have a Trading Partner ID and password obtained via the enrollment process on the HealthCare Provider Portal to submit electronic batch EDI X12N transactions.

To register for a production Trading Partner ID, visit the Arkansas Medicaid website: https://portal.mmis.arkansas.gov/armedicaid/provider/Home/tabid/135/Default.aspx.

2.3 Certification and Testing Overview

2.3.1 Compliance Testing

Not applicable

2.3.2 Full-cycle Testing

Full-cycle testing processes the submitted X12N transactions through the Arkansas Medicaid system. Although test claims will not be processed for payment, they will be validated against production files so they must contain valid patient, procedure, diagnosis, and provider information. We recommend that test health care claim payment/advice be processed on previous 837 testing submissions.

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3 Testing with the Payer

3.1 Compliance Testing

3.1.1 Testing Environment

The following table describes the environment and access information necessary for compliance testing.

WebBBS File Transfer System	See the Web Batch Submission Instructions manual.
Test Bed Data	Not required.
Required Fields	Use the instructions in the National Electronic Data Interchange Transaction Set Implementation Guide and the appropriate Arkansas Medicaid transaction companion guide section 7.

3.1.2 Testing Process

- Log on using your test Trading Partner ID and password.
- Download your 835 transaction(s) using the Web Batch Submission Instructions manual.

3.2 Full-cycle Testing

During full-cycle testing, an 835 transaction is provided as a result of a weekly financial cycle.

3.2.1 Testing Environment

The following table lists the environment and access information necessary for full-cycle testing.

WebBBS File Transfer System	See the Web Batch Submission Instructions manual.
Test Bed Data	Not required.
Required Fields	Use the required fields identified in the National Electronic Data Interchange Transaction Set Implementation Guide and the appropriate Arkansas Medicaid transaction companion guide section 7.

3.2.2 Testing Process

- Log on using your test Trading Partner ID and password.

Download your 835 transaction(s) using the Web Batch Submission Instructions manual.

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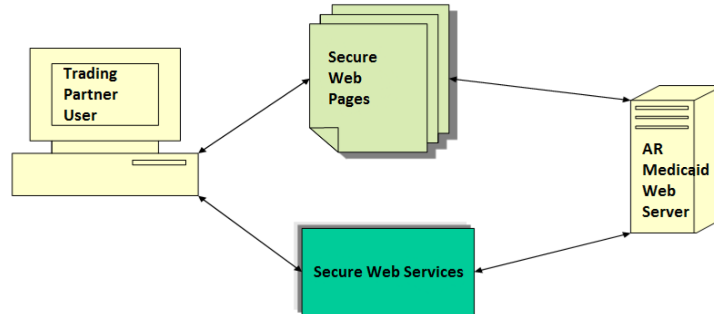
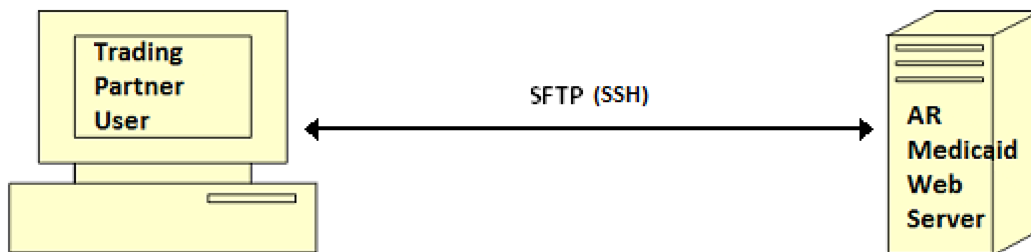
4 Connectivity with Payer Communications

4.1 Process Flows

The web interface is comprised of two independent HTTP/S application interfaces; a website that supports only batch ASC X12 transaction and a CAQH CORE Safe harbor interface capable of accepting both real-time and batch transactions. A diagram of the interaction flow is below.



The SFTP interface supports batch file uploads and downloads only. Users may use SFTP (SSH) clients such as Filezilla, Putty, and WS_FTP Pro to transfer files or develop software that will logon and transfer files programmatically using SSH protocol. Complete specifications for such software can be found in this document under the SFTP specification sections.



4.2 Transmission and Re-transmission Procedures

For information regarding transmission and re-transmission procedures, see the Web BBS documentation: https://medicaid.mmis.arkansas.gov/download/provider/hipaa/bbs.doc

4.3 Communication Protocol Specifications

For communication protocol specifications, see the Web BBS documentation: https://medicaid.mmis.arkansas.gov/download/provider/hipaa/bbs.doc

4.4 Passwords

For information regarding passwords, see the Web BBS documentation: https://medicaid.mmis.arkansas.gov/download/provider/hipaa/bbs.doc

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5 Payer Specific Business Rules and Limitations

Specific business rules and limitations for Arkansas Medicaid can be found in the provider manuals on the Arkansas Medicaid website: https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx

The manuals provide detailed information regarding billing for specific services and provider types and payer-specific editing and auditing.

5.1 Acknowledgements and Reports

Not applicable

5.2 Trading Partner Agreements

An EDI Trading Partner is defined as any Arkansas Medicaid customer (provider, billing service, software vendor, employer group, financial institution, etc.) who transmits to or receives electronic data from Arkansas Medicaid.

Other than the trading partner registration process outlined in the “Trading Partner Registration” section of this document, there are no additional agreements made by a trading partner of Arkansas Medicaid.

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6 Transaction-specific Information

The ASC X12N TR3 adopted under HIPAA is laid out using tables. The tables contain a row for each segment that requires additional information for compliance with Arkansas Medicaid. That information might:

1. Limit the repeat of loops or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite, and simple data elements
5. Be tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Arkansas Medicaid

In addition to the row for each segment, additional rows describe Arkansas Medicaid usage for composite and simple data elements and for any other necessary information, including transaction-specific details.

Notes and comments are placed at the deepest level of detail. For example, a note about a code value is placed on a row specifically for that code value, not in a general note about the segment.

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7 Transaction 835, Health Care Claim: Payment/Advice

Table 3: 835 Conventions

Loop ID – Loop Name	SEG	Element	Comments	Page
ISA – Interchange Control Header				
ISA – Interchange Control Header	ISA	ISA05	Value = 30	C.4
		ISA06	Value = 716007869	C.4
		ISA07	Value = ZZ	C.5
		ISA08	Value = Trading Partner ID	C.5
GS – Functional Group Header				
GS – Functional Group Header	GS	GS02	Value = same as ISA06	C.7
		GS03	Value = same as ISA08	C.7.
BPR – Financial Information				
BPR – Financial Information	BPR	BPR01	Value = I	70
		BPR02	Length = 10	71
		BPR03	Value = C	71
		BPR04	Value = ACH or CHK	72
		BPR05	When BPR04 = ACH Value = CCP	72
		BPR06	When BPR04 = ACH Value = 01	73
		BPR07	When BPR04 = ACH Value = 051000017	73
		BPR08	When BPR04 = ACH Value = DA	74
		BPR12	When BPR04 = ACH Value = 01	75
		BPR13	When BPR04 = ACH Length = 9	75
		BPR14	When BPR04 = ACH Length = 2	76
		BPR15	When BPR04 = ACH Length = 17	76
	TRN	TRN02	Length = 9	77
1000A – Payer Identification				
1000A – Payer Identification	N1	N101	Value = PR	87
1000B – Payee Identification				
1000B – Payee Identification	N1	N101	Value = PE	
		N104	If N103 = FI , length = 9 (SSN or EIN) If N103 = XX, length = 10 (NPI)	103

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Loop ID – Loop Name	SEG	Element	Comments	Page
	REF	REF02	REF01 = PQ, length = 9 (Medicaid Provider ID) REF01 = TJ, length = 10 (SSN or EIN)	107
2100 – Claim Payment Information				
2100 – Claim Payment Information	CLP	CLP01	Maximum length of 38 is supported. The 837 TR3s for CLM01 have that maximum of 20 characters will be supported, AR MMIS does store up to the maximum length of 38 if present for a claim.	123
		CLP03	Length = 9	125
		CLP04	Length = 9	125
		CLP05	Length = 9	125
		CLP07	Length = 13	127
	NM1	NM101	Value = QC Patient Name	137
		NM109	NM108 = MR Value = Recipient's Medicaid ID Length = 10	139
	NM1	NM101	Value = 74 Corrected Insured	143
	REF	REF02	Other Claim Related Identification If REF01 = G1 (Prior Authorization Number), Length = 10 If REF01 = F8 (Original Reference Number), Length = 13 If REF01 = EA (Medical Record Identification Number), Length = 15 If REF01 = BB (Authorization Number), Length = 14 — Magellan ICN for pharmacy claims	169-170
	AMT	AMT02	AMT01 = AU or DY Length = 9	182
	QTY	QTY02	QTY01 = CA Length = 4	184-185
2110 – Service Payment Information				
2110 – Service Payment Information	SVC	SVC01-2	If SV01-1 = AD or HC, Length = 4 If SV01-1 = N4, Length = 11 If SV01-1 = NU, Length = 4	188
	REF	REF02	REF01 = 6R (Line Item Control Number) Length = 50	206
		REF02	If REF01 = 1D, length = 9 (Medicaid Provider ID) If REF01= HPI, length = 10 (NPI) Rendering Provider Information	207
	AMT	AMT02	AMT01 = B6 (Allowed – Actual) Length = 9	211

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