Texas Medicaid

HIPAA Transaction
Standard Companion Guide

Refers to the Implementation Guide
Acute Care 837 Health Care
Claim: Dental
Based on ASC X12 version 005010

CORE v5010 Companion Guide

October 2016

Disclosure Statement

Preface

This Companion Guide to the v5010 ASC X12N Implementation Guide and associated errata adopted under Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging electronically with Texas Medicaid. Transmissions based on this Companion Guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12N 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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1. INTRODUCTION

Scope

Under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Secretary of the Department of Health and Human Services (HHS) is directed to adopt standards to support the electronic exchange of administrative and financial health care transactions. The purpose of the Administrative Simplification portion of HIPAA is to enable health information to be exchanged electronically and to adopt standards for those transactions.

Texas Medicaid defines a Trading Partner as any entity trading data with Texas Medicaid EDI. Trading partners include vendors, clearinghouses, Providers and billing agents.

The 5010 Technical Report Type 3 (TR3) dated May 2006 was used to create this Companion Guide for the 837 file format. All instructions in this document are written using information known at the time of publication and are subject to change.

Overview

This guide is intended as a resource to assist submitters in successfully conducting EDI 837 Health Care Claims: Dental transactions with Texas Medicaid. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

The purpose of this document is to assist the provider with Texas Medicaid-particular data sets for information specified in the National Electronic Data Interchange Transaction Set Implementation Guide for the file type. The federal government has set standards to simplify Electronic Data Interchange (EDI). To comply with the standard, Texas Medicaid has updated the data sets for EDI files to be in accordance with HIPAA and is utilizing the ASC X12 nomenclatures.

The instructions in this companion guide are not intended to be stand-alone requirements documents, and must be used in conjunction with the associated ANSI ASC X12N National Implementation Guide. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

References

The ANSI ASC X12N Implementation Guides are available for purchase at the Washington Publishing Company web site at: http://store.x12.org/store/healthcare-5010-consolidated-guides.

The Texas Medicaid EDI Connectivity Guide which contains instructions regarding connectivity options including CORE compliant Safe Harbor information, can be found on the EDI page of the Texas Medicaid website at: http://www.tmhp.com/Pages/EDI/EDI_Technical_Info.aspx.

The Companion Guides, published by Texas Medicaid can be found on http://www.tmhp.com/Pages/EDI/EDI_companion_guides.aspx

Additional Information

Security and Privacy Statement

Covered entities were required to implement HIPAA Privacy Regulations no later than April 14, 2003. A covered entity is defined as a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction. Providers that conduct certain electronic transmissions are responsible for ensuring these privacy regulations are implemented in their business practices. Health and Human Services Commission (HHSC) is a HIPAA Covered Entity. Accordingly, Texas Medicaid is operating as a HIPAA Business Associate of HHSC as defined by the federally mandated rules of HIPAA. A Business Associate is defined as a person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce.

The privacy regulation has three major purposes:

- To protect and enhance the rights of consumers by providing them access to their health information and controlling the appropriate use of that information;
- To improve the quality of health care in the United States by restoring trust in the health care system among consumers, health care professionals and the many organizations and individuals committed to the delivery of health care; and
- To improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy and protection.

2. GETTING STARTED

Working with Texas Medicaid

This section describes how to interact with Texas Medicaid's Electronic Data Interchange (EDI) systems.

EDI Help Desk is available to assist trading partners in exchanging data with Texas Medicaid. Below are details on how to register and contact the department for assistance.

Trading Partner Registration

HHSC requires any entity exchanging electronic data with Texas Medicaid to be enrolled in the Texas Medicaid Program and approved for the submission of X12 transaction sets.

Texas Medicaid Enrollment Forms and instructions are available at:
http://www.tmhp.com/Pages/SupportServices/PSS_Home.aspx

Successful enrollment in Texas Medicaid is required before proceeding with EDI.

To get started with EDI transactions, the necessary forms and instructions are available at:
http://www.tmhp.com/Pages/EDI/EDI_Forms.aspx

3. TESTING WITH TEXAS MEDICAID

Texas Medicaid requires that all Trading Partners who connect directly to successfully complete the testing process prior to submitting claims.

If the Provider or Billing Agent utilizes a Clearinghouse to submit the electronic claims, the entity connecting with Texas Medicaid must have successfully completed the testing process prior to claim submission.

Texas Medicaid provides a self-testing tool through Edifecs. Testing and Certification instructions, along with setup information can be found in Section 9.1 of the Texas Medicaid EDI Connectivity Guide found at:
http://www.tmhp.com/TMHP_File_Library/EDI/TMHP%20EDI%20Connectivity%20Guide.pdf

4. CONNECTIVITY WITH TEXAS MEDICAID/COMMUNICATIONS

Transmission Administrative Procedures

The Texas Medicaid EDI Connectivity Guide that contains specific instructions regarding connectivity options, can be found on the EDI page of the Texas Medicaid website at:
http://www.tmhp.com/Pages/EDI/EDI_Technical_Info.aspx

Communication protocol specifications

The Texas Medicaid EDI Connectivity Guide that contains specific instructions regarding connectivity options, along with CORE compliant Safe Harbor information, can be found on the EDI page of the Texas Medicaid website at:
http://www.tmhp.com/Pages/EDI/EDI_Technical_Info.aspx

Passwords

Texas Medicaid provides instruction on resetting of passwords in section 5.1 of the Texas Medicaid EDI Connectivity Guide found at:
http://www.tmhp.com/TMHP_File_Library/EDI/TMHP%20EDI%20Connectivity%20Guide.pdf

5. CONTACT INFORMATION

Customer Service

Texas Medicaid EDI Help Desk
The EDI Help Desk provides technical assistance only by troubleshooting Texas Medicaid EDI issues. Contact your system administrator for assistance with network, hardware, or telephone line issues.

To reach the Texas Medicaid EDI Help Desk, select one of the following methods:

- Fax 1-512-514-4230 or 1-512-514-4228
- Call 1-888-863-3638, option 3 (or call 1-512-514-4150, option 3)

The Texas Medicaid EDI Help Desk is available Monday through Friday, 7 a.m. to 7 p.m. CST.

Applicable websites/e-mail

This section contains detailed information about useful web sites and email addresses.

Texas Medicaid EDI Technical Information, such as code references, vendor file specifications, and additional Companion Guides can be found at:
http://www.tmhp.com/Pages/EDI/EDI_Technical_Info.aspx

The Texas Medicaid Provider Procedures Manual is found at:
http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx

EDI Helpful Links:

Washington Publishing Company - The Washington Publishing Company site includes reference documents pertaining to HIPAA, such as: implementation guides, data conditions, and the data dictionary for X12N standards.

Workgroup for Electronic Data Interchange (WEDI) - This site provides implementation materials and information.

National Uniform Billing Committee (NUBC) – This site is the official source of UB-04 billing information.

Texas Department of Aging and Disability Services (DADS)

Texas Department of State Health Services (DSHS)

Texas Health and Human Services Commission

6. CONTROL SEGMENTS/ENVELOPES

ISA-IEA

- Texas Medicaid does not support repetition of a simple data element or a composite data structure.
- Texas Medicaid will accept one ISA/IEA in each file and one GS/GE per ISA.
- Texas Medicaid uses "*" (asterisk) as the element separator, and "~" (tilde) as the segment separator.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
Control Segments						
C.3		ISA	Interchange Control Header			
C.4		ISA01	Authorization Information Qualifier	00		
C.4		ISA03	Security Information Qualifier	00		
C.4		ISA05	Interchange ID Qualifier	ZZ		
C.5		ISA06	Interchange Sender ID			Provider Submitter ID
C.5		ISA07	Interchange ID Qualifier	ZZ		
C.5		ISA08	Interchange Receiver ID			Production = 617591011C21P Testing = 617591011C21T
C.5		ISA11	Repetition Separator	| (pipe character)		
C.6		ISA14	Acknowledgment Requested	0 (zero)		
C.6		ISA15	Interchange Usage Indicator	P		ISA15="P" for both Production and Test
C.6		ISA16	Component Element Separator	: (colon character)		

GS-GE

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
Control Segments						
C.7		GS	Functional Group Header			
C.7		GS02	Application Sender's Code			Provider Submitter ID
C.7		GS03	Application Receiver's Code	617591011C21P		This is Texas Medicaid's Electronic Transmitter Group Identifier.

7. TEXAS MEDICAID SPECIFIC BUSINESS RULES AND LIMITATIONS

Texas Medicaid will accept up to 5000 transactions per batch. If a file is submitted with more than 5000 transactions the entire file will be rejected and not processed by Texas Medicaid.

X12 files with more than one GS-GE Functional Group will fail to process in the Texas Medicaid system.

The Texas Medicaid Provider Procedures Manual is the providers' principal source of information about Texas Medicaid. The most recent version is found at: http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx.

PWK06 Paperwork Identifier Definition

Texas Medicaid has specific qualifiers that must be used when transmitting other insurance information. Please utilize the following qualifiers for the PWK01 and PWK02:

183	2300	PWK01	Attachment Report Type Code	EB		Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)
184	2300	PWK02	Attachment Transmission Code	EL		Electronically only

The PWK06 is broken down below. In order for Texas Medicaid to recognize the other insurance information, the data structure below must be adhered to.

Texas Medicaid requires that the submitter use V5X and V5Y as the first 3 characters of this data element (s) to indicate that a denial has been received verbally from an insurance company. Verbal Denials required additional information regarding the insurance company and contact information about the verbal statement.
NOTE: x – the rest of the value after the requirement

Qualifiers V5X and V5Y
Required if other insurance gave a verbal denial.
Send in the following format:
First PWK Segment:
Position 1-3 = V5X
Position 4 = indicate 1 if relevant to 1st other insurance disposition, 2 if for 2nd other insurance disposition, and 3 if for 3rd other insurance disposition
Position 5 = space
Position 6-15 = Phone Number
Position 16 = space
Position 17- 41 = name of insurance representative
Position 42 = space
Position 43 – 50 = date of inquiry in CCYYMMDD format
Second PWK Segment:
Position 1-3 = V5Y
Position 4 = indicate 1 if relevant to 1st other insurance disposition, 2 if for 2nd other insurance disposition, and 3 if for 3rd other insurance disposition (Must be the same as position 4 of

V5X)
Position 5 – 34 = Reason given for denial

Qualifiers A5Q and A5R
Insurance company information required if other insurance was billed. Send in the following format:
First PWK Segment:
Position 1-3 = A5Q
Position 4 = indicate 1 if relevant to 1st other insurance disposition, 2 if for 2nd other insurance disposition, and 3 if for 3rd other insurance disposition
Position 5-14 = Phone Number
Position 15 – 32 = Ins. Co. Address
Second PWK Segment:
Position 1-3 = A5R
Position 4 = indicate 1 if relevant to 1st other insurance disposition, 2 if for 2nd other insurance disposition, and 3 if for 3rd other insurance disposition (Must be the same as position 4 of A5Q)
Position 5 – 24 = Ins. Co. City
Position 25 – 26 = Ins. Co. State
Position 27 – 35 = Ins. Co. Zip

Qualifier B8Z
Position 1 – 3 = B8Z
Texas Medicaid requires that for insurance disposition the submitter follow the below segment layout:
Position 4 = indicate 1 if relevant to 1st other insurance disposition, 2 if for 2nd other insurance disposition, and 3 if for 3rd other insurance disposition
Position 5 – 12 = date in CCYYMMDD format follow the below segment layout:
Position 4 = indicate 1 if relevant to 1st other insurance disposition, 2 if for 2nd other insurance disposition, and 3 if for 3rd other insurance disposition
Position 5 – 12 = date in CCYYMMDD format

NTE02 Claim Note Description Definition

Texas Medicaid requires the submitter follow the below layout:

Position 1 through 3: "DPC"
Position 4 through 8: remark code

When billing for comprehensive orthodontic treatment, procedure code D8080, three local codes must be submitted along with procedure code D8080. Local codes (procedure codes Z2009, Diagnostic workup approved; Z2011, Orthodontic appliance, upper; or Z2012, Orthodontic appliance, lower) must be placed in the NTE02. Use “01”, “02” or “03” prior to the local code to indicate the associated service line.

Example 1: For a claim with one detail, submitted with procedure code D8080 and remarks code Z2009, enter the information as follows: DPC01Z2009. The total billed would be $175.

Example 2: For a claim with two details, where details one and two are procedure code D8080 and the remarks codes are Z2009 and Z2011, enter the information as follows: DPC01Z200902Z2011.

Example 3: For a claim with three details, where all three details are submitted separately with procedure code D8080, enter the remarks code based on the order of the claim detail as follows: DPC01Z200902Z201103Z2012.

When billing for emergency or trauma-related dental services, the provider must enter the service line number associated with the emergency service followed by the word “Emergency” or

“Trauma” in the NTE02 (also enter a brief description of the Current Dental Terminology [CDT] procedure code used). Example: NTE*ADD*03Emergency D9110 Treatment of dental pain due to infection

CAS02 Texas Medicaid Disposition Code Chart

The code list is current as of the publication date. The code list is subject to change.

Criteria for CAS codes and Disposition Indicators
CAS (Claims Adjudication System) codes will be submitted by providers to drive Other Insurance/Third Party Resource disposition code for electronic claim submissions. Clerk will view disposition code on claim as before. Clerk will also view reason code on submitted claim image.

Disposition Code: D (denied) – Payment denied by Third Party Resource.

CAS	Description	Disp.
1	Deductible Amount.	D
4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
12	The diagnosis is inconsistent with the provider type. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
13	The date of death precedes the date of service.	D
14	The date of birth follows the date of service.	D
16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
18	Exact duplicate claim/service. (Use only with Group Code OA, except where state workers' compensation regulations require CO.)	D

19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	D
20	This injury/illness is covered by the liability carrier.	D
21	This injury/illness is the liability of the no-fault carrier.	D
22	This care may be covered by another payer per coordination of benefits.	D
26	Expenses incurred prior to coverage.	D
27	Expenses incurred after coverage terminated.	D
29	The time limit for filing has expired.	D
31	Patient cannot be identified as our insured.	D
32	Our records indicate the patient is not an eligible dependent.	D
33	Insured has no dependent coverage.	D
34	Insured has no coverage for newborns.	D
35	Lifetime benefit maximum has been reached.	D
39	Services denied at the time authorization/pre-certification was requested.	D
40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
49	This is a non-covered service because it is a routine/preventive exam, or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
51	These are non-covered services because this is a pre-existing condition. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
53	Services by an immediate relative or a member of the same household are not covered.	D
54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	D
61	Adjusted for failure to obtain second surgical opinion.	D
74	Indirect Medical Education Adjustment.	D
75	Direct Medical Education Adjustment.	D
76	Disproportionate Share Adjustment.	D
78	Non-Covered days/Room charge adjustment.	D
90	Ingredient cost adjustment. Usage: To be used for pharmaceuticals only.	D
91	Dispensing fee adjustment.	D

95	Plan procedures not followed.	D
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
107	The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
108	Rent/purchase guidelines were not met. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	D
110	Billing date predates service date.	D
111	Not covered unless the provider accepts assignment.	D
112	Service not furnished directly to the patient and/or not documented.	D
114	Procedure/product not approved by the Food and Drug Administration.	D
115	Procedure postponed, canceled, or delayed.	D
116	The advance indemnification notice signed by the patient did not comply with requirements.	D
117	Transportation is only covered to the closest facility that can provide the necessary care.	D
118	ESRD network support adjustment.	D
119	Benefit maximum for this time period or occurrence has been reached.	D
121	Indemnification adjustment - compensation for outstanding member responsibility.	D
122	Psychiatric reduction.	D
128	Newborn's services are covered in the mother's Allowance.	D
129	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	D
130	Claim submission fee.	D
133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	D
135	Interim bills cannot be processed.	D
136	Failure to follow prior payer's coverage rules. (Use only with Group Code OA.)	D
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.	D
140	Patient/Insured health identification number and name do not match.	D
142	Monthly Medicaid patient liability amount.	D
143	Portion of payment deferred.	D
146	Diagnosis was invalid for the date(s) of service reported.	D
147	Provider contracted/negotiated rate expired or not on file.	D
148	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	D

149	Lifetime benefit maximum has been reached for this service/benefit category.	D
150	Payer deems the information submitted does not support this level of service.	D
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	D
152	Payer deems the information submitted does not support this length of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
153	Payer deems the information submitted does not support this dosage.	D
154	Payer deems the information submitted does not support this day's supply.	D
155	Patient refused the service/procedure.	D
157	Service/procedure was provided as a result of an act of war.	D
158	Service/procedure was provided outside of the United States.	D
159	Service/procedure was provided as a result of terrorism.	D
160	Injury/illness was the result of an activity that is a benefit exclusion.	D
163	Attachment/other documentation referenced on the claim was not received.	D
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	D
166	These services were submitted after this payer's responsibility for processing claims under this plan ended.	D
167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
169	Alternate benefit has been provided.	D
170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
171	Payment is denied when performed/billed by this type of provider in this type of facility. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
172	Payment is adjusted when performed/billed by a provider of this specialty. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
173	Service/equipment was not prescribed by a physician.	D
174	Service was not prescribed prior to delivery.	D
175	Prescription is incomplete.	D
176	Prescription is not current.	D
177	Patient has not met the required eligibility requirements.	D
178	Patient has not met the required spend down requirements.	D
179	Patient has not met the required waiting requirements. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
180	Patient has not met the required residency requirements.	D
181	Procedure code was invalid on the date of service.	D
182	Procedure modifier was invalid on the date of service.	D
183	The referring provider is not eligible to refer the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D

185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
186	Level of care change adjustment.	D
188	This product/procedure is only covered when used according to FDA recommendations.	D
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	D
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	D
192	Non standard adjustment code from paper remittance. Usage: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.	D
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	D
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	D
195	Refund issued to an erroneous priority payer for this claim/service.	D
197	Precertification/authorization/notification/pre-treatment absent.	D
198	Precertification/notification/authorization/pre-treatment exceeded.	D
199	Revenue code and Procedure code do not match.	D
200	Expenses incurred during lapse in coverage.	D
201	Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR.) At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	D
202	Non-covered personal comfort or convenience services.	D
203	Discontinued or reduced service.	D
204	This service/equipment/drug is not covered under the patient's current benefit plan.	D
206	National Provider Identifier - missing.	D
207	National Provider identifier - Invalid format.	D
208	National Provider Identifier - Not matched.	D
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA.)	D
210	Payment adjusted because pre-certification/authorization not received in a timely fashion.	D
211	National Drug Codes (NDC), not eligible for rebate, are not covered.	D
212	Administrative surcharges are not covered.	D
213	Non-compliance with the physician self-referral prohibition legislation or payer policy.	D
219	Based on extent of injury. Usage: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	D

222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.	D
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.	D
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	D
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	D
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication.	D
231	Mutually exclusive procedures cannot be done in the same day/setting. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	D
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	D
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	D
237	Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	D
238	Claim spans eligible and ineligible periods of coverage. This is the reduction for the ineligible period. (Use only with Group Code PR.)	D
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	D
240	The diagnosis is inconsistent with the patient's birth weight. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
241	Low Income Subsidy (LIS) Co-payment Amount.	D
242	Services not provided by network/primary care providers.	D
243	Services not authorized by network/primary care providers.	D
245	Provider performance program withhold.	D
246	This non-payable code is for required reporting only.	D
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.	D
249	This claim has been identified as a readmission. (Use only with Group Code CO.)	D
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	D

251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	D
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	D
254	Claim received by the dental plan but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	D
256	Service not payable per managed care contract.	D
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA.)	D
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	D
261	The procedure or service is inconsistent with the patient's history.	D
262	Adjustment for delivery cost. Usage: To be used for pharmaceuticals only.	D
263	Adjustment for shipping cost. Usage: To be used for pharmaceuticals only.	D
264	Adjustment for postage cost. Usage: To be used for pharmaceuticals only.	D
265	Adjustment for administrative cost. Usage: To be used for pharmaceuticals only.	D
266	Adjustment for compound preparation cost. Usage: To be used for pharmaceuticals only.	D
267	Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	D
268	The Claim spans two calendar years. Please resubmit one claim per calendar year.	D
269	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
270	Claim received by the medical plan but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.	D
271	Prior contractual reductions related to a current periodic payment as part of a contractual payment schedule when deferred amounts have been previously reported. (Use only with Group Code OA.)	D
272	Coverage/program guidelines were not met.	D
273	Coverage/program guidelines were exceeded.	D
274	Fee/Service not payable per patient Care Coordination arrangement.	D
275	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR.)	D
276	Services denied by the prior payer(s) are not covered by this payer.	D
277	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance SHOP Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA.)	D
278	Performance program proficiency requirements not met. (Use only with Group Codes CO or PI.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
279	Services not provided by Preferred network providers. Usage: Use this code when there are member network limitations. For example, using contracted providers not in the member's 'narrow' network.	D

280	Claim received by the medical plan but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration.	D
281	Deductible waived per contractual agreement. Use only with Group Code CO.	D
282	The procedure/revenue code is inconsistent with the type of bill. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
283	Attending provider is not eligible to provide direction of care.	D
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.	D
285	Appeal procedures not followed.	D
286	Appeal time limits not met.	D
287	Referral exceeded.	D
288	Referral absent.	D
289	Services considered under the dental and medical plans. Benefits not available.	D
290	Claim received by the dental plan but benefits not available under this plan. Claim has been forwarded to the patient's medical plan for further consideration.	D
291	Claim received by the medical plan but benefits not available under this plan. Claim has been forwarded to the patient's dental plan for further consideration.	D
292	Claim received by the medical plan but benefits not available under this plan. Claim has been forwarded to the patient's pharmacy plan for further consideration.	D
296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.	D
297	Claim received by the medical plan but benefits not available under this plan. Submit these services to the patient's vision plan for further consideration.	D
298	Claim received by the medical plan but benefits not available under this plan. Claim has been forwarded to the patient's vision plan for further consideration.	D
299	The billing provider is not eligible to receive payment for the service billed.	D
300	Claim received by the Medical Plan but benefits not available under this plan. Claim has been forwarded to the patient's Behavioral Health Plan for further consideration.	D
301	Claim received by the Medical Plan but benefits not available under this plan. Submit these services to the patient's Behavioral Health Plan for further consideration.	D
302	Precertification/notification/authorization/pre-treatment time limit has expired.	D
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	D
A6	Prior hospitalization or 30-day transfer requirement not met.	D
A8	Ungroupable DRG.	D
B1	Non-covered visits.	D
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	D
B12	Services not documented in patient's medical records.	D
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	D
B14	Only one visit or consultation per physician per day is covered.	D
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	D

	Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	
B16	'New Patient' qualifications were not met.	D
B20	Procedure/service was partially or fully furnished by another provider.	D
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	D
B4	Late filing penalty.	D
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
B8	Alternative services were available and should have been utilized. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
P12	Workers' compensation jurisdictional fee schedule adjustment. Usage: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	D
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Usage: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	D
P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.	D
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA.)	D
P2	Not a work-related injury/illness and thus not the liability of the workers' compensation carrier. Usage: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	D
P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR.)	D
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Usage: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop	D

	2110 Service Payment information REF). To be used for Workers' Compensation only.	

Disposition Code: P (paid) - *Any* form of payment received from Third Party Resource.

CAS	Description	Disp.
2	Coinsurance Amount.	P
3	Co-payment Amount.	P
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA.)	P
24	Charges are covered under a capitation agreement/managed care plan.	P
44	Prompt-pay discount.	P
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability.)	P
59	Processed based on multiple or concurrent procedure rules. (For example, multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	P
66	Blood Deductible.	P
69	Day outlier amount.	P
70	Cost outlier - Adjustment to compensate for additional costs.	P
85	Patient Interest Adjustment (Use Only Group code PR.)	P
89	Professional fees removed from charges.	P
94	Processed in Excess of charges.	P
102	Major Medical Adjustment.	P
103	Provider promotional discount (e.g., Senior citizen discount).	P
131	Claim specific negotiated discount.	P
132	Prearranged demonstration project adjustment.	P
134	Technical fees removed from charges.	P
139	Contracted funding agreement - Subscriber is employed by the provider of services. Use only with Group Code CO.	P
144	Incentive adjustment, e.g. preferred product/service.	P
259	Additional payment for Dental/Vision service utilization.	P
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	P
B22	This payment is adjusted based on the diagnosis.	P

Disposition Code: Y (research) - A question requiring more research by clerk

CAS	Description	Disp.
100	Payment made to patient/insured/responsible party.	Y
104	Managed care withholding.	Y
105	Tax withholding.	Y
106	Patient payment option/election not in effect.	Y
187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)	Y
215	Based on subrogation of a third party settlement.	Y
216	Based on the findings of a review organization.	Y
293	Payment made to employer.	Y
294	Payment made to attorney.	Y
A0	Patient refund amount.	Y
B9	Patient is enrolled in a Hospice.	Y

SBR03 Benefit Code Definition

The code list is current as of the publication date. The code list is subject to change.

CA1: County Indigent Health Care Program (CIHCP)
CCP: Comprehensive Care Program (CCP)
CSN: Children with Special Health Care Needs (CSHCN) Services Program Provider
DE1: Texas Health Steps (THSteps) Dental
DM2: Durable medical equipment (DME) Home Health Acute Care
DM3: DME Home Health CSHCN
EC1: Early Childhood Intervention (ECI) Provider
EP1: THSteps Medical Provider
FP3: Family Planning
HA1: Hearing Aid
IM1: Immunization
MA1: Maternity
MH2: Mental Health Case Management
MTP: Medical Transportation Provider
TB1: Tuberculosis (TB) Clinic
WC1: Women, Infants, and Children (WIC) Clinic

8. ACKNOWLEDGEMENTS AND/OR REPORTS

Texas Medicaid provides HIPAA responses and acknowledgements that should be utilized by the Trading Partner for reconciliation purposes. Texas Medicaid does not provide proprietary reports as a standard part of the claims data process. Trading Partners should utilize the HIPAA responses provided for each transmission to reconcile claims.

The following responses will be received by the Trading Partner:

TA1 Transaction	Interchange Acknowledgement The TA1 will be sent if the submitter ID is not known or if the file received is structurally incorrect.
BID Document	Batch ID Report The BID file is sent as acknowledgment of file reception. This is not an indicator that the file was accepted; only received. This zero byte file will provide the Texas Medicaid assigned batch ID within the file name. *This response will not be returned files exchanged over the CORE Operating Rule “Safe Harbor” connection method.
999 Transaction	Implementation Acknowledgment This file provides high level transaction set response details for the 837 received. It does not contain transaction (claim) level responses.
277CA	Health Care Claim Acknowledgement The 277CA includes claim level acknowledgements including acceptance/rejection information. This file will not be sent if a negative 999 (rejection) or TA1 file has been returned.

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9. TRADING PARTNER AGREEMENTS

Trading Partners

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

Submitters have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

For example, a Trading Partner Agreement may specify, among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

Texas Medicaid Trading Partner Agreement will be found on this web page:
http://www.tmhp.com/Pages/EDI/EDI_Forms.aspx

10. TRANSACTION SPECIFIC INFORMATION

This section uses a table to describe how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed. The tables contain a row for each segment where Texas Medicaid has something additional, over and above the information in the IGs. That information can:

- Limit the repeat of loops, or segments
- Limit the length of a simple data element
- Specify a sub-set of the IGs 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 Texas Medicaid.

In addition to the row for each segment, one or more additional rows are used to describe Texas Medicaid's usage for composite and simple data elements and for any other information.

This section is used to describe the required data values that will be used by Texas Medicaid for those who submit a dental claim.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
78	2000A	PRV	Billing Provider Specialty Information			
78	2000A	PRV03	Provider Taxonomy Code			The Taxonomy code must be the Taxonomy code on file with Texas Medicaid.
82	2010AA	N1	Billing Provider Name			
85	2010AA	NM109	Billing Provider Identifier			National Provider ID (NPI) must be submitted unless the provider has an Atypical Provider ID (API) assigned which will be reported in Loop 2010BB.
86	2010AA	N3	Billing Provider Address			
86	2010AA	N301	Billing Provider Address Line			The Billing Provider address must be the address on file with Texas Medicaid.
87	2010AA	N4	Billing Provider City, State Zip Code			
87	2010AA	N401	Billing Provider City Name			The Billing Provider city name must be the city name on file with Texas Medicaid.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
88	2010AA	N403	Billing Provider Postal Zone or ZIP Code			The Billing Provider ZIP Code (9 digits) name must be the ZIP Code on file with Texas Medicaid.
89	2010AA	REF	Billing Provider Tax Identification			
89	2010AA	REF02	Billing Provider Tax Identification Number			The submitted code must match what is on file with Texas Medicaid
111	2010B	SBR	Subscriber Information			
112	2010B	SBR03	Reference Identification	CA1, CCP, CSN, DE1, DM2, EC1, EP1, FP3, HA1, IM1, MA1, MH2, MTP, TB1, WC1		The SBR03, if applicable, must match what is on file in the Texas Medicaid system based on the Provider address and Taxonomy code information. .
114	2010BA	NM1	Subscriber Name			
116	2010BA	NM108	Identification Code Qualifier	MI		
116	2010BA	NM109	Subscriber Primary ID			Medicaid Subscriber ID
124	2010BB	NM1	Payer Name			
123	2010BB	NM103	Payer Name	TEXAS MEDICAID		
125	2010BB	NM108	Identification Code Qualifier	PI		
125	2010BB	NM109	Payer Identifier	617591011C21P		
131	2010BB	REF	Billing Provider Secondary Identification			
131	2010BB	REF01	Identification Code Qualifier	G2		If the Billing Provider has an API instead of an NPI, the API must be sent in the REF02.
145	2300	CLM	Claim Information			
147	2300	CLM05-03	Claim Frequency Code	7, F, G, H, I, J, K, M, N, 0, 1, 2, 3, 4, 5, 6, 9, A, B, C, D, E, L, O, X, Y, Z, 8		

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
				7, F, G, H, I, J, K, M, N		Texas Medicaid will read these values as corrections (adjustment/appeal).
				0, 1, 2, 3, 4, 5, 6, 9, A, B, C, D, E, L, O, X, Y, Z		Texas Medicaid will read these values as a claim.
				8		Texas Medicaid will read this value as a voided claim
159	2300	PWK	Claim Supplemental Information			
161	2300	PWK06	Attachment Control Number			Refer to the payer specific rules when sending other insurance information
168	2300	REF	Payer Claim Control Number			
168	2300	REF02	Payer Claim Control Number			When appealing or adjusting a claim, Texas Medicaid will read the data in REF02 as the ICN (Internal Control Number) of the original claim.
179	2300		Claim Note			
179	2300	NTE02	Claim Note Text			Refer to the payer specific rules for NTE structure and usage
190	2310A	NM1	Referring Provider Name			
192	2310A	NM109	Referring Provider Identifier			NPI must be submitted unless the provider has an API assigned which will be reported in Loop 2310A Referring Provider Secondary Identification.
194	2310A	REF	Referring Provider Secondary Identification			
195	2310A	REF01	Reference Identification Qualifier	G2		If the provider has an API instead of an NPI, the API must be sent in the REF02.
196	2310B	REF	Rendering Provider Name			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
201	2310B	REF01	Reference Identification Qualifier	G2, LU		
			Provider Communication Number	G2		If the provider has an API instead of an NPI, the API must be sent in the REF02.
			Location Number	LU		The rendering provider zip code should be sent when REF01 = LU. The Rendering Provider 9 digit zip code must match what is on file with Texas Medicaid.
202	2310C	NM1	Service Facility Location Name			
204	2310C	NM109	Laboratory or Facility Primary Identifier			NPI must be submitted unless the provider has an API assigned which will be reported in Loop 2310C Service Facility Location Secondary Identification.
208	2310C	REF	Service Facility Location Secondary Identification			
208	2310C	REF01	Reference Identification Qualifier	G2		If the provider has an API instead of an NPI, the API must be sent in the REF02.
225	2320	CAS	Claim Level Adjustments			
227	2320	CAS02	Adjustment Reason Code			Refer to the payer specific rules for CAS02, CAS05, CAS08, CAS11, CAS14, CAS17
245	2330A	REF	Other Subscriber Secondary Identification			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
245	2330A	REF02	Reference Identification			Texas Medicaid requires the submitter enter the social security number of the insured in REF02 if other insurance was involved in the claim disposition.
251	2330B		Check Claim or Remittance Date			
251	2330B	DTP03	Date Time Period			The Other Payer Date Claim Paid is required by Texas Medicaid when other payers are present on the claim.
288	2400		Tooth Information			Texas Medicaid only reads the first TOO segment within each 2400 Loop. If submitting information regarding more than one tooth (additional TOO segments), Texas Medicaid recommends the submitter create additional details in subsequent 2400 Loops.
316	2420A	NM1	Rendering Provider Name			
318	2420A	NM109	Rendering Provider Identifier			NPI must be submitted unless the provider has an API assigned which will be reported in Loop 2310B Rendering Provider Secondary Identification.
320	2420A	REF	Rendering Provider Secondary Identification			
321	2310B	REF01	Reference Identification Qualifier	G2, LU		

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Provider Communication Number	G2		If the provider has an API instead of an NPI, the API must be sent in the REF02.
			Location Number	LU		The rendering provider zip code should be sent when REF01 = LU. The Rendering Provider 9 digit zip code must match what is on file with Texas Medicaid.
345	2430	CAS	Line Adjustments			
347	2430	CAS02	Adjustment Reason Code			Refer to the payer specific rules for CAS02, CAS05, CAS08, CAS11, CAS14, CAS17

11. APPENDICES

Transmission Examples

The 837D transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, claim level, and claim service line level. Billing providers who sort claims using this hierarchy will use the 837D more efficiently because information that applies to all lower levels in the hierarchy will not have to be repeated within the transaction.

Texas Medicaid Note:
As an assumption for these file formats, if the Subscriber is the same individual as the Patient then the Patient Loop is not to be populated per HIPAA compliance. Information sent in the 2000C loop will be ignored by Texas Medicaid.

In the following example carriage return line feeds are inserted in place of ~ character for improved readability purposes.

Texas Medicaid Example Transaction:

ISA*00* *00* *ZZ*111111111 *ZZ*617591011C21P
*151207*0941*|*00501*111111111*0*P*:
GS*HC*111111111*617591011C21P*20151207*0941*9*X*005010X224A2
ST*837*0001*005010X224A2
BHT*0019*00*111111*20151207*0941*CH
NM1*41*2*ORGANIZATION NAME*****46*111111111
PER*IC*TMC*TE*9999999999
NM1*40*2*TEXAS MEDICAID*****46*617591011C21P
HL*1**20*1
PRV*BI*PXC*193400000X
NM1*85*2*ORGANIZATION NAME*****XX*1891016697
N3*100 MAIN STREET
N4*TOWN*TX*123456789
REF*EI*111111111
HL*2*1*22*0
SBR*P*18*DE1******MC
NM1*IL*1*LAST NAME*FIRST NAME****MI*111111111
N3*100 MAIN STREET
N4*TOWN*TX*12345
DMG*D8*20030426*F
REF*SY*111111111
NM1*PR*2*TEXAS MEDICAID*****PI*D86916
CLM*11111111*119.43***11:B:1*N*C*Y*Y
DTP*472*D8*20151202
LX*1
SV3*AD:D0602*.01*11*00**1
DTP*472*D8*20151202
NM1*82*1*LAST NAME*FIRST NAME****XX*1111111111
PRV*PE*PXC*1223G0001X
REF*LU*123456789
LX*2
SV3*AD:D0150*35.32*11*00**1
DTP*472*D8*20151202

NM1*82*1*LAST NAME*FIRST NAME****XX*1111111111
PRV*PE*PXC*1223G0001X
REF*LU*123456789
LX*3
SV3*AD:D2391*84.1*11*00**1
TOO*JP*19*O
DTP*472*D8*20151202
NM1*82*1*LAST NAME*FIRST NAME****XX*1111111111
PRV*PE*PXC*1223G0001X
REF*LU*123456789
SE*41*0001
GE*1*9
IEA*1*111111111

Change Summary

The following is a log of changes made since the original version of the document was published.

	Change	Date
1	Updated Claim Supplemental Information PWK02 Data Value from AA to EL and description From: TMHP requests the submitter to utilize “AA” in this segment. To: TMHP requests the submitter to utilize “EL” in this segment. (Refer to SR 4333758 and 4298493)	11/10/11
2	Added section to support the MCO Claims portal and outbound claims from TMHP to MCO	03/01/12
3	Updated the description column for segment PWK06 to include information regarding how to submit the PWK06 segments with a max of 50 characters.	06/07/12
4	Updated element PWK06 to include information to only submit a max of 50 characters and updated example transaction.	08/01/12
5	Update the description of NTE02 to remove mention of submitting diagnosis codes using this field.	12/05/13
6	Example transactions updated.	07/08/14
7	Updated to CAQH CORE Operating Rules Phase IV Template	10/01/16
8	Updated CAS02 Texas Medicaid Disposition Code Chart table to reflect the updated information for CARC codes per SR 7161139 Modify Edit 00014 and CARC Processing Rules.	12/11/20