COMMONWEALTH OF VIRGINIA

Medicaid Enterprise System (MES)
MMIS Companion Guide

Health Care Claim: Institutional (837)

ASC X12N 837
VERSION 005010X223A2

January 31, 2022
Document Version 2.1

Department of Medical Assistance Services (DMAS)

VERSION CHANGE SUMMARY

VERSION NO.	DESCRIPTION	DATE
Version 1.0 – 1.1	Xerox VAMMIS FA 5010 Original Implementation	06/10/2011
Version 1.2	Correction for POA which will be submitted in the HI segment and Removed the K301 Data element Pg Reference (179)	06/30/2011
Version 1.3	Correction for the 2310A Attending Provider Secondary ID REF01 and REF02 Data Elements with G2 Value and API	08/31/2011
Version 1.4	Added the ISA07 Data Element Pg Reference (C.5) Correction for the 2310C Name Change from Other Provider Name to the Other Operating Physician Name Pg Reference (335)	09/19/2011 10/20/2011
Version 1.5	Modified Data Element Description for 2010BB-Loop	12/05/2011
Version 1.6	Added Referring Provider Data Elements - 2310F-Loop Removed the 2320 AMT data elements	03/06/2012
Version 1.7	Xerox Rebranding	06/04/2012
Version 1.8	Change NM-108 to NM101 for 2310F Referring Provider Name Pg Reference (352)	08/02/2012
Version 1.9	Updates for ICD-10 project	02/24/2014
Version 1.10	Modified NTE02 Data Element in 2300 Billing Note	11/04/2014
Version 2.0	Conduent Rebranding	05/19/2017
Version 2.1	Effective February 14, 2022 in preparation for MMIS Rebranding to MES April 4, 2022. Updated front matter including: Introduction – updated links, Purpose – reworded section, and Special Notes – reworded the section and on page 5 information added – DMAS MES EDI web portal access	01/31/2022

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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://store.x12.org/store.

PURPOSE

This guide is concerned with the processing of batch requests and submitted to Conduent as the Commonwealth of Virginia's Fiscal Agent and information source for Virginia Medicaid. Conduent adheres to all HIPAA standards and this guide contains clarifications and requirements that are specific to transactions and data elements contained in various segments.

- For providers with a FFS agreement to submit claims for payment.
- For HMOs with a capitation agreement to submit encounters for reporting purposes.

SPECIAL NOTES

1. 837 Claims or Encounters may be sent at any time 24 hours a day, 7 days a week, however...
   A) Fee-for-service Claims submitted by mid-afternoon will be processed in the current daily cycle. Claims submitted after 1 PM EST on Fridays will not be included in the current week's remittance cycle.
   B) Encounters should be submitted prior to noon on their scheduled submission date.

2. The 999 Response will normally be available for pickup 1 hour after file submission unless there are unforeseen technical difficulties.

3. Claim and Encounters should be submitted in separate ISA-IEA envelopes.

As of May 23, 2008 only the NPI will be accepted and used to adjudicate healthcare claims.

As of May 23, 2008 the API is use din place of Legacy ID. Non-healthcare providers that are not eligible to obtain an NPI will receive a new 10-digit Virginia Medicaid Atypical Provider ID (API).

Medicare coinsurance and deductible claims must be submitted using the NPI.

Conduent uses the MOVEit® DMZ 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 MOVEit® DMZ.

EDI Submitters can upload and retrieve batch files via the MOVEit® DMZ application using either of two methods:

a. Point a web browser to http://vammis-filetransfer.com and follow the web interfaceprompts to perform the desired task.

b. Use an SFTP Client application that references the vammis-filetransfer.com domain to perform the desired task.

MOVEit® DMZ is a secure file transfer and secure message server. It is a vital component of the MOVEit® family of secure file processing, storage, and transfer products developed by Ipswitch, Inc.

These products provide comprehensive, integrated, standards-based solutions for secure handling of sensitive information, including financial files, medical records, legal documents, and personal data.

More information or additional help regarding MOVEit® DMZ can be located on this web page: https://vamedicaid.dmas.virginia.gov/sites/default/files/2022-01/VAMMIS_File_Transfer_FAQ.pdf

The DMAS MES EDI web portal can be accessed from this web page:
https://login.vamedicaid.dmas.virginia.gov/SecureISS/landingpage
For initial EDI Enrollment as a Trading partner, complete the Electronic Trading Partner Agreement online. The initial online enrollment can be accessed from this web page: https://vamedicaid.dmas.virginia.gov/form/edi-enrollment. After completing the enrollment, you will receive your credentials along with a unique Service Center ID assigned by Virginia Medicaid via email from no-reply@va.healthinteractive.net. The Virginia Medicaid EDI test coordinator at Conduent will reach out with testing instructions after the Trading Partner Agreement is signed and approved.

The MES EDI web portal allows Service Centers or Trading Partners to:

- Enroll to submit healthcare transactions electronically
- Authorize trading partners or service centers to retrieve and/or modify electronic X12 transactions
- Self-service for password updates

Use the following link to access the MES EDI Portal FAQs:

https://login.vamedicaid.dmas.virginia.gov/SecureISS/faqLoginPage

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Data Element Descriptions

Page	Loop	Segment	Data Element	Comments
C.3	N/A	ISA	ISA01 - Authorization Information Qualifier	Use "00" – No Authorization Information Present
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 4-character service center ID assigned by Virginia Medicaid
C.5	N/A	ISA	ISA07 – Interchange ID Qualifier	Use "ZZ" – Mutually defined
C.5	N/A	ISA	ISA08 – Interchange Receiver ID	"VAMMIS FA"
C.5	N/A	ISA	ISA12 Interchange Control Version Number	00501- Control Version Number
C.5	N/A	ISA	ISA14 – Acknowledgment Requested	Use "0" - No Interchange Acknowledgement Requested
C.7	N/A	GS	GS02 – Application Sender's Code	Use 4-character service center ID assigned by Virginia Medicaid.
C.7	N/A	GS	GS03 – Application Receiver's Code	'VAMMIS FA'
C.8	N/A	GS	GS08 - Version/Release Industry ID Code	"005010X223A2".
72	1000A	NM1	NM109- Submitter Identifier	Use 4-character service center ID assigned by Virginia Medicaid.
77	1000B	NM1	NM103-Name Last or Organization Name	Use "Dept of Med Assist Svcs"
80	2000A – Billing Provider Speciality Information	PRV	PRV03 – Provider Taxonomy Code	DMAS requires taxonomy codes on claims when the provider has not enumerated with separate NPIs based on the type of service being provided. Taxonomy codes do not need to be sent with an API.
86	2010AA – Billing Provider Name	NM1	NM108 – Identification Code Qualifier	XX – NPI

Page	Loop	Segment	Data Element	Comments
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

Page	Loop	Segment	Data Element	Comments
89	2010AA – Billing Provider Name	N4	N403 – Billing Provider's Zip Code	The billing provider zip code (along with the address information in the 2010AA N3 segment) is required and may be used for pricing. Providers are required to submit the 9-digit zip code.
90	2010AA-Billing Provider Secondary ID	REF	REF01-Reference Identification Qualifier	Note: Medicaid will pay the billing provider and not the Pay-to-provider (loop 2010AB). EI – Employer's Identification Number
90	2010AA	REF	REF02-Billing Provider Tax Identification Number	When sending the EI qualifier, use the Employer Identification Number.
113 - 114	2010BA-Subscriber Name	NM1	NM108-Identification Code Qualifier	Use "MI".
114	2010BA	NM1	NM109-Subscriber Primary Identifier	Use the patient's 12-digit enrollee ID number. **Note: For providers submitting Medicare coinsurance & deductible claims use the Medicaid ID.
129-130	2010BB- Payer Name	REF	REF01-Reference Identification Qualifier	**Use G2 – Provider Commercial Code** Note: This qualifier may only be used by non-healthcare providers who are unable to obtain an NPI ID
130	2010BB- Payer Name	REF	REF02-Billing provider secondary Identifier	VAMMIS Medicaid Provider ID, REF02 must contain the API (ATYPICAL PROVIDER IDENTIFIER).
146	2300-Claim Information	CLM	CLM01-Claim Submitter's ID	For Encounters, this should be the HMO's claim number.

Page	Loop	Segment	Data Element	Comments
147	2300-Claim Information	CLM	CLM05-3 Claim Frequency Code	Use "1" for original claim. Use "7" for replacement. Use "8" for void. For claims with an admission date of 3/1/2006 or later, as well as for all claims reimbursed using DRG (inpatient and rehab hospitals), use the standard frequency codes to appropriately indicate interim bills. For claims with an admission date

Page	Loop	Segment	Data Element	Comments
				prior to 3/1/2006 that are not reimbursed using DRG (i.e., other than inpatient and rehab hospitals), always use '1' for the frequency of an original claim.
159	2300 - Claim Information	PWK	PWK06– Attachment Control Number	Use if PWK02 = "BM", "EL", "EM", or "FX" The Attachment Control Number is a composite of three specific fields and can be up to 33 positions with no embedded spaces or special characters(i.e. slashes, dashes,etc): The first field is the Patient Account Number (Provider assigned) and can be a maximum of 20 positions. The second field is the From Date Of Service (DOS) associated with the first line on the claim - MMDDCCYY. The third field is a sequential number (5 positions, numeric) established/incremented by the Provider for every electronic claim submitted. The sequence # is right justified, zero filled. The Attachment Control Number should be the same for every attachment associated with a specific claim.
160	2300 - Claim Information	CN1	CN101-Contract Type Code	Required for Encounters.

Page	Loop	Segment	Data Element	Comments
165	2300	REF-Referral Number	REF02- Referral Number	Referral Number
167	2300	REF-Prior Authorizatio n	REF02-Prior Authorization Number	Use 11 character number assigned by Virginia Medicaid.
168	2300	REF-Payer Claim Control Number	REF02-Claim Original Reference Number	For FFS claims, use the 16 character Reference Number assigned by Virginia Medicaid. Note: For encounters, this should be the HMO's original claim number (up to 20 characters).

Page	Loop	Segment	Data Element	Comments
182	2300	NTE	NTE02-Billing Note Text	Provide free-text remarks, if needed. Virginia Medicaid will use first occurrence of this segment. Object Code – from position 1 to 6
187	2300	HI – Principal Diagnosis	HI01-1 Code List Qualifier Code	Use "BK" for ICD-9 Principal Diagnosis or "ABK" for ICD-10 Principal Diagnosis
190	2300	HI- Admitting Diagnosis	HI01-1 Code List Qualifier Code	Use "BJ" for ICD-9 Admitting Diagnosis or "ABJ" for ICD-10 Admitting Diagnosis
221	2300	HI- Diagnosis Related Group (DRG) Information	HI01-2 Diagnosis Related Group (DRG) Code	Required for Claims or Encounters if paid by DRG.
242	2300	HI- Principal Procedure Information	HI01-1 Code List Qualifier Code	Use "BR" (ICD9 Principal Procedure) or "BBR" (ICD-10 Principal Procedure)
242	2300	HI- Principal Procedure Information	HI01-2 Principal Procedure Code	See the ICD-9 or ICD-10 CM Code books for acceptable procedure codes.
244-259	2300	HI- Other Procedure Information	HI01-1, HI02-1, …, HI12-1 Code List Qualifier Code	Use "BQ" (ICD-9 Procedure) or "BBQ" (ICD-10 Procedure)
244-259	2300	HI - Other Procedure Information	HI01-1, HI02-1, …, HI12-1 Procedure Code	See the ICD-9 or ICD-10 CM Code books for acceptable procedure codes.
286	2300	HI-Value information	HI01-1 Code list Qualifier	Use "BE"
286	2300	HI-Value information	HI01-2 Value Code	Use "FC"
287	2300	HI-Value information	HI01-5 Value Code Amount	Patient Paid Amount
323	2310A- Attending Provider Name	NM1	NM108 – Identification Code Qualifier	XX – NPI

Page	Loop	Segment	Data Element	Comments
326	2310A- Attending Provider Name	REF	REF01-Reference Identification Qualifier	Use G2- Provider commercial Number
327	2310A	REF	REF02-Attending Physician Secondary Identifier	Only the 10-digit API should be Submitted

330	2310B-Operating Physician Name	NM1	NM108 – Identification Code Qualifier	XX – NPI

Page	Loop	Segment	Data Element	Comments
331	2310B - Operating Physician Name	REF	REF01-Reference Identification Qualifier	Use G2- Provider commercial Number
Page	**Loop**	**Segment**	**Data Element**	**Comments**
332	2310B	REF	REF02- Operating Physician Secondary Identifier	Only the 10-digit API should be Submitted
335	2310C– Other Operating Physician Name	NM1	NM108 – Identification Code Qualifier	XX – NPI
336	2310C– Other Operating Physician Name	REF	REF01-Reference Identification Qualifier	Use G2- Provider commercial Number
337	2310C	REF	REF02- Other Provider Secondary Identifier	Only the 10-digit API should be submitted.
352	2310F- Referring Provider Name	NM1	NM101 – Entity Identifier Code	Should always be 'DN' for Referring Provider
353	2310F- Referring Provider Name	NM1	NM108 – Identification Code Qualifier	Use 'XX' for NPI
353	2310F- Referring Provider Name	NM1	NM109 – Identification Code	Use this to submit the Primary Care Provider NPI (also Medallion PCP). **NOTE**: If the Attending Provider reported in 2310A is the same as the Referring provider, do not send this segment.
355	2310F -Referring Provider Secondary Identification	REF	REF01-Reference Identification Qualifier	Use G2- Provider commercial Number
355	2310F -Referring Provider Secondary Identification	REF	REF02- Referring Provider Secondary Identifier	Only the 10-digit API should be Submitted
356	2320 – Other Subscriber Information	SBR		If the patient has Medicare or other coverage, repeat this loop for each other payer. Do not put information about Virginia Medicaid coverage in this loop.

Page	Loop	Segment	Data Element	Comments
359	2320 – Other Subscriber Information	SBR	SBR09 – Claim filling indicator	**Note: For providers submitting Medicare coinsurance & deductible claims – use "MA" or "MB" to indicate a Medicare payer.
362	2320 – Other Subscriber Information	CAS	CAS02 – Claim Adjustment Reason Code	For HMO submitted denied Encounters, use CAS02 Claim Adjustment Reason Code (code source 139) to indicate the denial reason. **Note: For providers submitting Medicare coinsurance & deductible

				claims –Use “1” for Deductible amounts Use “2” for Coinsurance amounts Use “66” for Blood Deductible amounts Adjustment amounts may be reported at the claim line or service line but not both.

Page	Loop	Segment	Data Element	Comments
381	2330A – Other Subscriber Name	NM1	NM109 – Other Insured Identifier	**Note: For providers submitting Medicare coinsurance & deductible claims – Use the Medicare ID for the enrollee
387	2330B – Other Payer Name	NM1	NM109 – Other Payer Primary ID#	**Note: For providers submitting Medicare coinsurance & deductible claims – 2330B, NM109 should match the value you are submitting in 2430, SVD01
426	2400 – Service Line	SV2	SV201 – Service Line Revenue Code	Virginia Medicaid requires a 4 digit revenue code. If a 3 digit revenue code is submitted, it will be right justified and zero filled.
426	2400	SV2		Virginia Medicaid recommends submitting 350 or fewer service lines for each institutional claim. Claims submitted with more than 350 service lines may be subject to processing delays.
453	2410 – Drug Identification	LIN	LIN02 – Product or Service ID Qualifier	Use “N4” for NDC code.
453	2410 – Drug Identification	LIN	LIN03 – National Drug Code	An NDC code is required when a ‘J’ 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.

Page	Loop	Segment	Data Element	Comments
454	2410 – Drug	CTP	CTP04 – Quantity	Input the quantity of units
	Pricing			
455	2410 – Drug Pricing	CTP	CTP05 – Composite Unit of Measure	Input the unit/basis of measure
484	2430 – Service Line Adjudication Information	CAS	CAS02 – Claim Adjustment Reason Code	For HMO submitted denied Encounters, use CAS02 Claim Adjustment Reason Code (code source 139) to indicate the denial reason. **Note: For providers submitting Medicare coinsurance & deductible claims – Use “1” for Deductible amounts Use “2” for Coinsurance amounts Use “66” for Blood Deductible amounts Adjustment amounts may be reported at the claim line or service line but not both.