Connecticut interChange MMIS

Connecticut Medical Assistance Program

5010 Companion Guide

November 1, 2018

Connecticut Department of Social Services (DSS)
55 Farmington Ave
Hartford, CT 06105

DXC Technology
55 Hartland Street
East Hartford, CT 06108

Companion Guide Amendment History

The following log provides a history of changes that have been made to the Companion Guide.

Version	Version Date	Reason for Revision	Section	Page(s)
1.0	3/28/12	Initial Release	All	All
1.1	8/24/2012	Change to # 5 on Overall 837 Health Care 83* Formatting. Replace value 061274678 with 445498161	2.2.9, 2.2.10 and 2.2.11	37, 43, and 50
1.2	2/2013	Removed specific information regarding 270/271 and 276/277. Created new 270/271 and 276/277 Companion Guides for Affordable Care Act.	2.2.4 and 2.2.5	
1.3	8/2013	Removed references to PCCM. Deleted 834 section. All formatted and reworded references to ASC X12 data to obtain copyright.		
1.4	10/2013	Added effective end date to 820	2.2.6	9
1.5	10/2013	corrected X217 to X218 and updated DSS address on cover	2.22	cover, 5, 9
1.6	11/2015	Updates from HP to Hewlett Packard Enterprise	All	All
1.7	4/10/2017	Update PWK section for ACN and Hewlett Packard Enterprise to DXC Technology updates	2.2.10 All	33 All
	4/10/2017	Update PWK section for ACN	2.2.8	19-20
	4/10/2017	Update PWK section for ACN	2.2.9	26-27
1.8	6/28/2017	Changed HPE to DXC Technologies	ALL	All

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1.9	7/10/2017	Removed reference to ICD9 and replaces with ICD10	2.2.8, 2.2.9, 2.2.10	20, 26, 33
1.10	11/29/2017	changes made for address requirement to rendering	2.2.8 2.2.10	15,28
1.11	3/29/2018	change notes/comments from Insured Health Insurance Claim Number (HIC) Medicare number to Medicare Beneficiary Identifier (MBI)	2.2.6	10
1.12	4/10/2018	Effective date of October 1,2018f or change on 820 to report MBI	2.26	10
1.13	11/1/2018	Changes to update the CADAP Transition to DPH/Magellan	2.2.6	10

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1.11 Table of Contents

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1 Document Overview

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

1.1 Purpose of the Document

The Connecticut Department of Social Services (DSS) and its fiscal agent, DXC Technology are responsible for processing electronic transactions for the Connecticut Medical Assistance Program. This document provides trading partners with a guide that communicates the Connecticut Medical Assistance Program specific information required to successfully exchange transactions electronically with DXC Technology in ASC X12 and NCPDP D.0 standard formats and must be used in conjunction with the HIPAA 5010 Implementation Guides. The information contained in these manuals is for both billing providers and technical staff.

1.2 EDI Guide Content Summary

A summary of the remaining sections of the Companion Guide is provided below.

Section 1 – Document Overview

This section describes the purpose and outlines the content of the Connecticut Medical Assistance Program Companion Guide. Electronic submitters should use the Implementation Guides and Companion Guide for format and code set information. In addition to the Implementation Guide and the Companion Guide, electronic submitters should use Chapter 8 of the Provider Manual for specific Connecticut Medical Assistance Program claim submission instructions and policy guidelines. Chapter 8 can be found at the following link: https://www.ctdssmap.com/CTPortal/Information/Publications/tabid/40/Default.aspx

Section 2 – EDI Transaction Processing

This section describes the EDI process that supports the Connecticut Medical Assistance Program and provides a description of Connecticut-specific requirements for each of the transaction sets currently supported by the Connecticut Medical Assistance Program.

Section 3 –Trading Partner Enrollment

This section provides trading partner enrollment information that includes a step-by-step description of the activities each trading partner must complete to successfully exchange electronic transactions in the EDI environment. Upon completion of these activities, each trading partner receives a “Production Ready” status with the Connecticut Medical Assistance Program and its fiscal agent, DXC Technology, and may begin submitting transactions.

Section 4 – System Requirements

This section provides a brief description of the system requirements for the transactions and provides links to documents that contain more detailed information, as well as links to required forms.

Section 5 – Appendix

This section contains links to answers for frequently asked questions, as well as DXC Technology contact information.

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2 EDI Transaction Processing

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2.1 Transaction Processing Overview

Trading Partners exchange batch and interactive transactions with the Connecticut Medical Assistance Program. Batch X12 transactions are uploaded and downloaded via a Web-based application. A Functional Acknowledgement is created for batch claim transactions once the syntactical analysis is complete. Generally, all batches are processed within 24 hours of receipt and Functional Acknowledgements are available for download during that time. Interactive X12 and NCPDP transactions are processed real-time through a Value Added Network rather than directly submitting to the Connecticut Medical Assistance Program. The following table indicates the transactions that are available and the method of delivery.

Transaction	Method of Delivery
ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response	Batch/Interactive
ASC X12N 276/277 Health Care Claim Status Request and Response	Batch/Interactive
ASC X12N 835 Health Care Claim Payment/Advice	Batch
ASC X12N 837 Health Care Claim: Institutional	Batch
ASC X12N 837 Health Care Claim: Dental	Batch
ASC X12N 837 Health Care Claim: Professional	Batch
ASC X12N 999 Acknowledgement for Health Care Insurance	Batch
NCPDP Telecommunication Standard Format Version D.0	Interactive
ASC X12N 278 Health Care Services Review: Request and Response	Batch/Interactive

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2.2 Connecticut Medical Assistance Program Companion Guides

2.2.1 Introduction

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance payers in the United States comply with the electronic data interchange standards for health care as established by the Department of Health and Human Services. The ASC X12N and NCPDP implementation guides have been established as the standards for compliance. The ASC X12 TR3s that detail the full requirements for these transactions are available at http://store.x12.org/store/The NCPDP implementation guide is available at http://www.ncpdp.org/.

The following information is intended to serve solely as companion documents to the ASC X12 and NCPDP transactions. The use of these documents is only for the purpose of clarification allowed within the HIPAA transaction sets.

Electronic submitters should use the Implementation Guide and Companion Guide for format and code set information. In addition to the Implementation Guide and Companion Guide, electronic submitters should use Chapter 8 of the Provider Manual for specific Connecticut Medical Assistance Program claim submission instructions and policy guidelines.

These documents are subject to change as new information is available. Please check the Connecticut Medical Assistance Program Web site at www.ctdssmap.com regularly for updated information.

2.2.2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 2 of this document.

Unique ID	Name
005010X279A1	Health Care Eligibility Benefit Inquiry and Response (270/271)
005010X212	Health Care Claim Status Request and Response (276/277)
005010X218	Payment Order / Remittance Advice
005010X221A1	Health Care Claim Payment/ Advice (835)
005010X224A2	Health Care Claim: Dental(837)
005010X223A2	Health Care Claim: Institutional (837)
005010X222A1	Health Care Claim: Professional (837)

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2.2.3 Instruction Tables

These tables contain one or more rows for each segment for which supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

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2.2.4 ASC X12N/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271) – See separate Companion Guide for this transaction

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2.2.5 ASC X12N/005010X212 Health Care Claim Status Request and Response - See separate Companion Guide for this transaction

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2.2.6 ASC X12N/005010X218 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)

Effective end date is 12/31/2013. The 820 Payment Order/Remittance Advice file is sent to PDP entities for premium payments. The following companion document provides data clarification for the 820 Payment Order/Remittance Advice (005010X218) transaction.

005010X218 Payment Order Remittance Advice

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA	Interchange Control Header		
	ISA11	Repetition Separator	"^"	CT will use carrot sign.
	BPR	Financial Information		
	BPR01	Transaction Handling Code	C, D, I , P, U, X	Always "I" = Remit only
	BPR03	Credit/Debit Flag Code		Always "C" = Credit
	BPR04	Payment Method Code		Always "NON" = Non payment
	TRN	REASSOCIATION TRACE NUMBER		
	TRN01	Trace Type Code	1, 3	Always "3" = Financial Reassociation Trace Number
	TRN02	Reference Identification		Check number is reported here
	REF	Premium Receivers Identification Key		
	REF01	Reference ID Qualifier		"18"=Plan's Number .
	REF02	Identification Code		If REF01 = 18 then, 5 digit plan's number

Loop ID	Reference	Name	Codes	Notes/Comments
1000A	N1	Premium Receivers Name		
1000A	N103	Identification Code Qualifier	1, 9, EQ, FI, XV	Always "EQ" = Insurance Company Assigned Identification Number
1000A	N104	Identification Code		Plan's Number
1000B	N1	Premium Payers Name		

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Loop ID	Reference	Name	Codes	Notes/Comments
1000B	N103	Identification Code Qualifier	1, 9, 24, 75, EQ, FI, PI	Always “FI” = Federal Taxpayer’s Identification Number
	N104	Identification Code		Always "061274678" CT DSS
2000B	ENT	Individual Remittance		
2000B	ENT03	Identification Code Qualifier	34, EI, II	Always “34” = Social Security Number
2100B	NM1	Individual Name		
2100B	NM101	Entity Identifier Code	DO, EY, QE, IL	Always “IL” = Insured or Subscriber
2000B	NM108	Identification Code Qualifier	34, EI, N	Always “N” Insured’s Unique Identification Number
	NM109	Identification Code		Medicare Beneficiary Identifier (MBI) Effective 10/1/2018
2300B	RMR	INDIVIDUAL PREMIUM REMITTANCE DETAIL		
2300B	RMR01	Reference Identification Qualifier	11, 9J, AZ, B7, CT, ID, IJ, IK, KW	Always “AZ” = Health Insurance Policy Number
2300B	RMR02	Reference Identification		For PDP will be 3-digit plan code plus “C” for CADAP or “D” for Dual. ** Effective for dates of service November 1, 2018 and forward the CADAP plan has transitioned to Magellan Rx Management.
2300B	REF	INDIVIDUAL PREMIUM REMITTANCE DETAIL		
2300B	REF01	Reference Identification Qualifier	14, 18, 2F, 38, E9, LU, ZZ	Always “ZZ” = Mutually Defined
2300B	REF02	Reference Identification		Client’s Connecticut Medicaid number

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2.2.7 ASC X12N/005010X221A1 Health Care Claim Payment/Advice (835)

The 835 Health Care Payment/Advice Transaction is used to provide health care providers with remittance and payment information regarding claims submitted to the Connecticut Medical Assistance Program. The 835 Health Care Claim Payment/Advice transactions will supply remittance advice information only. Pending claim information is excluded from the 835 Health Care Claim Payment/Advice transactions. The sort order for the 835 Health Care Claim Payment/Advice transactions will follow the current paper RA sort order. These transactions will only be available via a Web download to Connecticut Medical Assistance Program Trading Partners requesting electronic remittance advice information.

The following companion document provides data clarification for the 835 Health Care Payment/Advice (005010X221A1) transaction set.

Special Notes – Applicable to Entire Transaction

Subscriber, Insured, and Member = Client in Connecticut Environment

The Connecticut Medical Assistance Program does not allow for dependents to be enrolled under a primary subscriber, rather all clients are primary subscribers within each program.

Provider Identification = National Provider Identifier (NPI) or Non-medical provider identifier

The Connecticut Medical Assistance Program will use the National Provider ID or Provider Tax ID in N104 in the 1000B (Payee Identification).

Connecticut Medicaid Health Plan ID = Connecticut Federal Tax ID

The Connecticut Medical Assistance program will use the Federal Tax ID in all instances requiring a Health Plan ID. At such a time as the National Health Plan ID is approved and available, that ID will be used.

005010X221A1 835 Health Care Claim Payment/Advice

Loop ID	Reference	Name	Codes	Notes/Comments
	ST	Transaction Set Header		
	ST02	Transaction Set Control Number		Connecticut's remittance advice number.
	BPR	Financial Information		
	BPR01	Transaction Handling Code		Always "I" = Remittance Information Only
	BPR03	Credit/Debit Flag Code		Always "C" = Credit
	BPR04	Payment Method Code		"ACH" = Automated Clearing House (ACH) "CHK" = Check "NON" = No Payment

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Loop ID	Reference	Name	Codes	Notes/Comments
				(applicable for State Transfers of funds between State Agencies)
	BPR07	(DFI) Identification Number		When BPR06 = "01" value in BPR07 is ABA Routing Number "011900571"
	TRN	Reassociation Trace Number		
	TRN02	Reference Identification		Check Number or EFT Trace Number When BPR04 = ACH, the Trace Number will begin with 01190057 plus the payee routing number and a unique trace number for the transaction.
	TRN03	Originating Company Identifier		Connecticut's Federal Tax ID preceded by "1" = "061274678"
1000A	N1	Payer Identification		
1000A	N102	Name		"CT DSS MMIS CONTRACT ADMINISTRATOR" All caps
1000A	PER	Payer Business Contact Information		
1000A	PER01	PAYER CONTACT INFORMATION	CX	
1000A	PER02	Name		"HPE PROVIDER ASSISTANCE CENTER"
1000A	PER03	Communication Number Qualifier	TE	Always "TE" = Telephone
1000A	PER04	Communication Number		Connecticut Provider Assistance Center phone number for issues related to the Remittance/Payment Advice. (8008428440)
1000A	PER	PAYER BUSINESS CONTACT INFORMATION (Payer Technical Contact Information)		
1000A	PER01	Payer Technical Contact Information)	BL	Connecticut EDI Help Desk phone number for file and technical issues related to the 835
	PER02	Name		EDI HELP DESK

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Loop ID	Reference	Name	Codes	Notes/Comments
	PER03	Communication Number Qualifier	TE	Always “TE” = Telephone
	PER04	Communication Number		8006880503
1000B	N1	Payee Identification		
1000B	N103	Identification Code Qualifier		“FI” – Federal Taxpayer’s Identification Number “XX” - Centers for Medicare & Medicaid Services (CMS) National Provider Identifier.
1000B	N104	Identification Code		Value based on qualifier from N103.
1000B	REF	Payee Additional Identification		
1000B	REF01	Reference Identification Qualifier		“PQ” – Payee Identification
1000B	REF02	Reference Identification		The taxonomy code (10 digits) followed by a comma (,) followed by zip code of 5 or 9 digits. Total field length of 20.
1000B	REF01	Reference Identification Qualifier		“TJ” – Federal Taxpayer’s Identification Number is populated in this 2nd REF segment, when a qualifier of XX is present in N103 and the NPI in N104, if supplied on the incoming 837 transaction.
1000B	REF02	Reference Identification		Federal Taxpayer’s Identification Number is populated in this 2nd REF segment, when a qualifier of XX is present in N103 and the NPI is in N104, if supplied on the incoming 837 transaction.
2100	CLP	Claim Payment Information		
2100	CLP05	Monetary Amount		Patient Liability Amount on Nursing Home claims or Patient Responsibility Amount for Cost Share.
2100	CLP06	Claim Filing Indicator Code		“MC”=Medicaid
2100	CLP07	Reference Identification		Will contain the 13-character ICN (Internal Control Number) of Claim –

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Loop ID	Reference	Name	Codes	Notes/Comments
				Important for all inquiries on claim status and adjustments to original claims
2100	NM1	Patient Name		
2100	NM108	Identification Code Qualifier		"MC" – Non-medical Provider Identifier "XX" - Centers for Medicare & Medicaid Services (CMS) National Provider Identifier
2100	NM109	Identification Code		Value based on qualifier from NM108
2100	NM1	Service Provider Name		
2100	NM108	Identification Code Qualifier		"MC" – Non-medical Provider Identifier "XX" - Centers for Medicare & Medicaid Services (CMS) National Provider Identifier
2100	NM109	Identification Code		Value based on qualifier from NM108.
2100	REF	Other Claim Related Identification		
2100	REF01	Reference Identification Qualifier		"EA" – Medical Record Identification Number or "SY" = Social Security Number (Only provided if submitted on original claim) Format not to include "-characters. (e.g. 000000000 not 000-00-0000).
2100	REF02	Reference Identification		Medical Record Identification Number or Social Security Number as indicated from REF01 qualifier. (Only provided if submitted on original claim)

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2.2.8 ASC X12N/005010X224A2 Health Care Claim: Dental (837)

The 837 Dental Transaction is used to submit health care claims and encounter data to a payer for payment. The following companion document provides data clarification for the 837 Health Care Claim: Dental (005010X224A2 transaction set). (Addenda dated June 2010)

Special Notes – Applicable to Entire Transaction

Provider Identification = National Provider Identifier (NPI)

With the implementation of 5010, files submitted with invalid NPI will reject and claims will not be processed.

For all providers with NPI, the provider NPI, Taxonomy Code and /or Zip Code+4 must be received in the appropriate loops. The loops are:

- *2000A Billing/Pay to Provider Specialty Information(Taxonomy)*
- *2010AA Billing Provider (NPI and Zip Code+4)*
- *2310B Rendering Provider (NPI and Taxonomy)*
- *2420A Rendering Provider (NPI and Taxonomy)*

The NPI will be sent in the NM109 where NM108 equals XX. The Taxonomy Code will be sent in the PRV03 where PRV02 equals PXC and the Zip Code+4 must be sent in N403. All zip codes must be numeric, no hyphens, length of 9. *Please note that the combination of NPI, Taxonomy Code, and Zip Code+4 is used in determining the correct Automated Voice Response System (AVRS) Provider Number under which a claim is to be processed. Claims lacking this information may deny if a match cannot be made to a valid AVRS Provider Number.*

Connecticut Medical Assistance Program Health Plan ID = Connecticut Federal Tax ID

The Connecticut Medical Assistance Program will use the CT Federal Tax ID in all instances requiring a Health Plan ID. At such a time as the National Health Plan ID is approved and available, that ID will be used.

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Overall 837 Health Care Claim Dental Formatting

Item Number	Connecticut Medical Assistance Program Specifications
1	A transmission with multiple GS-GE's within one ISA-IEA will be accepted.
2	A transmission will be rejected if an invalid Version/Release/Industry Identifier Code is submitted in GS08. Dental claims should be submitted with '005010X224A2' in GS08.
3	Dollar amounts in excess of 9,999,999.99, while accepted, will result in non-payment.
4	Negative values submitted in amount fields, while accepted, will result in non-payment.
5	A transmission may be rejected if an invalid carrier code is submitted in the ISA08 Interchange Receiver ID. The Connecticut Medical Assistance Program carrier code is '445498161'
6	Dental and other transactions cannot be mixed within the same ST-SE envelope.
7	Billing information is to be entered in Loop 2010AA Billing Provider.
8	Dependent Loops of transactions will not be processed with the exception of Third Party Claims where the Connecticut Medical Assistance Program client is a dependent on other primary insurance.
9	A maximum of 50 details per claim will be processed. Details in excess of 50 on any one claim will fail HIPAA compliance.

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005010X222 Health Care Claim: Dental

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA	Interchange Control Header		
	ISA08	Interchange Receiver ID		Always “445498161”
		Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose Code	00, 18	“00” – Original
	BHT06	Transaction Type Code	31, CH, RP	Claim or Encounter Indicator “CH” – Chargeable (Use with Dental Health Care Claim) “RP” – Reporting (Use with Dental Health Care Encounter) “31” - **Subrogation Demand (Do not use for CT)** Claims submitted using “RP” or “31” in BHT06 will process. However, they will be denied.
1000A	NM1	Submitter Name		
1000A	NM109	Identification Code		Unique ID assigned by DSS/HPE; this identification will be assigned once an EMC submitter is authorized to submit claims to HPE. A transmission will be rejected when sent with an unauthorized submitter identification number.
1000B	NM1	Receiver Name		
1000B	NM103	Name Last or Organization Name		“CT DSS MMIS CONTRACT ADMINISTRATOR”
1000B	NM109	Identification Code		“061274678” designates the Connecticut Medical Assistance Program receiver ID.

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For All Provider Identification Sections

For Dental Providers

NM1 segment should contain the NPI in NM109 with NM108 set to XX for health care providers. The corresponding REF segment, when NM108=XX, must contain REF01 of EI for Employer's Identification Number (EIN) or SY for Social Security Number (SSN). REF02 contains the value for the healthcare provider based on the qualifier used in REF01. The length of EIN must be equal to 10 with hyphen or 9 without. The length of SSN must be equal to 11 with hyphens or 9 without.

Specialty Information

Under HIPAA guidelines, Provider Specialty Information is situational as to whether it is required for payer processing of the claim. Now that NPI has been implemented, it is recommended that the PRV (Taxonomy Code) information always be sent to further assist in processing the claim since NPI, Taxonomy Code and Zip Code+4 are used to identify a given provider. Claims lacking specialty information will deny if the correct provider cannot be identified.

Loop ID	Reference	Name	Codes	Notes/Comments
2010AA	NM1	Billing Provider Name		
2010AA	NM109	Identification Code		For providers with NPI: Valid 10 digit NPI assigned to the provider when NM108 qualifier equals XX.
2010AA	N4	Billing Provider City, State, Zip Code		
2010AA	N403	Postal Code		Billing Provider nine digit Zip Code
2000B	HL	Subscriber Hierarchical Level		Implement with recommendation of maximum of 5000 CLM segments in a single transaction (ST-SE)
2000B	HL04	Hierarchical Child Code	0	Always "0" (zero), for Connecticut Medical Assistance Program. No Subordinate HL Segment in this Hierarchical Structure.
2000B	SBR	Subscriber Information		
2000B	SBR04	Name (Insured Group Name)		Always "MEDICAID"

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Loop ID	Reference	Name	Codes	Notes/Comments
2000B	SBR09	Claim Filing Indicator Code	11, 12, 13, 14, 15, 16, 17, AM, BL, CH, CI, DS, FI, HM, LM, MA, MB, MC, OF, TV, VA, WC, ZZ	Always “MC” Medicaid
2010BA	NM1	Subscriber Name		
2010BA	NM102	Entity Type Qualifier	1, 2	Always “1”, Person
2010BA	NM108	Identification Code Qualifier	MI, II	Always “MI”, Member Identification Number
2010BA	NM109	Subscriber Primary Identifier		9-character Unique Medicaid Client ID assigned by DSS
2010BB	NM1	Payer Name		
2010BB	NM103	Name Last or Organization Name		Organization Name, Suggest using “HPE/CTMAP”
2010BB	NM108	Identification Code Qualifier	PI , XV	“PI” – Payer Identification
2010BB	NM109	Identification Code		“75-2548221”
2300	CLM	Claim Information		
2300	CLM01	Claim Submitter’s Identifier		Patient Account Number will accept up to 38 characters. The value received will be returned in the 835 transaction.
2300	CLM05-3	Claim Filing Indicator Code	1, 7,8,	The claim frequency type code will indicate Connecticut Medical Assistance Program processing as follows: ‘7’ (Replacement claim), ‘8’ (Void claim). Any other values submitted in this field will cause a claim to process as an original.
2300	REF	Original Reference Number (ICN)		
2300	REF01	Claim Original Reference Number	F8	Required when submitting a voided or replacement claim as indicated by CLM05-3
2300	REF02	Reference Identification		Use the control number assigned to the last approved claim.

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Loop ID	Reference	Name	Codes	Notes/Comments
2300	HI	Health Care Diagnosis Code		3 –7 byte ICD10 -CM Diagnosis codes, no decimal
2400	SV3	Dental Services		
2400	SV302	Line Item Charge Amount		Total submitted charges should equal the sum of the line item charge amounts.
2430	SVD	Line Adjudication Information		
2430	SVD06	Assigned Number		If services are bundled, recommend using the corresponding LX1 value of the bundled service line, with up to 3 characters allowed

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2.2.9 ASC X12N/005010X223A2 Health Care Claim: Institutional (837)

The 837 Institutional Transaction is used to submit health care claims and encounter data to a payer for payment. This format is used to bill long term care, inpatient, outpatient, and home health claims. The following companion document provides data clarification for the 837 Health Care Claim: Institutional (005010X223A2) transaction set. (Addenda dated April 2010)

Special Notes – Applicable to Entire Transaction

Subscriber, Insured, and Member = Client in the Connecticut Medical Assistance Program Environment

The Connecticut Medical Assistance Program does not allow for dependents to be enrolled under a primary subscriber, rather all clients are primary subscribers within each program.

Provider Identification = National Provider Identifier (NPI) or Non-medical provider identifier

For all covered entities, the provider NPI, Taxonomy Code and Zip Code+4 must be received in the appropriate loops. All zip codes must be numeric, no hyphens, length is 9. The loops are:

- *2000A Billing/Pay to Provider Specialty Information (Taxonomy)*
- *2010AA Billing Provider (NPI and Zip Code+4)*

The NPI will be sent in the NM109 where NM108 equals XX. The Taxonomy Code will be sent in the PRV03 where PRV02 equals PXC.

For all covered entities, the provider NPI, Taxonomy and Zip Code+4 must be received in the appropriate loops as required by the 5010 standard. The loops are:

- *2310A Attending Physician - NPI, Taxonomy*
- *2310B Operating Physician - NPI*
- *2310C Other Operating Physician - NPI*
- *2310D Rendering Physician - NPI*
- *2310E Service Facility Location – NPI, Address*
- *2310F Referring Physician - NPI*

The NPI will be sent in the NM109 where NM108 equals XX. The Zip Code+4 will be sent in N403. All zip codes must be numeric, no hyphens, length is 5 or 9.

For all Non-medical providers where an NPI is not assigned, the claim must contain the

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Connecticut Medical Assistance Program Provider ID within the appropriate loops within the REF segment where REF01 equals G2.
Note that the Billing Provider Secondary ID segment which can contain this provider ID is in a new location, Loop 2010 BB.

Connecticut Medical Assistance Program Health Plan ID = Connecticut Federal Tax ID

The Connecticut Medical Assistance Program will use the CT Federal Tax ID in all instances requiring a Health Plan ID. At such a time as the National Health Plan ID is approved and available, that ID will be used.

Overall 837 Health Care Claim Institutional Formatting

Item Number	Connecticut Medical Assistance Program Specifications
1	A transmission with multiple GS-GE's within one ISA-IEA will be accepted.
2	A transmission will be rejected if an invalid Version/Release/Industry Identifier Code is submitted in GS08. Institutional claims should be submitted with '005010X223A2' (dated April 2010) in GS08.
3	Dollar amounts in excess of 9,999,999.99, while accepted, will result in non-payment.
4	Negative values submitted in amount fields, while accepted, will result in non-payment.
5	A transmission may be rejected if an invalid receiver ID is submitted in the ISA08 Interchange Receiver ID. The Connecticut Medical Assistance Program Receiver ID is '445498161'.
6	Professional and Institutional transactions cannot be mixed within the same ST-SE envelope.
7	Billing information is to be entered in Loop 2010AA Billing Provider.
8	A maximum of 999 details per claim will be processed. Details in excess of 999 on any one claim will fail HIPAA compliance.
9	The NPI will be required on all incoming Medicare coinsurance and deductible claims. The trading partner should enter the NPI in Loop 2010AA NM109–Billing Provider Identifier on claims submitted to Medicare.
10	The NDC code, N4 Modifier and HCPCS code will be required on outpatient claims in Loop 2410 when certain physician administered drugs are billed.

005010X223 Health Care Claim: Institutional

Loop ID	Reference	Name	Codes	Notes/Comments

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Loop ID	Reference	Name	Codes	Notes/Comments
	ISA	Interchange Control Header		
	ISA08	Interchange Receiver ID		Always “445498161”
	GS	Functional Group Header		
	GS03	Application Receiver’s ID		Always “445498161”
	BHT	Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose Code	00, 18	“00” – Original
	BHT06	Transaction Type Code		Claim or Encounter Indicator “CH” – Chargeable (Use with Institutional Health Care Claim) “RP” – Reporting (Use with Institutional Health Care Encounter) Claims submitted using ‘RP’ in BHT06 will process. However, they will be denied unless the submitter is a Connecticut Managed Care Organization. Value ‘31’(subrogation) is not used by CT Medicaid.
1000A	NM1	Submitter Name		
1000A	NM109	Identification Code		Unique ID assigned by HPE; this identification will be assigned once an EMC submitter is authorized to submit claims to HPE. A transmission will be rejected when sent with an unauthorized submitter identification number
1000B	NM1	Receiver Name		
1000B	NM103	Name Last or Organization Name		“CT DSS MMIS CONTRACT ADMINISTRATOR” All caps
1000B	NM109	Identification Code		“061274678” designates the Connecticut Medical Assistance Program receiver ID.

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For Medical Providers – The following applies to all provider identification sections:

NM1 segment should contain the NPI in NM109 with NM108 set to XX for health care providers. The corresponding REF segment, when NM108=XX, must contain REF01 of EI for Employer's Identification Number (EIN) or SY for Social Security Number (SSN). REF02 contains the value for the healthcare provider based on the qualifier used in REF01. The length of EIN must be equal to 10 with hyphen or 9 without. The length of SSN must be equal to 11 with hyphens or 9 without.

For Non-Medical Providers – The following applies to all provider identification sections:

NM108 and NM109 are not populated when the Provider does not have an NPI. The corresponding REF segment, where REF01=G2 should contain the Non-Medical Provider Identifier.

Provider Specialty

Provider Specialty Information is made situational as to whether it is required for payer processing of the claim. It is recommended that the PRV (Taxonomy Code) information always be sent per Implementation Guide specifications to further assist in processing the claim since NPI, Taxonomy Code, and Zip Code are used to identify a given provider.

Loop ID	Reference	Name	Codes	Notes/Comments
2000B	HL	Subscriber Hierarchical Level		Implement with recommendation of maximum of 5000 CLM segments in a single transaction (ST-SE)
2000B	HL04	Hierarchical Child Code		Always "0" (zero), for Connecticut Medical Assistance Program. No Subordinate HL Segment in this Hierarchical Structure.
2000B	SBR	Subscriber Information		
2000B	SBR04	Name		When submitting a claim to the CT Medical Assistance Program field should be populated with 'Medicaid' CT Medical Assistance program does not have a group number.
2000B	SBR09	Claim Filing Indicator Code		Should be "MC", Medicaid
2010BA	NM1	Subscriber Name		
2010BA	NM102	Entity Type Qualifier		Always "1", Person

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Loop ID	Reference	Name	Codes	Notes/Comments
2010BA	NM108	Identification Code Qualifier		Always “MI”, Member Identification Number
2010BA	NM109	Identification Code		9-character Unique Medicaid Client ID assigned by DSS; must be left justified
2010BB	NM1	Payer Name		
2010BB	NM103	Name Last or Organization Name		Organization Name, Suggest using “HPE/CTMAP”
2010BB	NM108	Identification Code Qualifier	PI	“PI” – Payer Identification
2010BB	NM109	Identification Code		“75-2548221”
2010BB	REF	Billing Provider Secondary Identification		
2010BB	REF01	Reference Identification Qualifier		New segment Billing Provider Secondary ID, use qualifier ‘G2” when the Billing Provider is a Non-Covered Entity.
2010BB	REF02	Reference Identification		New segment Billing Provider Secondary ID, enter 9 digit Provider AVRS ID when the Billing Provider is a Non-Covered Entity.
2300	CLM	Claim Information		
2300	CLM01	Claim Submitter’s Identifier		Patient Account Number will accept up to 38 characters. The value received will be returned in the 835 transaction.
2300	CLM05-3	Claim Frequency Type Code		The claim frequency type code will indicate Connecticut Medical Assistance Program processing as follows: ‘7’ (Replacement claim), ‘8’ (Void claim). Any other values submitted in this field will cause a claim to process as an original.
2300	REF	Payer Claim Control Number		
2300	REF01	Reference Identification Qualifier		“F8” – Original Reference Number Required when submitting a voided or replacement claim as indicated by CLM05-3.
2300	REF02	Reference Identification		Use the control number assigned to the last approved claim.

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Loop ID	Reference	Name	Codes	Notes/Comments
2300	HI	Principal, Admitting, Patient Reason For Visit, E-Code and Other Diagnosis Information		Diagnosis codes have a maximum size of five, and decimal points must not be entered.
2300	HI	Principal Procedure Information		Surgical procedures will be accepted in ICD-10 formats. Not CTXIX specific.
2300	HI	Value Information		Value codes beyond 12 occurrences will be ignored. Value Codes are now used to report Covered Days (HI0x-2 = 80) or Non-Covered Days (HI0x-2 = 81), HI0x-7 = number of days
2310A	REF	Attending Provider Secondary Identification		
2310A	REF01	Reference Identification Qualifier		For non-medical providers: “G2” – Provider Commercial Number
2310A	REF02	Reference Identification		Please enter the 9 digit AVRS Provider ID with a qualifier of G2 in the REF01.
2330B	NM1	Other Payer Name		
2330B	NM109	Identification Code		Enter the Connecticut Medical Assistance Program Carrier Code. These code values can be found at http://www.ctdssmap.com
2400	SV2	Institutional Service Line		
2400	SV202-1	Product/Service ID Qualifier		“HC” Required if outpatient billing and revenue codes 250-253, 258-260, 273 or 634-637 are billed.
2400	SV202-2	Product/Service ID		HCPCS code required if outpatient billing and revenue codes 250-253, 258-260, 273 or 634-637 are billed.
2400	SV105	Quantity		Service unit counts in excess of 9999, while accepted, will result in non-payment.
2410	LIN	Drug Identification		NDC information for Outpatient transactions will be processed in Loop 2410. Required if billing HCPCS codes in Q, S or J series.
2410	LIN02	Product/Service ID		“N4”

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Loop ID	Reference	Name	Codes	Notes/Comments
		Qualifier		Outpatient claims must include the NDC data for all physician administered drugs.
2410	LIN03	Product/Service ID		Enter the NDC code for the physician administered drug. Limit one per service line/detail.
2410	CTP	Drug Quantity		
2410	CTP04	Quantity		Drug unit count Outpatient claims must include the NDC data for all physician administered drugs.
2410	CTP05-1	Unit or Basis for Measurement Code		F2 = International Unit GR = Gram ME = Milligram ML = Milliliter UN = Unit
2430	SVD	Line Adjudication Information		
2430	SVD06	Assigned Number		If services are bundled, recommend using the corresponding LX1 value of the bundled service line, with up to 3 characters allowed

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2.2.10 ASC X12N/005010X222A1 Health Care Claim: Professional (837)

The 837 Professional Transaction is used to submit health care claims and encounter data to a payer for payment. The following companion document provides data clarification for the 837 Health Care Claim: Professional (005010X222A1 transaction set. (Addenda dated June 2010)

Special Notes – Applicable to Entire Transaction

Provider Identification = National Provider Identifier (NPI) or Atypical provider identifier

With the implementation of 5010, files submitted with invalid NPI will reject and claims will not be processed.

For all providers with NPI, the provider NPI, Taxonomy Code and / or Zip Code+4 must be received in the appropriate loops. The loops are:

- *2000A Billing/Pay to Provider Specialty Information(Taxonomy)*
- *2010AA Billing Provider (NPI and Zip Code+4)*
- *2310B Rendering Provider (NPI and Taxonomy)*
- *2420A Rendering Provider (NPI and Taxonomy)*

The NPI will be sent in the NM109 where NM108 equals XX. The Taxonomy Code will be sent in the PRV03 where PRV02 equals PXC and the Zip Code+4 must be sent in N403. All zip codes must be numeric, no hyphens, length of 9. *Please note that the combination of NPI, Taxonomy Code, and Zip Code+4 is used in determining the correct Automated Voice Response System (ARVS) Provider Number under which a claim is to be processed. Claims lacking this information may deny, if a match cannot be made to a valid AVRS Provider Number.*

For all atypical providers where an NPI is not assigned, the claim must contain the Connecticut Medical Assistance Program Provider ID within the appropriate loops within the REF segment where REF01 equals G2. Claims lacking this information may deny, if a match cannot be made to a valid AVRS Provider Number.

Connecticut Medical Assistance Program Health Plan ID = Connecticut Federal Tax ID

The Connecticut Medical Assistance Program will use the CT Federal Tax ID in all instances requiring a Health Plan ID. At such a time as the National Health Plan ID is approved and available, that ID will be used.

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Overall 837 Health Care Claim Professional Formatting

Item Number	Connecticut Medical Assistance Program Specifications
1	A transmission with multiple GS-GE's within one ISA-IEA will be accepted.
2	A transmission will be rejected if an invalid Version/Release/Industry Identifier Code is submitted in GS08. Professional claims should be submitted with '005010X222A1' in GS08.
3	Dollar amounts in excess of 9,999,999.99, while accepted, will result in non-payment.
4	Negative values submitted in amount fields, while accepted, will result in non-payment.
5	A transmission may be rejected if an invalid carrier code is submitted in the ISA08 Interchange Receiver ID. The Connecticut Medical Assistance Program carrier code is '445498161'
6	Professional and Institutional transactions cannot be mixed within the same ST-SE envelope.
7	Billing information is to be entered in Loop 2010AA Billing Provider. Additional Billing information is to be submitted in Loop 2100BB for atypical providers.
8	Dependent Loops of transactions will not be processed with the exception of Third Party Claims where the Connecticut Medical Assistance Program client is a dependent on other primary insurance.
9	A maximum of 50 details per claim will be processed. Details in excess of 50 on any one claim will fail HIPAA compliance.
10	The NPI will be required on all incoming Medicare coinsurance and deductible claims. The trading partner should enter the NPI in Loop 2010AA NM109–Billing Provider Identifier on claims submitted to Medicare.
11	The NDC and N4 modifier will be required in Loop 2410 when billing S, Q or J series HCPCS codes.

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005010X222 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA	Interchange Control Header		
	ISA08	Interchange Receiver ID		Always “445498161”
		Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose Code	00, 18	“00” – Original
	BHT06	Transaction Type Code	31, CH, RP	Claim or Encounter Indicator “CH” – Chargeable (Use with Professional Health Care Claim) “RP” – Reporting (Use with Professional Health Care Encounter) Claims submitted using “RP” in BHT06 will process. However, they will be denied.
1000A	NM1	Submitter Name		
1000A	NM109	Identification Code		Unique ID assigned by DSS/HPE; this identification will be assigned once an EMC submitter is authorized to submit claims to HPE. A transmission will be rejected when sent with an unauthorized submitter identification number.
1000B	NM1	Receiver Name		
1000B	NM103	Name Last or Organization Name		“CT DSS MMIS CONTRACT ADMINISTRATOR” All caps
1000B	NM109	Identification Code		“061274678” designates the Connecticut Medical Assistance Program receiver ID.

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For All Provider Identification Sections

For Medical Providers

NM1 segment should contain the NPI in NM109 with NM108 set to XX for health care providers. The corresponding REF segment, when NM108=XX, must contain REF01 of EI for Employer's Identification Number (EIN) or SY for Social Security Number (SSN). REF02 contains the value for the healthcare provider based on the qualifier used in REF01. The length of EIN must be equal to 10 with hyphen or 9 without. The length of SSN must be equal to 11 with hyphens or 9 without.

For Non-Healthcare Providers

The corresponding REF segment, where REF01=G2 should contain the AVRS Provider ID

Specialty Information

Under HIPAA guidelines, Provider Specialty Information is situational as to whether it is required for payer processing of the claim. Now that NPI has been implemented, it is recommended that the PRV (Taxonomy Code) information always be sent to further assist in processing the claim since NPI, Taxonomy Code and Zip Code+4 are used to identify a given provider. Claims lacking specialty information will deny if the correct provider cannot be identified.

Loop ID	Reference	Name	Codes	Notes/Comments
2010AA	NM1	Billing Provider Name		
2010AA	NM109	Identification Code	XX	For providers with NPI Valid 10 digit NPI assigned to the provider when NM108 qualifier equals XX. For atypical providers: NM108 and NM109 at this loop should not be submitted. Send AVRS provider number in 2010BB REF02
2010AA	N4	Billing Provider City, State, Zip Code		
2010AA	N403	Postal Code		Billing Provider nine digit Zip Code
2000B	HL	Subscriber Hierarchical Level		Implement with recommendation of maximum of 5000 CLM segments in a single transaction (ST-SE)

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Loop ID	Reference	Name	Codes	Notes/Comments
2000B	HL04	Hierarchical Child Code	0	Always “0” (zero), for Connecticut Medical Assistance Program. No Subordinate HL Segment in this Hierarchical Structure.
2000B	SBR	Subscriber Information		
2000B	SBR04	Name (Insured Group Name)		Always ‘Medicaid’
2000B	SBR09	Claim Filing Indicator Code	11, 12, 13, 14, 15, 16, 17, AM, BL, CH, CI, DS, FI, HM, LM, MA, MB, MC, OF, TV, VA, WC, ZZ	Should be “MC”, Medicaid
2010BA	NM1	Subscriber Name		
2010BA	NM102	Entity Type Qualifier	1, 2	Always “1”, Person
2010BA	NM108	Identification Code Qualifier	MI, II	Always “MI”, Member Identification Number
2010BA	NM109	Subscriber Primary Identifier		9-character Unique Medicaid Client ID assigned by DSS; must be left justified
2010BB	NM1	Payer Name		
2010BB	NM103	Name Last or Organization Name		Organization Name, Suggest using “HPE/CTMAP”
2010BB	NM108	Identification Code Qualifier	PI , XV	“PI” – Payer Identification
2010BB	NM109	Identification Code		“75-2548221”
2010BB	REF	Payer Secondary Identification		
2010BB	REF01	Reference Identification Qualifier	2U, EI, FY, NF, G2	‘G2” when the Billing Provider is a atypical
2010BB	REF02	Reference Identification		AVRS id of an atypical provider
2300	CLM	Claim Information		
2300	CLM01	Claim Submitter’s Identifier		Patient Account Number will accept up to 38 characters. The value received will be returned in the 835 transaction.

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Loop ID	Reference	Name	Codes	Notes/Comments
2300	CLM05-3	Claim Filing Indicator Code	1, 7,8	The claim frequency type code will indicate Connecticut Medical Assistance Program processing as follows: '7' (Replacement claim), '8' (Void claim). Any other values submitted in this field will cause a claim to process as an original.
2300	REF	Original Reference Number (ICN)		
2300	REF01	Reference Identification Qualifier	F8	Required when submitting a voided or replacement claim as indicated by CLM05-3
2300	REF02	Claim Original Reference Number		Use the control number assigned to the last approved claim.
2300	CRC	EPSDT Referral		EPSDT information must be entered in Loop 2300 if the EPSDT indicator in Loop 2400 SV111 equals 'Y'.
2300	HI	Health Care Diagnosis Code		3-7 byte ICD10 CM Diagnosis codes, no decimal points.
2310B	REF	Rendering Provider Secondary Identification		
2310B	REF01	Reference Identification Qualifier	OB, 1G, G2	'G2" when the Billing Provider is a atypical
2310B	REF02	Reference Identification		AVRS id of an atypical provider
2400	SV1	Professional Service		
2400	SV104	Quantity		Service unit counts in excess of 9999 while accepted, will result in non-payment.
2410	LIN	Drug Identification		NDC information for Professional transactions will be processed in Loop 2410. Required if billing HCPCS codes in Q, S or J series.
2410	CTP	Drug Pricing		NDC information for Professional transactions will be processed in Loop 2410. Required if billing HCPCS codes in Q, S or J series.

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Loop ID	Reference	Name	Codes	Notes/Comments
2420A	REF	Rendering Provider Secondary Identification		
2420A	REF01	Reference Identification Qualifier	0B, 1G, G2	'G2" when the Billing Provider is a atypical
2420A	REF02	Reference Identification		AVRS id of an atypical provider
2430	SVD	Line Adjudication Information		
2430	SVD06	Assigned Number		If services are bundled, recommend using the corresponding LX1 value of the bundled service line, with up to 3 characters allowed

2.3 Getting Started

Any entity intent upon becoming a trading partner should review the Connecticut Medical Assistance Program's requirements presented in this document in order to assess any changes required by both their business and technical operations to comply with the state's EDI processing requirements.

2.3.1 Trading Partner Agreement

The Trading Partner Agreement (TPA) is a contract between parties who have chosen to become electronic business partners. The TPA stipulates the general terms and conditions under which the partners agree to exchange information electronically. The agreement defines participant roles, communication, privacy and security requirements, and identifies the electronic documents to be exchanged. The Trading Partner Agreement is used by all entities that wish to establish an electronic relationship with the Connecticut Medical Assistance Program. However, EDI production transactions will not be allowed until all testing has been successfully completed. A Trading Partner Agreement must be in place with the state's fiscal agent DXC Technology before testing can begin. DXC Technology's EDI team will work with the trading partner's staff to exchange and analyze technical information.

Click here to view the Trading Partner User's Guide.

2.4 Connectivity Testing

DXC Technology and the trading partner will test their communication links. A successful test will occur when transaction sets can be sent and an appropriate response is returned. For example, an ASC X12N 837 Claim submission will be responded to with an ASC X12N 999 Implementation Acknowledgement for Health Care Insurance transaction in return.

2.5 Transaction Testing

DXC Technology and the trading partner will ensure that all participants in the process are communicating with each other properly. DXC Technology and the trading partner will mutually agree to the test period for this phase. The trading partner cannot begin production transmissions until transaction

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testing has been successfully completed. The Trading Partner Agreement must be in place with DXC Technology before testing can begin.

2.6 Production and Maintenance

Trading partners shall receive advance notice prior to changes being made to any of the transaction sets. Updates may or may not involve software changes. EDI update notification will be sent to the designated trading partner representatives at the specified locations. The state requires notification if there is a change in the trading partner representative or location to which updates are sent.

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3 System Requirements

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3.1 Telecommunications

The Connecticut Medical Assistance Program currently supports a Web-based connection. To obtain information regarding the telecommunication requirements, please see the Vendor Interface Specification document.

Click here to view the Vendor Interface Specification document.

3.2 EDI Hardware/Software Selection

Each trading partner will determine if any modifications to their technical infrastructure will be needed to perform and support EDI functions. (If the organization is currently EDI-enabled, this step may already be completed.) Assuming that the current platform is adequate to meet our processing requirements, the primary focus for evaluation and selection will be for a software package.

There are a number of commercially available software packages on the market. Trading Partners need to evaluate and select the software package that will meet their needs. DXC Technology offers a free software package named Provider Electronic Solutions, to Connecticut Medical Assistance Program providers.

3.3 Data Transport

Specific information about what types of transactions are supported and modes of data transportation are included in the Vendor Interface Specification document.

3.4 Application Development

The trading partner will need to modify their business application systems and test their accuracy to ensure that the systems will effectively process all of the required data from transactions received and also provide the data that will ultimately be transmitted in an EDI format.

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4 Appendix

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4.1 DXC Technology Contacts

For information about electronic claims submission or how to become a trading partner, please contact the Provider Assistance Center at:

1-800-842-8440 Toll free

4.2 Frequently Asked Questions (FAQs)

The following link will bring you to a list of the most frequently asked questions regarding HIPAA.

https://www.ctdssmap.com/CTPortal/Information/HIPAA/tabId/42/Default.aspx

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