COMMONWEALTH OF VIRGINIA

Encounter Processing Solution (EPS)

Medicaid Enterprise System (MES)

Companion Guide

For 837 Institutional Health Care Encounter Transactions

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Department of Medical Assistance Services (DMAS)

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Publication Version Change Summary

Version	Date	Revision Description	Prepared By:
1.0	13MAR2017	DMAS MES 5010 Original Implementation	DMAS
1.1	07JUN2017	1- Corrected all 837I Page references. 2- Changes made for guide updates and Other Payer Segment usage and associated payment amounts. Page 4 – Updated GS02 for Service Center information. Page 4 – PRV03-Provider Taxonomy Code – Removed reference to API in Comments. Page 5 – Removed REF02-Billing Provider Secondary Identifier from document as related to API. Page 7 – Removed REF02-Attending Provider Secondary Identifier from document as related to API. Page 7 – Removed REF02-Operating Provider Secondary Identifier from document as related to API. Page 7 – Removed REF02-Other Operating Provider Secondary Identifier from document as related to API. Page 7 – Removed REF02-Referring Provider Secondary Identifier from document as related to API. Page 7 – Updated and added additional information associated to the Other Payer segments that are required for EPS validation. Page 8 – Updated and added additional information associated to the Other Payer segments that are required for EPS validation. Added AMT Segment information and deleted CAS Segment information. Page 9 - Updated and added additional information associated to the Other Payer segments that are required for EPS validation. Added SVD Segment information and updated CAS Segment information.	DMAS
1.2	23JUN2017	Page 3 – ISA01 Comments for value 03 changed to Additional Data Identification. Page 3 – ISA02 Data Element name changed to Authorization Information. Page 3 – ISA12 reference removed as is redundant with the 837P 5010 TR3 Implementation Guide.	DMAS
1.3	28JUL2017	Page 3 – ISA11 information added. Page 3 – ISA Segment Terminator added. Page 5 – Loop 2010BB, Segment NM1 Payer Name added. Page 9 – Loop 2430, Segment DTP – Claim Check or Remittance Date added.	DMAS

1.4	10JAN2018	Page 2 – Additional paragraph added to Section 3- SPECIAL NOTES concerning the maximum number of revenue service lines that can be submitted Page 9 – Added Segment LX and SV2 to show the maximum number of revenue service lines permitted for EPS	DMAS
2.0	06APRIL2018	Revised for Medallion 4.0 Implementation: Page 3 - Added additional comments to ISA02 – Authorization Information pertaining to Medallion 4. Page 3 - Added additional comments to ISA06 – Interchange Sender ID pertaining to Medallion 4. Page 4 - Added additional comments to GS02 – Application Sender's Code pertaining to Medallion 4. Page 4 - Added additional comments to NM109- Submitter Identifier pertaining to Medallion 4.	DMAS
2.1	04MAY2018	Page 6 – Removed length restriction in Comments for REF02-Reference Number.	DMAS
2.2	05FEB2018	Revised for D-SNP Implementation Page 3 - Added additional comments to ISA02 – Authorization Information pertaining to D-SNP Program. Page 3 - Added additional comments to ISA06 – Interchange Sender ID pertaining to D-SNP Program. Page 4 - Added additional comments to GS02 – Application Sender's Code pertaining to D-SNP Program. Page 4 - Added additional comments to NM109- Submitter Identifier pertaining to D-SNP Program. Page 6 – Note comment added for the D-SNP Program Page 7 – Note comment added for the D-SNP Program	DMAS
2.3	28AUG2020	Revised to include 2 new K3 Segments for Readmission and Emergency Room Reductions in Payment Page 7 – Added new K3 Segment and information for Medicaid Hospital Readmissions Policy payment reductions Page 8 – Added new K3 Segment and information for Emergency Room Utilization Program payment reductions	DMAS

2.4	07JUN2023	Revised to include changes needed for Home Health (HH) Electronic Visit Verification (EVV) changes mandated by CMS effective 07/01/2023. Page 9 & 10 – Added Segments NM1, N3, N4, and REF to be used to report the service location address where the HH services occurred for the MMIS member. Page 12 - Added SV202-7 field and added additional information to the NTE02 field, Page 13 - Added NM103, NM104, REF01, and REF02 fields.	DMAS
2.5	06JUL2023	Page 12 – Modified SV202-7 field to reflect hours from 00 – 24 to 00 – 23	DMAS
2.6	15AUG2023	Revised to include new HCP Segments for submission of Allowed Amount. This will be included in both the claim (2300 Loop) and the service line (2400 Loop). Page 9 – Added new HCP Segment for the 2300 Loop for information required for allowed amount information for the claim. Page 12 – Added new HCP Segment for the 2400 Loop for information required for allowed amount information for each service line.	DMAS

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1 INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N implementation guides. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

2 PURPOSE

This guide is concerned with the processing of batch requests and responses submitted to DMAS for Virginia Medicaid. DMAS adheres to all HIPAA standards and this guide contains clarifications and requirements that are specific to transactions and data elements contained in various segments. This guide is associated with the submission of 837I encounters by contracted MCOs and other entities, which are required to submit encounters.

3 SPECIAL NOTES

837 Encounters may be sent at any time 24 hours a day, 7 days a week; however encounters should be submitted on their scheduled submission date based on the agreement established with DMAS. Contact the MCO/Contract Encounter Analyst if a scheduled submission is delayed and needs to be rescheduled.

The TA1, TA1HR, ACK, and the X12ERROR response files will normally be available for pickup 1 hour after file submission unless there are unforeseen technical difficulties. The 999, 999HR, and 277CA response files will be available immediately after the file submission is processed. Refer to the EDI Procedures Manual for more information about the outputs produced during EDI processing.

All references to Medicaid are used for simplicity, but other programs supported by DMAS are also included, such as FAMIS and TDO.

All encounters received will be processed using the NPI or Atypical Provider Identifier (API).

Non-healthcare providers that are not eligible to obtain an NPI will receive a new 10-digit Virginia Medicaid Atypical Provider ID (API).

DMAS uses the GoAnywhere MFT application to transmit batch EDI data into the Virginia Medicaid system. All Service Centers must have applied and been authorized by the Virginia EDI Coordinators office before using GoAnywhere MFT to transmit files.

EDI Submitters can upload and retrieve batch files via the GoAnywhere MFT application. Please refer to the EDI Procedures Manual for additional information related to using GoAnywhere MFT.

Note: At this time, the maximum number of Revenue Service Lines (Loop 2400, LX Segment and SV2 Segments) that can be submitted to EPS is 350 due to the MMIS constraints.

4 DATA ELEMENT DESCRIPTIONS

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Page	Loop	Segment	Data Element	Comments
C.3	N/A	ISA	ISA01 - Authorization Information Qualifier	Use “03” - Additional Data Identification
C.4	N/A	ISA	ISA02 – Authorization Information	Use 4-character Service Center ID assigned by DMAS Virginia Medicaid. Values currently in use: CP14 – CP19 for CCC Plus NE01 for NEMT Transportation M444 – M449 for Medallion 4 DS14 – DS19 for D-SNP
C.4	N/A	ISA	ISA03 – Security Information Qualifier	Use “00” - No Security Information Present
C.4	N/A	ISA	ISA05 – Interchange ID Qualifier	Use “ZZ” - Mutually defined
C.4	N/A	ISA	ISA06 – Interchange Sender ID	Use to denote Service Center/Service Center Subcontractor relationship, see following example below: CP14000 (Service Center CP14 that has no associated Subcontractor for this submission). Or: CP14001 (Service Center CP14 and associated Subcontractor 001). M444000 (Service Center M444 that has no associated Subcontractor for this transmission) or M444001 (Service Center M444 and associated Subcontractor 001) DS14000 for D-SNP
C.5	N/A	ISA	ISA07 – Interchange ID Qualifier	Use “ZZ” – Mutually defined
C.5	N/A	ISA	ISA08 – Interchange Receiver ID	“VAMES EPS”
C.5	N/A	ISA	ISA11 – Repetition Separator	Use “^” – Carat Separator
C.5	N/A	ISA	ISA14 - Acknowledgment Requested	Use “1” - Interchange Acknowledgement Requested
C.5	N/A	ISA	ISA16 - Component Element Separator	Use “:” – Colon Separator

Page	Loop	Segment	Data Element	Comments
C.5	N/A	ISA	Segment Terminator	Use "~" – Tilde Terminator
C.7	N/A	GS	GS02 – Application Sender's Code	Use 7-character Service Center ID/Service Center Subcontractor ID assigned by DMAS Virginia Medicaid. Examples are: CP14000 indicates Service Center CP14001 indicates a subcontractor for Service Center CP14. M444000 indicates Service Center, M444001 indicates a subcontractor for Service Center M444 DS14000 indicates Service Center.
C.7	N/A	GS	GS03 – Application Receiver's Code	"VAMES EPS"
C.8	N/A	GS	GS08 - Version/Release Industry ID Code	"005010X223A2"
72	1000A-Submitter Name	NM1	NM109- Submitter Identifier	Use 4-character Service Center ID assigned by DMAS Virginia Medicaid. Values currently in use: CP14 – CP19 for CCC Plus M444 – M449 for Medallion 4 DS14 – DS19 for D-SNP
77	1000B	NM1	NM103-Name Last or Organization Name	Use "Dept of Medical Assistance Services"
77	1000B-Receiver Name	NM1	NM109-ID Code	Use "VAMES EPS"
80	2000A – Billing Provider Specialty Information	PRV	PRV03 – Provider Taxonomy Code	Required if Billing Provider NPI is submitted.
86	2010AA - Billing Provider Name	NM1	NM108 – Identification Code Qualifier	XX – NPI
87	2010AA-Billing Provider Name	N3	N301-Billing Provider Address Line	The Billing Provider Address must be a physical address. Note: Post Office Box or Lock Box addresses are not accepted
89	2010AA - Billing Provider Name	N4	N403 – Billing Provider's Zip Code	The Billing Provider 9-digit zip code (along with the address information in the 2010AA N3 segment) is required.
90	2010AA-Billing Provider Secondary ID	REF	REF01-Reference Identification Qualifier	EI – Employer's Identification Number

Page	Loop	Segment	Data Element	Comments
90	2010AA	REF	REF02-Billing Provider Tax Identification Number	Employer Identification Number

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Page	Loop	Segment	Data Element	Comments
113	2010BA-Subscriber Name	NM1	NM108-Identification Code Qualifier	Use "MI"
114	2010BA	NM1	NM109-Subscriber Primary Identifier	Use the 12-digit Member ID Number assigned by Virginia Medicaid.
123	2010BB-Payer Name	NM1	NM103- Payer Name	Use "VAMES EPS".
123	2010BB-Payer Name	NM1	NM108-Identification Code Qualifier	Use "PI".
123	2010BB-Payer Name	NM1	NM109- Payer Identifier	Use "DMAS MEDICAID".
144	2300-Claim Information	CLM	CLM01-Claim Submitter's ID	For Encounters, this should be the submitter's claim number ID.
166	2300-Claim Information	REF-Payer Claim Control Number	REF02 – Claim Original Reference Number	For encounters, use the submitter's original claim number ID.
176	2300-Claim Information	K3 – File Information	K301- Fixed Format Information	This K3 segment/field is used to convey the date encounter received by the MCO, the date adjudicated by the MCO, the date paid by the MCO, the date for resubmissions from the MCO (if appropriate), and the payment status (Paid/Denied) of the encounter. The format for K301 is: K3*DREC-CCYYMMDD DADJ-CCYYMMDD DPYM-CCYYMMDD DRES-CCYYMMDD PYMS-P~ (Paid) or PYMS-D~ (Denied) Examples are as follows: For a paid encounter: K3*DREC-20170101 DADJ-20170105 DPYM-20170111 PYMS-P~ For a denied encounter: K3*DREC-20170101 DADJ-20170105 DPYM-20170111 PYMS-D~ For resubmission of a paid encounter: K3*DREC-20170101 DADJ-20170105 DPYM-20170111 DRES-20170115 PYMS-P~ For resubmission denied encounter: K3*DREC-20170101 DADJ-20170105 DPYM-20170111 DRES-20170115 PYMS-D~ Note: This segment is not used for the D-SNP Program

Page	Loop	Segment	Data Element	Comments
176	2300 – Claim Information	K3 - File Information	K301 - Fixed Format Information	This K3 segment/field is used to submit the data required for encounters needed by DMAS for rate setting. The information supplied will be in the exact format as the CN1 Segment fields CN101 – CN106. *This information is being requested in order to be used with the K3 Segment as the CN1 Segment is not HIPAA compliant.* The format for K301 is: K3*CN101-99 CN102-9999999.99 CN103-999 CN104-xxx CN105-999 CN106-xxxx. Note: The CN101 field for this K3 segment is required and the remaining fields are optional The data values needed for all supplied fields are described in the 837P 5010 TR3 Guide on Pages 158-159. Examples are as follows: K3*CN101-01 CN102-50.23 CN103-34 CN104-AB1 CN105-57 CN106-V01 (all 6 fields supplied) or K3*CN101-09 CN106-V01 (2 fields supplied) or K3*CN101-04 (required field only) Note: • There should be at least one space between each field • Each pair must have one hyphen between field and value • Fields can be in any order • No hyphen (-) allowed in the value Note: This segment is not used for the D-SNP Program
176	2300 – Claim Information	K3-File Information	K301-Fixed Format Information	This K3 segment/field is used to submit the data required for Medallion 4 and CCC Plus managed care programs encounters that indicate a payment reduction was done for the entire claim based on the new DMAS Medicaid Hospital Readmissions Policy effective 07/01/2020. If not applicable, do not submit. The format for this K3 Segment is as follows: K3*READMT-235.16~ K3*READMT-213~ The amount field must be supplied with a 2 position decimal amount when a decimal value is present.

Page	Loop	Segment	Data Element	Comments
176	2300 – Claim Information	K3-File Information	K301-Fixed Format Information	This K3 segment/field is used to submit the data required for Medallion 4 and CCC Plus managed care programs encounters that indicate a payment reduction was done for the entire claim based on the new DMAS Emergency Room Utilization Program effective 07/01/2020. . If not applicable, do not submit. The format for this K3 Segment is as follows: K3*NONEMG-486.12~ K3*NONEMG-389~ Note: The amount field must be supplied with a 2 position decimal amount when a decimal value is present.

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Page	Loop	Segment	Data Element	Comments
218	2300	HI – Diagnosis Related Group (DRG) Information	HI01-2 Diagnosis Related Group (DRG) Code	Required for Encounters if paid by DRG.
284	2300	HI-Value information	HI01-1 Code list Qualifier	Use “BE”
284	2300	HI-Value information	HI01-2 Value Code	Use “FC”
285	2300	HI-Value information	HI01-5 Value Code Amount	Patient Paid Amount

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Page	Loop	Segment	Data Element	Comments
314	2300 – Claim Information	HCP	HCP01-Pricing Methodology	This element is used for the Claim header allowed amount information required for submission to DMAS. Value is 03 (Priced at Contractual Percentage)
314	2300 – Claim Information	HCP	HCP02-Monetary Amount	This element is used for the Claim header allowed amount information required for submission to DMAS. Value will be the amount allowed for the claim.
321	2310A – Attending Provider Name	NM1	NM108 – Identification Code Qualifier	XX – NPI
328	2310B – Operating Physician Name	NM1	NM108 – Identification Code Qualifier	XX – NPI
333	2310C - Other Operating Physician Name	NM1	NM108 – Identification Code Qualifier	XX – NPI
341	2310E – Servicing Facility Location Name	NM1	NM103 – Entity Identifier Code	For Home Health (HH) EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. Value must be ''HH EVV Service Location'. This will be used to indicate where the HH EVV services were performed for the MMIS member.
344	2310E – Servicing Facility Location Address	N3	N301 – Address Information	For Home Health (HH) EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. This will be used to indicate the street address where the HH EVV services were performed for the MMIS member.
345	2310E – Servicing Facility Location City, State, ZIP Code	N4	N401 – City Name	For Home Health (HH) EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. This will be used to indicate the City where the HH EVV services were performed for the MMIS member.
346	2310E – Servicing Facility Location City, State, ZIP Code	N4	N402 – State Code	For Home Health (HH) EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. This will be used to indicate the State Code where the HH EVV services were performed for the MMIS member.

Page	Loop	Segment	Data Element	Comments
346	2310E – Servicing Facility Location City, State, ZIP Code	N4	N403 – Postal Code	For Home Health (HH) EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. This will be used to indicate the ZIP Code where the HH EVV services were performed for the MMIS member.
347	2310E – Servicing Facility Location Secondary Identifier	REF	REF01 – Reference Identification Qualifier	For Home Health (HH) EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. The value for this element will be 'LU'.
347	2310E – Servicing Facility Location Secondary Identifier	REF	REF02 – Reference Identification Qualifier	For Home Health (HH) EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. The value for this element will be '99999'.
350	2310F – Referring Provider Name	NM1	NM101 – Entity Identifier Code	Should always be 'DN' for Referring Provider
351	2310F – Referring Provider Name	NM1	NM108 – Identification Code Qualifier	Use 'XX' for NPI
351	2310F – Referring Provider Name	NM1	NM109 – Identification Code	Note: If the Attending Provider reported in 2310A is the same as the Referring provider, do not send this segment.
354	2320 – Other Subscriber Information	SBR		If the patient has Medicare or other coverage, repeat this loop for each payer with associated payment amounts. Additionally, one iteration of this loop must be used to represent the Medicaid coverage with the payment amount for any associated Medicaid expenditures. The EPS Service Center payer ID value is identified in Loop 1000A NM109 and must equal Loop 2330B NM109 value for Medicaid payments.
355	2320- Other Subscriber Information	SBR	SBR01 - Payer Responsibility Sequence Number Code	Ensure that the MC (Medicaid) value is always the last payer in sequence

Page	Loop	Segment	Data Element	Comments
356	2320 – Other Subscriber Information	SBR	SBR09 – Claim filling indicator	Use the following codes as applicable for this field: MA to indicate Medicare A as payer MB to indicate Medicare B as payer MC to indicate Medicaid as payer (required) OF to indicate Medicare D as payer Other values as listed in the 837P TR3 Guide are acceptable.
364	2320 - Other Subscriber Information	AMT - COB Payer Paid Amount	AMT02 - Payer Paid Amount	All payments associated for the encounter should be reported using this segment for the appropriate payer. The payment amount for any associated Medicaid expenditures must be reported.
385	2330B – Other Payer Name	NM1	NM109 – Other Payer Primary ID#	NM109 in Loop 2330B must match the value in SVD01 in Loop 2430. For EPS encounters, the 4-character Service Center ID assigned by Virginia Medicaid will be used.

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Page	Loop	Segment	Data Element	Comments
423	2400-Service Line	LX-Service Line Number	LX01-Assigned Number	The maximum number for EPS is 350
424	2400-Service Line	SV2-Institutional Service Line		The maximum number of revenue service lines for EPS is 350.
424	2400-Service Line	SV2-Institutional Service Line	SV202-7 - Description	For Home Health (HH) services (CLM05-1 Facility Type Code = 32 or 34), this field is required and is the time the services began and ended for EVV requirements. Format is HHMM-HHMM. HH will be 00 – 23 and MM will be 00 – 59. Example is 1130-1630 (11:30AM – 4:30PM). The time cannot exceed 24 hours based on the revenue line's DOS and must be within 0000 – 2359 for a single day.
441	2400-Service Line	NTE-Third Party Organization Notes	NTE02 - Description	This NTE segment/field is used to indicate if the service line was paid or denied, and is required for all service lines. The format for this NTE02 field is: PYMS-P (Paid Service Line) or PYMS-D (Denied Service Line) Examples are as follows: NTE*TPO*PYMS-P~ NTE*TPO*PYMS-D~
443	2400-Service Line	HCP	HCP01-Pricing Methodology	This element is used for the service line allowed amount information required for submission to DMAS. Value is 03 (Priced at Contractual Percentage)
443	2400-Service Line	HCP	HCP02-Monetary Amount	This element is used for the service line allowed amount information required for submission to DMAS. Value will be the amount allowed for the service line.

Page	Loop	Segment	Data Element	Comments
451	2410 – Drug Identification	LIN	LIN03 – National Drug Code	An NDC code is required when a drug related procedure code is billed in the SV2 segment (2400, SV202-2) and the bill type (2300, CLM05-1) is '13'. Virginia Medicaid will capture only the first occurrence of the LIN segment for each revenue line. If billing for a compound medication with more than one NDC, then each applicable NDC must be sent as a separate revenue line.
471	2420D-Referring Provider Name	NM1	NM103-Name Last	For Home Health (HH) EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. This field is used to identify the Last Name of the HH Attendant delivering the services.
471	2420D-Referring Provider Name	NM1	NM104-Name First	For Home Health (HH) EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. This field is used to identify the First Name of the HH Attendant delivering the services.
474	2420D-Referring Provider Secondary ID	REF	REF01-Reference Identfication Qualifier	For Home Health (HH) EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. The value for this element is G2 (Provider Commercial Number). This field is used to identify the type of identifier for the REF02 value associated to the HH Attendant delivering the services.
474	2420D-Referring Provider Secondary ID	REF	REF02-Reference Identfication	For Home Health (HH) EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. This field is used to identify the unique Attendant ID (not SSN or FEIN) for the HH Attendant delivering the services.
476	2430-Line Adjudication Information	SVD	SVD01-Other Payer Primary Identifier	For EPS encounters, SVD01 must match the value in NM109 in Loop 2330B. The 4-character Service Center ID assigned by Virginia Medicaid will be used. This element is mandatory.
477	2430-Line Adjudication Information	SVD	SVD02-Service Line Paid Amount	The amount paid for each service line shall be reported in this field for associated payments, including Medicaid (MC) related payments. This element is mandatory
482	2430 – Service Line Adjudication Information	CAS	CAS02-Claim Adjustment Reason Code	For EPS encounters, use CAS02 Claim Adjustment Reason Code (Code Source 139) to indicate denial of payment reduction reason for the service line.

Page	Loop	Segment	Data Element	Comments
486	2430-Line Adjudication Information	DTP	DTP03-Adjudication or Payment Date	This is the date the encounter (claim) line was paid to the provider in the CCYYMMDD format. This element is mandatory.