TMHP
TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Texas Medicaid

HIPAA Transaction Standard Companion Guide

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

CORE v5010 Companion Guide

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: Professional 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			Acute Care Claims Production = 617591011C21P Testing = 617591011C21T LTSS (Long Term Services and Support) Claims Production = 617591011LTSSP Testing = 617591011LTSST
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			Identical to ISA06
C.7		GS03	Application Receiver's Code			Identical to ISA08

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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.

PWK05 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

Vision:

Texas Medicaid requires that submitters send vision prescription data in the NTE segment associated with the first service line on the claim. The submitter should follow the below NTE02 field layout:
Position 1 through 5: new prescription right sphere,
Position 6 through 10: new prescription right cylinder,
Position 11 through 15: new prescription near right,
Position 16 through 20: new prescription intermediate right,
Position 21 through 25: new prescription left sphere,
Position 26 through 30: new prescription left cylinder,
Position 31 through 35: new prescription near left,
Position 36 through 40: new prescription intermediate left,
Position 41 through 45: old prescription right sphere,
Position 46 through 50: old prescription right cylinder,
Position 51 through 55: old prescription near right,
Position 56 through 60: old prescription intermediate right,
Position 61 through 65: old prescription left sphere,
Position 66 through 70: old prescription left cylinder,
Position 71 through 75: old prescription near left,
Position 76 through 80: old prescription intermediate left.

Family Planning:

Texas Medicaid requires submitters send family planning data in the NTE segment associated with the first service line on the claim. The submitter should follow the below NTE02 field layout:
Position 1: Client Race valid values are:
“1” = White,
“2” = Black or African American,
“4” = American Indian or Alaskan Native,
“5” = Asian,
“6” = Unknown or not reported,
“7”= Native Hawaiian or other Pacific Islander,
“8”= More than one race
A value is not required in Position 1 when Claim Title code 'J' is entered in Position 39.

Position 2: Client ethnicity code valid values are:
“0” = Non-Hispanic,
“5” = Hispanic
A value is not required in Position 2 when Claim Title code 'J' is entered in Position 39.

Position 3: Marital status code. Valid values are:
“1” = Married,
“2” = Never married,
“3” = Formerly married,
A value is not required in Position 3 when Claim Title code 'J' is entered in position 39.

Position 4 through 5: Number of times pregnant
A value is not required in Position 4 through 5 unless Claim Title code 'C' is entered in position 39.

Position 6 through 7: Number of live births
A value is not required in Position 6 through 7 unless Claim Title code 'C' is entered in position 39.

Position 8 through 9: Number of living children
A value is not required in Position 8 through 9 unless Claim Title code 'C' is entered in position 39.

Position 10: Client indicator values:
“Y”= New,
“N”= Existing.
A value is not required in Position 10 when Claim Title code 'J' is entered in position 39.

Position 11 through 22: Income amount
A value is not required in Position 11 through 22 when Claim Title code 'J' is entered in position 39.

Position 23 through 25: Number of people supported
A value is not required in Position 23 through 25 when Claim Title code 'J' is entered in position 39.

Position 26: Valid values for birth control method before:
“a” = Oral contraceptive,
“b” = 1-Month hormonal injection,
“c” = 3-Month hormonal injection,
“d” = Cervical cap/diaphragm,
“e” = Abstinence,
“f” = Hormonal Implant,
“g” = Male condom,
“h” = Female condom,
“i” = Hormonal/Contraceptive patch,
“j” = Spermicide (used alone),
“k” = Intrauterine device (IUD),
“l” = Vaginal ring,
“m” = Fertility awareness method (FAM),
“n” = Sterilization,
“o” = Contraceptive sponge,
“p” = Other method,
“q” = Method unknown,
“r” = No method (If value "r" is used for position 27, then position 29 is required)
A value is not required in Position 26 unless Claim Title code 'C' is entered in position 39.

Positon 27: Birth control method after. See above for valid values.
A value is not required in Position 27 unless Claim Title code 'C' is entered in position 39.

Position 28: Practitioner level code, valid values:
“1” =Physician,
“2”=Nurse,
”3”=Mid-Level,
“4”=Other.
A value is not required in Position 28.

Position 29: No contraception reason, valid values:
Blank = Not applicable,
“a” = Refused,
“b” = Pregnant,
“c” = Inconclusive pregnancy test,
“d” = Seeking pregnancy,
“e” = Infertile,

“f” = Rely on partner,
“g” = Medical.
A value is not required in Position 29 unless the value “r” entered in position 27.

Position 30: Title X payment, valid values:
“F” = Full pay,
“P” = Partial pay,
“N” = No pay.
A value is not required in Position 30 unless Claim Title code 'B' is entered in position 39.

Position 31 through 38: Eligibility date in the following format: CCYYMMDD
A value is not required in Position 31 through 38 unless Claim Title code 'C' is entered in position 39.

Position 39: Title code valid values are:
“A” = Title V Family Planning,
“B” = Title X Family Planning (2017),
“C” = Title XIX Family Planning,
“D” = Title XX Family Planning,
“E” = Titles V and X Family Planning,
“G” = Title X and XX Family Planning,
“H” = Primary Health Care,
“I” = Expanded Primary Health Care,
“J” = FPP Family Planning (1500)

Position 40-42: Client county code

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
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
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. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	D
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 2110 Service Payment information REF). To be used for Workers' Compensation only.	D

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
232	Institutional Transfer Amount. Usage: Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.	P
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.	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
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.

9. TRADING PARTNER AGREEMENTS

This section contains general information concerning Trading Partner Agreements (TPA).

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
83	2000A	PRV	Billing Provider Specialty Information			
83	2000A	PRV03	Provider Taxonomy Code			The Taxonomy code must be the Taxonomy code on file with Texas Medicaid.
87	2010AA	N1	Billing Provider Name			
90	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.
91	2010AA	N3	Billing Provider Address			
91	2010AA	N301	Billing Provider Address Line			The Billing Provider address must be the address on file with Texas Medicaid.
92	2010AA	N4	Billing Provider City, State Zip Code			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
92	2010AA	N401	Billing Provider City Name			The Billing Provider city name must be the city name on file with Texas Medicaid.
93	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.
94	2010AA	REF	Billing Provider Tax Identification			
94	2010AA	REF	Billing Provider Tax Identification Number			The submitted code must match what is on file with Texas Medicaid
116	2000B	SBR	Subscriber Information			
117	2000B	SBR03	Subscriber Group or Policy Number	CA1, CCP, CSN, DE1, DM2, EC1, EP1, FP3, HA1, IM1, MA1, MH2, TB1, WC1		The SBR03, if applicable, must match what is setup in the Texas Medicaid system based on the Provider address and Taxonomy code information. .
115	2010BA	NM1	Subscriber Name			
116	2010BA	NM108	Identification Code Qualifier	MI		Texas Medicaid requires the submitter enter MI for the Member Identification Number for proper adjudication of the file.
129	2010BA	REF	Subscriber Secondary Identification			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
129	2010BA	REF02	Subscriber Supplemental Identifier			For DSHS DFPP, PHC claims. If filing for Teen Counseling service, populate REF02 with *000000000.* If not filing for Teen Counseling service, then populate REF02 with client Social Security Number (SSN) or if client SSN is unknown, populate with *000000001*.
133	2010BB	NM1	Payer Name			
134	2010BB	NM103	Payer Name	TEXAS MEDICAID		
134	2010BB	NM108	Identification Code Qualifier	PI		
134	2010BB	NM109	Payer Identifier	617591011C21P		
140	2010BB	REF	Billing Provider Secondary Identification			
140	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.
157	2300	CLM	Claim Information			
159	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		
				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**
182	2300	PWK	Claim Supplemental Information			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
183	2300	PWK06	Attachment Control Number			Refer to the payer specific rules when sending other insurance information
194	2300	REF	Prior Authorization			
196	2300	REF02	Prior Authorization Number			Mandatory when the service provided was assigned an authorization number.
196	2300	REF	Payer Claim Control Number			
196	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. When resubmitting a claim previously rejected, Texas Medicaid will read the data in REF02 as the previous transaction ID.
205	2300	REF	Demonstration Project Identifier			
205	2300	REF02	Demonstration Project Identifier	DSHS		Texas Medicaid requires if submitting a PHC claim, the value in REF02 must be “DSHS”. Texas Medicaid will look for REF02 to be equal to “DSHS” in order to map the values present in 2300 NTE02 Claim Note segment for a PHC claim. Loop 2300 NTE02 Claim Note position 39 must equal “H” for PHC claims.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
209	2300		Claim Note			
209	2300	NTE01	Note Reference Code	ADD		Additional Information
210	2300	NTE02	Claim Note Text			Texas Medicaid will only read the first 41 characters of the 80 available for adjudication. Refer to the payer specific rules for NTE segment.
257	2310A	NM1	Referring Provider Name			
259	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.
260	2310A	REF	Referring Provider Secondary Identification			
260	2310A	REF01	Reference Identification Qualifier	G2		If the provider has an API instead of an NPI, the API must be sent in the REF02.
262	2310B	NM1	Rendering Provider Name			The Rendering Provider must be a member of the Billing Provider Group in the Texas Medicaid system.
264	2310B	NM109	Rendering Provider Identification			NPI must be submitted unless the provider has an API assigned which will be reported in Loop 2310B Rendering Provider Secondary Identification.
265	2310B	PRV	Rendering Provider Specialty Information			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
265	2310B	PRV03	Provider Taxonomy Code			If sent, the Rendering Provider Taxonomy Code must match the Taxonomy Code setup with Texas Medicaid.
267	2310B	REF	Rendering Provider Secondary Identification			
268	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 zip code must match what is on file with Texas Medicaid.
269	2310C	NM1	Service Facility Location Name			
271	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.
275	2310C	REF	Service Facility Location Secondary Identification			
275	2310C	REF01	Reference Identification Qualifier	G2		If the provider has an API instead of an NPI, the API must be sent in the REF02.
288	2310E	N4	Ambulance Pickup Location City, State, Zip Code			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
289	2310E	N403	Postal Code			Texas Medicaid requires the 9-digit ZIP code of the Ambulance pick-up location reported.
293	2310F	N4	Ambulance Drop-off Location City, State, Zip Code			
294	2310F	N403	Postal Code			Texas Medicaid requires the 9-digit ZIP code of the Ambulance drop-off location reported.
299	2320	CAS	Claim Level Adjustments			
301	2320	CAS02	Claim Adjustment Reason Code			Refer to the payer specific rules for CAS02, CAS05, CAS08, CAS11, CAS14, CAS17
319	2330A	REF	Other Subscriber Secondary Identification			
319	2330A	REF02	Other Insured Additional Identifier			Texas Medicaid requires the submitter enter the social security number of the insured in REF02 if other insurance was involved in the claim disposition.
325	2330B	DTP	Check Claim or Remittance Date			
325	2330B	DTP03	Adjudication or Payment Date			The Other Payer Date Claim Paid is required by Texas Medicaid when other payers are present on the claim.
351	2400	SV1				

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
357	2400	SV112	Family Planning Indicator			The presence of SV112 = *Y* for ALL details in a claim indicates a Family Planning claim is being billed. If you are a title XIX only provider, you do not need to indicate it is a family planning claim. However, if you do indicate the claim as family planning, additional family planning demographic data will be needed in the NTE02 segment
413	2400	NTE	Line Note			
413	2400	NTE01	Note Reference Code	ADD		
413	2400	NTE02	Line Note Text			Position 1 through 3: *GPC* Position 4 through 8: EOB remark code EOB Code List
430	2420A	NM1	Rendering Provider Name			The Rendering Provider must be a member of the Billing Provider Group in the Texas Medicaid system.
432	2420A	NM109	Rendering Provider Identifier			NPI must be submitted unless the provider has an API assigned which will be reported in Loop 2420A Rendering Provider Secondary Identification.
433	2420A	PRV	Rendering Provider Specialty Information			If sent, the Rendering Provider Taxonomy Code must match the Taxonomy Code setup with Texas Medicaid.
434	2420A	REF	Rendering Provider Secondary Identification			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
434	2420A	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 zip code must match what is on file with Texas Medicaid.
484	2430	CAS	Line Adjustments			
486	2430	CAS02	Claim Adjustment Reason Code			Refer to the payer specific rules for CAS02, CAS05, CAS08, CAS11, CAS14, CAS17

11. APPENDICES

Transmission Examples

The 837P 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 837P 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*0507*^*00501*013571653*1*P*:
GS*HC*111111111*617591011C21P*20151207*0507*13571653*X*005010X222A1
ST*837*0001*005010X222A1
BHT*0019*00*11111111*20101212*0945*CH
NM1*41*1*LASTNAME*FIRSTNAME****46*111111111
PER*IC**TE*1111111111
NM1*40*2*TMHP*****46*617591011C21P
HL*1**20*1
PRV*BI*PXC*1223G0001X
NM1*85*2*ORGANIZATION NAME*****XX*1111111111
N3*100 MAIN STREET
N4*TOWN*TX*123456789
REF*EI*111111111
HL*2*1*22*0
SBR*P*18*******MC
NM1*IL*1*LASTNAME*FIRSTNAME*T***MI*111111111
N3*100 MAIN STREET
N4*TOWN*TX*12345
DMG*D8*19991231*F
REF*SY*111111111
NM1*PR*2*Texas Medicaid*****PI*617591011C21P
N4*TOWN*TX*12345
CLM*111111111111*85***11:B:1*Y*A*Y*Y
REF*G1*111111111111111
HI*ABK*Z01.411
NM1*82*1*LASTNAME*FIRSTNAME****XX*111111111
PRV*PE*PXC*1223G0001X
REF*LU*12345
LX*1
SV1*HC:99201*85*UN*1***1
DTP*472*D8*20151015
SE*30*0001
```

GE*1*905
IEA*1*000000905

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	Section added for MCO claims Portal	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	Added Loop 2300 REF01 and REF02 Demonstration Project Identifier for submitting EPHC and PHC claims. Updated “TMHP notes” in Loop 2010BA NM109 Subscriber Name, Loop 2010BA REF01 Subscriber Secondary Identification, Loop 2300 REF01 and REF02 Demonstration Project Identifier and Loop 2300 NTE02 Claim Note to include references to PHC and EPHC claims.	04/18/14
6	Updated the links to wpc.com and tmhp.com as old links were not working, changed the title date and updated the instructions for Loop 2010AA REF02 to say “EIN” and “SSN” instead of “EI” and “SY”.	02/13/15
7	Updated the description of Billing Provider Loop 2010AA, REF01 to say that Tax ID (EIN) field is required for an EPHC or PHC provider only if the Family Planning Indicator in Loop 2400 SV112=Y but still required if client has Medicaid.	02/19/15
8	Removed “F = Titles X and XIX Family Planning” from Position 39 Title Code Valid Values in Loop 2300 NTE02	02/19/15
9	Updated Health Care Diagnosis Code section to include ICD9 for BK and BF qualifiers and added two rows for ICD10 diagnosis code qualifiers ABK and ABF. Also corrected HIO1 segment to be HI01.	06/04/15
V1	Updated to CAQH CORE Operating Rules Phase IV Template.	10/01/16
V2	Removed Reference of EPHC 2300 REF02 Page 29 of 37 Texas Medicaid requires if submitting a PHC ~~or an EPHC~~ claim, the value in REF02 must be “DSHS”. Texas Medicaid will look for REF02 to be equal to “DSHS” in order to map the values present in 2300 NTE02 Claim Note segment for a PHC ~~or an EPHC~~ claim. Loop 2300 NTE02 Claim Note position 39 must equal “H” for PHC claims ~~and equal “I” for EPHC claims~~.	01/10/17
V2.1	Added the text “This field is not required when Claim Title code ‘J’ is entered in position 39.” to the Family Planning NTE02 Claim Note Description Definition section for positions 1-3 and 10-25. Added the text "This field is not required unless Claim Title code 'C' is entered in position 39." to the Family Planning NTE02 Claim Note Description Definition section for positions 4-9 and 26-38. Updated Title code value ‘B’ description in position 39 to include “(2017)”. Added Title code value ‘J’ and description to position 39.	01/11/2017

V2.2	Updated Family Planning NTE02 Claim Note Description Definition section for Positions 1-26 and 31-39 on pages 16-18.	01/17/2017
V2.4	Update text in Position 26 beside valid value “r = No Method” from (If “r” is used for Position 26, then Position 27 is required) to (If “r” is used for Position 27, then Position 29 is required). Added the text “A value is not required in Position 28” to the Family Planning NTE02 Claim Note Description Definition section for position 28. Added the text “A value is not required in Position 31 through 38 unless Claim Title code 'C' is entered in position 39” to the Family Planning NTE02 Claim Note Description Definition section for positions 31 through 38.	01/25/2017
V2.5	Added the text “A value is not required in Position 27 Claim Title code 'C' is entered in position 39” to the Family Planning NTE02 Claim Note Description Definition section for position 27. Added the text “A value is not required in Position 29 unless the value “r” is entered in Position 27” to the Family Planning NTE02 Claim Note Description Definition section for position 29.	01/26/2017
V2.6	Updated month and year on cover page. Removed the duplicate ‘Workgroup for Electronic Data Interchange (WEDI)’ link on page 11. Changed ‘.’ {period} or ‘;’ {semi-colon} to ‘,’ and then ‘ ‘ {space} (for the last sentence) to match the formatting in the rest of the sections on pages 16-18. Added an ‘:’ after Position 1 and Position 2. Add ‘:’ {colon} to end of sentence for Positions 11 through 22. Changed “Pos.” to “Position” for Positions 27-40 Added ‘segment.’ to the end of the note in the NOTES/COMMENTS box for the 2300 NTE02 information on page 30.	01/31/2017
V2.7	Page 11 - ISA08 – Added LTSS (Long Term Services and Support) Receiver IDs Page 13 – Updated GS02 - Same as ISA06 Page 13 – Updated GS03 - Same as ISA08 Page 28 - Payer Identifier added NM103 relevant information	
10	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