



MassHealth



MassHealth

Standard Companion Guide

Health Care Payment/Advice (835)

Refers to the Implementation Guides Based on
ASC X12N Version 005010X221A1

February 2024

Disclosure Statement

This *MassHealth Standard Companion Guide* (“Companion Guide”) serves as a companion document to the corresponding *ASC X12N/005010X221 Health Care Payment/Advice (835)*, its related Addenda (005010X221A1), and its related Errata (005010X221E1). MassHealth strongly encourages its Trading Partners to use this Companion Guide in conjunction with the *ASC X12 Implementation Guide* to develop the HIPAA batch transaction. Copies of the ASC X12 Technical Report Type 3s (TR3s) are available for purchase at www.x12.org. The document further specifies the requirements to use when preparing, submitting, receiving, and processing electronic health care administrative data.

This document supplements, but does not contradict, disagree, oppose, or otherwise modify the 005010X279 implementation specification in a manner that will make its implementation by users out of compliance. Tables contained in this Companion Guide align with the CAQH CORE v5010 Companion Guide Template. The template is available at www.caqh.org.

About MassHealth

In Massachusetts, the Medicaid and Children’s Health Insurance Program (CHIP) are combined into one program called MassHealth. MassHealth provides comprehensive health insurance and dental coverage for eligible individuals, families, and people with disabilities across the Commonwealth of Massachusetts. The program serves over 2.4 million residents in the state. MassHealth’s coverage is managed and facilitated through an array of programs, including Fee for Service, Accountable Care Organizations (ACOs), and Managed Care Organizations (MCOs), which enable members to choose the plan that best meets their needs. The agency is nationally recognized for providing high quality care in an innovative and cost-effective manner.

See www.mass.gov/masshealth.

Medicaid Management Information System and Provider Online Service Center

The Medicaid Management Information System (MMIS) and the Provider Online Service Center (POSC) both support the web-based provider portal that is utilized by MassHealth providers and relationship entities to access, submit and retrieve transactions and information that support the administration of health care to MassHealth members. The POSC provides access to online functions such as member eligibility verification, claim submission and status, prior authorization, referrals, pre-admission screening, online remittance advices, and reports. The tool also facilitates the submission and retrieval of HIPAA ASC X12 transactions.

Contact for Additional Information

MassHealth Customer Service
PO Box 278
Quincy, MA 02171-0278
Email: edi@mahealth.net
Phone: (800) 841-2900
Fax: (617) 988-8971

Preface

This *MassHealth Standard Companion Guide* to the *005010 ASC X12N Implementation Guide* clarifies and specifies the data content when exchanging transactions electronically with MassHealth. *The MassHealth Standard Companion Guide* is not intended to convey information that in any way exceeds or replaces the requirements or usages of data expressed in the Implementation Guides. Neither the Executive Office of Health and Human Services nor MassHealth is responsible for any action or inaction, nor the effects of such action or inaction, taken in reliance on the contents of this guide.

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1. Introduction

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires MassHealth and all other health insurance payers in the United States to comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of the U.S. Department of Health and Human Services (HHS). The ASC X12N implementation guides are the standards of compliance for electronic health-care transactions.

■ SCOPE

The standard adopted by HHS for electronic health-care transactions is ASC X12N Version 005010, which became effective January 1, 2012. The unique version/release/industry identifier code for the 835 Health Care Payment/Advice: Institutional Transactions is 005010X221A1.

This Companion Guide assumes compliance with all loops, segments, and data elements contained in the 005010X221A1. It defines the requirements for HIPAA transactions submitted to and/or received from MassHealth.

■ OVERVIEW

MassHealth created this Companion Guide for its Trading Partners to supplement the *ASC X12N Implementation Guide*. This guide contains MassHealth-specific instructions related to the following.

- Data formats, content, codes, business rules, and characteristics of the 835 electronic transaction;
- Technical requirements and transmission options; and
- Information on testing procedures each Trading Partner must complete before transmitting electronic transactions.

The information in this document supersedes all previous communications from MassHealth about this 835 electronic transaction. The following standards supplement those outlined in the MassHealth provider manuals. These standards in no way supersede MassHealth regulations.

Use this guide in conjunction with information found in your MassHealth provider manual.

■ REFERENCES

The *ASC X12N Implementation Guide* specifies in detail the required formats for transactions exchanged electronically with an insurance company, health-care payer, or government agency. The Implementation Guide contains requirements for the use of specific segments and data elements within those segments and applies to all health-care providers and their Trading Partners. It is critical that your IT staff and/or software vendor review this document in its entirety and follow the stated requirements to exchange files with MassHealth while maintaining HIPAA compliance.

The Implementation Guides for ASC X12N and all other HIPAA standard transactions are available electronically at www.x12.org.

■ ADDITIONAL INFORMATION

The intended audience for this document is the technical and operational staff responsible for generating, receiving, and reviewing electronic health-care transactions. In addition, this information should be shared with the provider's billing office to ensure that all accounts are reconciled in a timely manner.

2. Getting Started

■ WORKING WITH MASSHEALTH

MassHealth Trading Partners can exchange electronic health care transactions with MassHealth by directly uploading and downloading transactions via the Provider Online Service Center (POSC) or system-to-system using the MassHealth connectivity submission method. Submitters must determine whether they will utilize the industry standard, Simple Object Access Protocol (SOAP)/Web Services Description Language (WSDL), or HyperText Transfer Protocol (HTTP) Multipurpose Internet Mail Extensions (MIME) Multipart Web service, to support the submission of transactions via MassHealth's connectivity method.

After determining the transmission method, each Trading Partner must successfully complete testing of the HIPAA transaction before testing the MassHealth connectivity submission method. Additional information is in the next section of this companion guide. After successful completion of testing, you may exchange production transactions.

Please contact MassHealth Customer Service at (800) 841-2900 or via email at edi@mahealth.net for assistance with the MassHealth connectivity submission method.

■ TRADING PARTNER REGISTRATION

All MassHealth Trading Partners are required to sign a Trading Partner Agreement (TPA), as described in [Section 9](#) below. If you have elected to use a third party to perform electronic transactions on your behalf, you will also be required to complete an [Electronic Remittance Advice \(ERA\) Enrollment Form](#). If you have already completed this form, you are not required to complete it again. Please contact MassHealth Customer Service at (800) 841-2900 or via email at edi@mahealth.net if you have any questions about these forms.

■ CERTIFICATION AND TESTING OVERVIEW

All Trading Partners that exchange electronic batch transactions with MassHealth must complete Trading Partner testing. This includes vendors, clearinghouses, and billing intermediaries that submit on behalf of providers, as well as providers that MassHealth defines as atypical. At the completion of testing, Trading Partners are certified.

Test transactions exchanged with MassHealth should include a representative sample of the various types of transactions that you would normally conduct with MassHealth. The size of the file should be between 25 and 50 transactions.

MassHealth posts on its website a [list](#) of vendors, clearinghouses, and billing intermediaries that have completed Trading Partner testing. If a billing intermediary or software vendor submits electronic transactions on your behalf, please view the list on our website. Providers who use a billing intermediary or software vendor do not need to test for electronic transactions that their entity submits on their behalf.

3. Testing with MassHealth

Typically, before exchanging production transactions with MassHealth, each Trading Partner must complete testing. All Trading Partners who plan to exchange transactions must contact MassHealth Customer Service at (800) 841-2900 in advance to discuss the testing process, criteria, and schedule. Trading Partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

MassHealth issues a standard 835 in the production environment. Trading Partners should be aware of the following.

- Providers with no claims on an 835 will not have any CLP segments.
- Providers with professional, institutional, and pharmacy claims adjudicated at the claim service-line level will note 2110 loops on the 835, due to adjudication at the detail level. MMIS reports a single claim with multiple service lines as one CLP (loop 2100) and multiple SVC (loop 2110).
- Providers with inpatient claims will note on the 835 that there is no 2110 CAS segment due to adjudication at the header level.

Test 835 File-naming Convention

The 835 files produced by MassHealth have the following naming convention.

XXXXXXXXXX.835.WEB.hhmmssnnn.jjj, where	
XXXXXXXXXX	Indicates the Trading Partner ID assigned by MassHealth OR 10-character MMIS provider ID/ service location (PID/SL).
HHMMSSSS	Indicates the hours, minutes, seconds, and sub-seconds when the file was created
nnn	Indicates the sequence number
jjj	Indicates the Julian date when the file was created

4. Connectivity with MassHealth/Communications

The 835 files will be available for Trading Partners to download from the POSC for at least 180 days. Trading Partners requiring access to their 835s beyond the 180-day period should contact MassHealth Customer Service. (See [Section 5](#) - contact information.)

■ TRANSMISSION ADMINISTRATIVE PROCEDURES

System Availability

The system is typically available 24 hours a day, 7 days a week, with the exception of scheduled maintenance windows.

■ PRODUCTION FILE-NAMING CONVENTION

835 files produced by MassHealth have the following naming convention.

XXXXXXXXXX.835.WEB.hhmmssnnn.jjj, where	
XXXXXXXXXX	Indicates the Trading Partner ID assigned by MassHealth OR 10-digit MMIS provider ID/service location (PID/SL).
HHMMSSSS	Indicates the hours, minutes, seconds, and sub-seconds when the file was created.
nnn	Indicates the sequence number.
jjj	Indicates the Julian date when the file was created.

■ COMMUNICATION PROTOCOL SPECIFICATIONS

Provider Online Service Center (POSC)

The POSC is a web-based tool accessible via the internet, which aids providers in effectively managing their business with MassHealth electronically. The POSC may be used to

- Enroll as a MassHealth provider;
- Manage a provider's profile information;
- Enter claims via direct data entry (DDE);
- Enter member eligibility requests via DDE;
- View member eligibility response transactions;
- Upload and download batch transaction files;
- Access reports; and
- Receive messages/communications.

■ CORE CONNECTIVITY SUBMISSION METHOD

MassHealth provides a Committee on Operating Rules for Information Exchange (CORE) connectivity submission method that allows Trading Partners to submit HIPAA transactions from their system directly to the MMIS via internet protocol using one of the two Envelope Standards: Hyper Text Transfer Protocol (HTTP) Multipurpose Internet Mail Extensions (MIME) Multipart (Envelope Standard A) or Simple Object Access Protocol (SOAP)/Web Services Description Language (WSDL) (Envelope Standard B) to ensure a standardized safe harbor connectivity. For Envelope Standard B, this system-to-system EDI Web service is supported by a standard CORE schema and WSDL as defined in the section 4.2.2.

Specifications for SOAP+WSDL are in the Phase II CORE 270: Connectivity Rule Document. While the HTTP MIME Multipart does not provide a standard schema specification, MMIS implementation of the HTTP MIME Multipart assumes that each data element has the corresponding “name” property that matches the SOAP schema definitions as well as the same “operations” names.

For more information about MassHealth’s CORE Connectivity Method, contact MassHealth Customer Service at (800) 841-2900 or by email at edi@mahealth.net.

■ PASSWORDS

Providers using the POSC to submit their EDI transactions must follow MassHealth’s requirements for use of passwords. Providers, trading partners, and relationship entities that have been assigned a User ID/password to access MMIS Provider Online Service Center (POSC) and connectivity methods are solely responsible for the use of that user ID and password. Sharing User IDs and password is a violation of the Virtual Gateway (VG) Terms and Conditions. Each user is prompted to agree with the VG Terms and Conditions upon initial sign-in on any Commonwealth VG hosted application (e.g., MMIS). Each User ID that violates the Terms and Conditions may be subject to termination.

Each provider is responsible for managing their own data and access to their organization’s data through the MMIS security function. Each provider must take all necessary precautions to ensure that they are safeguarding their information and sharing their data (i.e., granting access) only with users and entities who meet their required privacy standards.

It is equally important that providers know who on their staff are linked to other providers or entities that perform functions on their behalf. Once a staff person terminates or the relationship with another entity that performs functions for your organization is terminated, the provider must ensure that access is removed and accounts are de-linked. MassHealth is not responsible for any action taken by any individual in MMIS whose access results from a provider’s failure to abide by these requirements.

In the event that the Primary User and assigned backup leaves the provider, trading partner, or relationship entity organization, that organization must immediately identify a replacement Primary User, complete a new Data Collection Form (DCF), and submit it to MassHealth to officially notify the agency of the change.

For more information on passwords and the use of passwords, contact MassHealth Customer Service at (800) 841-2900.

5. Contact Information

■ EDI CUSTOMER SERVICE

For written correspondence

MassHealth Customer Service
PO Box 278
Quincy, MA 02171-0278

For electronic claims/hard media submissions

MassHealth Customer Service
PO Box 278
Quincy, MA 02171-0278
Email: edi@mahealth.net
Phone: (800) 841-2900
Fax: (617) 988-8971

■ EDI TECHNICAL ASSISTANCE

MassHealth Customer Service
PO Box 278
Quincy, MA 02171-0278
Email: hipaasupport@mahealth.net
Phone: (800) 841-2900

■ PROVIDER SERVICE NUMBER

MassHealth Customer Service
PO Box 278
Quincy, MA 02171-0278
Email: provider@masshealthquestions.com
Phone: (800) 841-2900
Fax: (617) 988-8974

■ APPLICABLE WEBSITES/EMAIL

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. See www.x12.org.

Centers for Medicare & Medicaid Services (CMS)

- CMS is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health-Care Transactions and Code Sets Model Compliance Plan at <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index>. See <https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/code-sets>.

Committee on Operating Rules for Information Exchange (CORE)

- A multiphase initiative of CAQH, CORE is a committee of more than 100 industry leaders who help create and promulgate a set of voluntary business rules focused on improving physician and hospital access to electronic patient insurance information at or before the time of care. See www.caqh.org.

Council for Affordable Quality Healthcare (CAQH)

- A nonprofit alliance of health plans and trade associations, working to simplify health care administration through industry collaboration on public-private initiatives. Through two initiatives—the Committee on Operating Rules for Information Exchange (CORE) and Universal Provider Data source (UPD)—CAQH aims to reduce the administrative burden for providers and health plans. See www.caqh.org.

MassHealth (MH)

- The MassHealth website assists providers with HIPAA billing and policy questions, as well as enrollment support. See www.mass.gov/masshealth.

National Committee on Vital and Health Statistics (NCVHS)

- The National Committee on Vital and Health Statistics was established by Congress to serve as an advisory body to the U.S. Department of Health and Human Services on health data, statistics and national health information policy. See www.ncvhs.hhs.gov.

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. See <http://www.wpc-edi.com/>.

6. Control Segments/Envelopes

■ ISA (INTERCHANGE CONTROL HEADER)

This section describes MassHealth's use of the interchange control segments. It includes the expected sender and receiver codes, authorization information, and delimiters. The charts below, and all charts in this document, align with the CAQH CORE v5010 Companion Guide Template format. The template is available at www.caqh.org.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.4	-----	ISA01	Authorization Information Qualifier	00	
C.4	-----	ISA02	Authorization Information		10 blank spaces
C.4	-----	ISA03	Security Information Qualifier	00	
C.4	-----	ISA04	Security Information		10 blank spaces
C.4	-----	ISA05	Interchange ID Qualifier	ZZ	
C.4	-----	ISA06	Interchange Sender ID	DMA7384	Claims from MassHealth providers
				HSN3644	Claims from HSN providers
C.5	-----	ISA07	Interchange ID Qualifier	ZZ	
C.5	-----	ISA08	Interchange Receiver ID		Trading Partner ID assigned by MassHealth (10-character MMIS provider ID/service location)
C.5	-----	ISA11	Repetition Separator		Value ^
C.6	-----	ISA14	Acknowledgement Requested	0	MassHealth does not request interchange acknowledgment (TA1).
C.6	-----	ISA16	Component Element Separator		Value ':'

■ GS (FUNCTIONAL GROUP HEADER)

This section describes MassHealth's use of the functional group control segments. It includes a description of application sender and receiver codes.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	-----	GS02	Application Sender's Code	DMA7384	Claims from MassHealth providers
				HSN3644	Claims from HSN providers
C.7	-----	GS03	Application Receiver's Code		Trading Partner ID assigned by MassHealth (10-character MMIS provider ID/service location)

7. MassHealth-Specific Business Rules and Limitations

MassHealth will send all fully adjudicated claims from a weekly cycle in one ST/SE segment, even if the number of CLP segments exceeds 10,000.

This limit of 10,000 CLP segments is a recommendation for the 835 transaction, but not a requirement. Trading Partners, especially those handling a large claim volume, are encouraged to test their compliance software internally proactively to ensure that it allows more than 10,000 CLP segments in one 835 transaction.

MassHealth will issue a separate ISA/IEA and GS/GE for each payee within the 835. Trading Partners that support multiple providers should evaluate their systems immediately to confirm that they are aligned with modifications outlined within this Companion Guide, and ensure that systems, related downstream interfaces, and practice management systems, are modified, as appropriate, to accommodate the changes.

The 835 transaction is available to those Trading Partners with a signed TPA on file. The 835 transactions are generated at the completion of each weekly claim adjudication cycle for each provider with at least one paid or denied claim appearing in a subsequent pay-cycle. Information about pended or suspended claims can be obtained from the MassHealth proprietary remittance advice, which can be found on the POSC or via requesting the 276 Claims, Status Inquiry and Response transactions. Since an 835 transaction must balance to a single check/electronic funds transfer (EFT), MassHealth is obligated to include all fully adjudicated claims from a weekly cycle, regardless of how the claim was submitted (POSC, paper, or as an 837 transaction). As usual, the State Comptroller sends the payment check or EFT separately.

The 835s are generated based on the ERA Enrollment/Modification Form the provider has submitted to MassHealth. All MassHealth providers are identified by provider ID service location (PID/SL) within MMIS. If the provider has chosen to receive 835s for all associate payees (PID/SLs) to a designated Trading Partner within the group, MassHealth will generate all 835s to the designated Trading Partner by indicating a different transaction set for each payee. If the provider has chosen to receive individual 835s for all PID/SLs in the TPA, all providers will receive 835s for their PID/SL. If the provider has chosen a clearinghouse to receive the 835 on their behalf, the clearinghouse will receive the provider's 835 in a separate transaction set within the Interchange Control Envelope.

Payment and Remittance Schedule

835s are available for retrieval each week.

Retroactive Pay Cycles

When a retro cycle produces a separate payment from the regular weekly claims run, a separate 835 transaction is also produced.

835 Transactions in Response to Retail Pharmacy Claims

Retail pharmacy providers will receive their payment and 835 from MassHealth. Although MMIS does not accept pharmacy claims, it receives the adjudicated pharmacy claim information from the Pharmacy Online Processing System (POPS) vendor, to be subsequently included in the MMIS financial process. The MMIS 835 for pharmacy claims generates from this information. Information

about the contents in the retail pharmacy 835 transaction may be requested by calling MassHealth Pharmacy Technical Help Desk at (866) 246-8503.

835 Transactions in Response to Dental Claims

Dental providers submitting both dental and medical claims will receive their payment and 835 from MassHealth. Adjudicated dental claim information is received from DentaQuest, a third-party vendor, to be subsequently included in the MassHealth financial process. It is from this information that the MassHealth 835 for dental claims is generated. If a provider submits both dental and medical claims, they will access their 835 transaction from MassHealth. If a provider submits only dental claims, the 835 is distributed by DentaQuest. These providers should work with DentaQuest to establish connectivity to receive their 835 transaction.

Support contact information for DentaQuest follows below.

DentaQuest/MassHealth Dental Program
MassHealth
P.O. Box 2906
Milwaukee, WI 53201-2906
Phone: (800) 207-5019
Email: ecclaims@masshealth-dental.net
Website: www.masshealth-dental.net

Claim Level Data-CLP Segment

MassHealth denies claims with header-submitted charges not matching the total detail-submitted charges. These claims will be reported on the 835 with only header information (a CLP segment with a CAS segment offsetting the billed amount) and no SVC data.

If the sum of the claim payment amounts (CLP04s) on the 835 transaction minus the provider level adjustment is positive, then a check or EFT payment is produced. One check or one EFT payment must balance to one 835 transaction. As a result, each 835 can have only one ST and SE segment. MassHealth produces all the provider's paid and/or denied claims in a weekly cycle in one ST/SE segment, even if the number of CLP segments exceeds 10,000.

If the sum of the claim payment amounts (CLP04s) on the 835 minus the provider level adjustment is zero or negative, then no check or EFT payment is sent. The 835 is still produced, but the financial fields are zero-filled, as they will not be applicable.

Claims Adjustment - Denied Claims with a CAS Segment

If a denied claim has a nonzero, other paid amount, and the other paid amount is not equal to the billed amount, the other paid amount will be reported as an adjustment, and the remaining dollars will then be divided across all reportable Claim Adjustment Reason Codes (CARCs). If the claim is reported at the detail and header edits exist, the header edits will be added to each of the detail lines and will be included in the distribution of the remaining dollars for that detail CAS.

If a denied claim has a nonzero, other paid amount, the other paid amount is equal to the billed amount. The other paid amount will not be reported as an adjustment, and all the adjustment dollars will be divided across all reportable CARCs.

Please see [Appendix B](#) – Business Scenarios for examples of how claims adjustment reason codes for denied claims are reported.

Default Dates

When an invalid date is submitted on the claim, or when a claim has a fatal error before the system can store the dates that were submitted on the claim, a default date of “19000101” will be coded on the 835 transaction for any date field.

Additional Information for Member Name

The member name submitted with a claim may be up to 60 characters for the last name and 35 characters for the first name. Loop 2100 patient name segment will report the last and first name as submitted with the claim. Loop 2100 corrected patient/insured name is only reported when the submitted name is different from the one stored in the MMIS database.

DRG Information for Acute Inpatient Hospital Claims

MassHealth is reporting the DRG information for inpatient hospitals claims, upon implementation of the DRG pricing methodology. The DRG value returned from 3M grouper, as well as the weight used in the calculation of the DRG price, will report in CLP11/CLP12.

MassHealth will not report the DRG information for the denied inpatient hospital claims, even if the claim DRG pricing was successfully calculated and the claim denied for other reasons.

Inpatient Adjudication Information

Concurrently with the DRG implementation, MassHealth will begin reporting the MIA segment for all header reported claims, even those not using DRG pricing. The MIA segment will report DRG information, if applicable, and up to five header posted remark codes.

EAPG Information for Acute Outpatient Hospital Claims

MassHealth will report EAPG information at the service line level for acute outpatient hospital claims upon implementation of the Adjudicated Payment per Episode of Care (APEC) pricing methodology. The EAPG value returned from 3M grouper will be reported in the 2110: REF Service Identification segment with qualifier (2110:REF01) equal to 1S.

Outpatient Adjudication Information

If an outpatient episode is eligible for outlier payment, MMIS calculates the outlier amount that will be reported on the 835 as a CAS segment with a CARC of 70. The outlier 2110: CAS segment will be posted to the first paid service line for that episode.

The 3M-assigned consolidation, packaging, and/or discounting flags are cross-walked to EOB codes in MMIS. In turn, the EOB codes are mapped to unique remark codes. If a service line has gone through consolidation, packaging and/or discounting, the respective remark codes will be noted in the LQ segment of 2110 service loop with a qualifier of HE.

8. Acknowledgements and/or Reports

MassHealth does not require an acknowledgement and will ignore the receipt of any 999 transactions.

9. Trading Partner Agreements

Providers who intend to conduct electronic transactions with MassHealth must sign the MassHealth TPA. A copy of the agreement is available at www.mass.gov or by contacting MassHealth Customer Service at (800) 841-2900.

■ TRADING PARTNERS

Electronic Data Interchange (EDI) defines a Trading Partner as any entity (provider, billing service, software vendor, employer group, financial institution, etc.) that conducts electronic transactions with MassHealth. The Trading Partner and MassHealth acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Each party agrees to take all steps reasonably necessary to ensure that all electronic transactions between them conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated thereunder.

Payers have EDI TPAs that accompany the standard Implementation Guide to ensure the integrity of the electronic transaction process. The TPA relates 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.

10. Transaction-Specific Information

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed through the use of tables. The tables contain a row for each segment that MassHealth has something specific and 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 subset of the IGs internal code listings;
- clarify the use of loops, segments, composite, and simple data elements; and
- provide other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with MassHealth.

In addition to the row for each segment, MassHealth uses one or more additional rows to describe its usage for composite and simple data elements and for any other information. Notes and comments are placed at the highest level of detail. For example, a note about a code value is placed on a row specifically for that code value, not in a general note about the segment.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
70	-----	BPR01	Transaction Handling Code	I, H	
72	-----	BPR04	Payment Method Code	ACH, NON	
72	-----	BPR05	Payment Format Code	CCP	
74	-----	BPR11	Originating Company Supplemental Code		MassHealth uses this field for tracking purposes to assist in issue resolution. It is populated with a voucher number from MMARS.
82	-----	REF02	Receiver Identifier		MassHealth returns the 835 receiver's National Provider Identifier (NPI) or MassHealth- assigned PID/SL if the receiver does not have NPI.
86	-----	DTM02	Production Date		This attribute is also known as the financial run date. The run date is calculated based on the system date in which the financial cycle was initiated.
87	1000A	N102	Payer Name		This value is always Commonwealth of Massachusetts/EOHHS/ Office of Medicaid.
95	1000A	PER01	Contact Function Code	CX	Payers Claim Office
95	1000A	PER03	Communication Number Qualifier	TE	
95	1000A	PER05	Communication Number Qualifier	8008412900	The phone number on the 835 will be that of MassHealth Customer Service. However, if the questions are about a pharmacy claim, use the MassHealth Pharmacy Technical Help Desk at (866) 246-8503. If questions are about a dental claim, use the DentaQuest phone number (800) 207-5019.
96	1000A	PER05	Communication Number Qualifier	EM	

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
96	1000A	PER06	Payer Contact Communication Number		www.mass.gov/masshealth The email address on the 835 will be for MassHealth Customer Service: edi@mahealth.net For DentaQuest, email: www.masshealth-dental.net
97	1000A	PER01	Contact Function Code	BL	Technical Department
98	1000A	PER03	Communication Number Qualifier	EM	
98	1000A	PER04	Payer Contact Communication Number		hipaasupport@mahealth.net
99	1000A	PER05	Communication Number Qualifier	UR	
99	1000A	PER06	Payer Contact Communication Number		www.mass.gov/masshealth
103	1000B	N103	Identification Code Qualifier	XX, FI	MassHealth uses the NPI qualifier when the NPI is returned. In the Payee Identification Code, MassHealth uses the federal taxpayer's identification number qualifier, when the provider tax ID is returned in the Payee Identification Code.
103	1000B	N104	Payee Identification Code		MassHealth returns NPI. For an atypical provider, MassHealth returns provider tax ID.
104	1000B	N301	Payee Address Line		In MMIS, this field is not used, therefore the billing address on file will not be returned.
105	1000B	N401	Payee City Name		In MMIS, this field is not used, therefore the billing address on file will not be returned.
106	1000B	N402	Payee State Code		In MMIS, this field is not used, therefore the billing address on file will not be returned.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
106	1000B	N403	Payee Postal Zone or ZIP Code		In MMIS, this field is not used, therefore the billing address on file will not be returned.
107	1000B	REF01	Reference Identification Qualifier	TJ, PQ	
108	1000B	REF02	Additional Payee Identifier		MassHealth returns federal taxpayer's identification number when the NPI is returned in the Payee Identification Code. MassHealth returns MMIS PID/SL when the provider tax ID is returned in the Payee Identification Code (for atypical providers).
124	2100	CLP02	Claim Status Code	1, 2, 3, 4, 22	
125	2100	CLP05	Patient Responsibility Amount		
127	2100	CLP08	Facility Type Code		
127	2100	CLP09	Claim Frequency Code		
128	2100	CLP11	Diagnosis Related Group (DRG) Code		MassHealth only returns the DRG value from 3M grouper for inpatient hospital claims priced using DRG. This does not apply to any other claim type.
128	2100	CLP12	Diagnosis Related Group (DRG) Weight		MassHealth returns the DRG weight used to calculate the DRG price for inpatient hospital paid claims. This does not apply to any other claim type.
128	2100	CLP13	Discharge Fraction		
131	2100	CAS01	Claim Adjustment Group Code		
131	2100	CAS02	Adjustment Reason Code		
137	2100	NM1	Patient Name		For 837 and POSC claims, MassHealth returns the patient's name information as submitted on the claim. For paper claims, MassHealth returns the patient's name on file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
143	2100	NM1	Corrected Patient or Insured Name		This segment is only populated if the Subscriber Name received on an 837 or DDE differs from the name on file. This segment is never populated for claims received on paper.
144	2100	NM103	Corrected Patient or Insured Last Name		If the Subscriber Primary Identifier (member name) submitted with the original claim is not found in our system, MassHealth populates the Corrected Patient Last and First name with "name missing." (maximum 60 characters).
144	2100	NM104	Corrected Patient or Insured First Name		MassHealth returns a maximum of 1 character for this field when the search returns a result. (maximum 35 characters).
147	2100	NM103	Rendering Provider Last or Organization Name		For 837 claims, MassHealth returns the claim level rendering provider information as submitted on the claim. For paper and DDE claims, MassHealth returns the rendering provider's name on the database.
147	2100	NM104	Rendering Provider First Name		
148	2100	NM105	Rendering Provider Middle Name or Initial		
148	2100	NM108	Identification Code Qualifier	XX	This segment will be populated only if the rendering provider's NPI is submitted on the original claim.
				MC	This segment will be populated only if the rendering provider's Atypical (PID/SL) is submitted on the original claim.
149	2100	NM109	Rendering Provider Identifier		

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
153	2100	NM1	Corrected Priority Payer Name		This segment is populated to report the payer that caused the claim to deny with TPL edit. If multiple payers caused the claim to deny for TPL edit, MassHealth prioritizes the payer to be reported. (Medicare takes priority.)
154	2100	NM103	Corrected Priority Payer Name		Carrier name is populated here.
154	2100	NM108	Identification Code Qualifier	PI	
154	2100	NM109	Corrected Priority Payer Identification Number		MassHealth carrier ID is populated here.
159	2100	MIA	Inpatient Adjudication Information		MassHealth returns the MIA segment for all inpatient claims. The MIA segment will report DRG information if applicable and up to five remark codes.
160	2100	MIA02	PPS Operating Outlier Amount		MassHealth returns the DRG cost outlier amount in this field. Only claims for inpatient hospitals using DRG pricing will have this field populated with the cost outlier amount.
161	2100	MIA04	Claim DRG Amount		MassHealth returns the base DRG amount for all inpatient hospital claims using the DRG pricing methodology. This is the DRG payment before other adjustments such as patient payment, TPL, etc., have been applied.
161	2100	MIA05	Claim Payment Remark Code		MassHealth returns the remark code for all inpatient claims.
162	2100	MIA10	PPS-Capital HSP DRG Amount		MassHealth returns the PPS capital, hospital-specific portion (DRG) amount calculated within the DRG pricing formula.
164	2100	MIA20	Claim Payment Remark Code		For all inpatient claims, MassHealth returns the second remark code here, when more than one remark code is available.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
165	2100	MIA21	Claim Payment Remark Code		For all inpatient claims, MassHealth returns the third remark code here, when more than two remark codes are available.
165	2100	MIA22	Claim Payment Remark Code		For all inpatient claims, MassHealth returns the fourth remark code here, when more than three remark codes are available.
165	2100	MIA23	Claim Payment Remark Code		For all inpatient claims, MassHealth returns the fifth remark code here, when more than four remark codes are available.
169	2100	REF01	Reference Identification Qualifier	EA, SY, G1, F8, 6P	
170	2100	REF02	Other Claim Related Identifier		MassHealth will display the appropriate identified that corresponds to the REF01 segment.
173	2100	DTM	Statement From or To Date		MassHealth always populates this element.
182	2100	AMT01	Amount Qualifier Code	AU, F5	
183	2100	AMT02	Claim Supplemental Information Amount		
187	2110	SVC01-1/	Product or Service ID Qualifier	NU	For certain institutional services with only a revenue code, this qualifier is used.
		SVC01-2	Adjudicated Procedure Code		
187	2110	SVC01-1/	Product or Service ID Qualifier	HC	For other institutional services with HCPCS, this qualifier is used.
		SVC01-2	Adjudicated Procedure Code		
187	2110	SVC01-1/	Product or Service ID Qualifier	HC	For professional services with HCPCS, this qualifier is used.
		SVC01-2	Adjudicated Procedure Code		
187	2110	SVC01-1/	Product or Service ID Qualifier	AD	For dental services, this qualifier is used.
		SVC01-2	Adjudicated Procedure Code		
187	2110	SVC01-1/	Product or Service ID Qualifier	N4	For 837 and pharmacy services with NDCs, this qualifier is used.
		SVC01-2	Adjudicated Procedure Code		

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
190	2110	SVC04	National Uniform Billing Committee Revenue Code		For institutional services with both HCPCS and revenue code, the revenue code will be reported here.
198	2110	CAS01	Claim Adjustment Group Code		
198	2110	CAS02	Adjustment Reason Code		
204	2110	REF01	Reference Identification Qualifier	1S	
205	2110	REF02	Provider Identifier		MassHealth returns the service line EAPG value.
207	2110	REF01	Reference Identification Qualifier	1D, HPI	
208	2110	REF02	Rendering Provider Identifier		MassHealth returns the service level rendering provider information as submitted on the claim only if different from the claims service provider and/or from the payee.
211	2110	AMT01	Amount Qualifier Code	B6	
212	2110	AMT02	Service Supplemental Amount		Allowed amount from the service line
215	2110	LQ	Health Care Remark Codes		There are as many iterations of this segment as needed to accommodate each unique remark code associated with the service line.
215	2110	LQ01	Code List Qualifier Code	HE	
217	-----	PLB	Provider Adjustment		This segment is used only if there are non-claim-related adjustments and/or adjustments made by MMARS.
218	-----	PLB03	Adjustment Identifier		
219	-----	PLB03-1	Adjustment Reason Code	72, CT, FB, IR, LE, WO, CS	
222	-----	PLB03-2	Provider Adjustment Identifier		All 9s will be populated here when a MMARS adjustment has been performed.

APPENDICES

Appendix A. Implementation Checklist

This appendix contains all necessary steps for implementing the transactions with MassHealth.

1. Call the EDI Help Desk with any questions at (800) 841-2900. See [Section 5—Contact Information](#)
2. Check www.mass.gov/masshealth for the latest information on MassHealth's system.
3. Confirm that you have an EOHHS User Name and/or Provider ID.
4. Confirm that you can access the live system (and the test environment, if testing) with your POSC username.
5. Make the appropriate changes to your systems/business processes to comply with the *ASC X12 V5010 Implementation Guide* and the *MassHealth Standard Companion Guide*.
 - If you have a third-party vendor or use third-party software, work with your vendors to have the appropriate software installed.
 - If testing the system-to-system connectivity method interface, the Trading Partner or provider must work with your software vendor to have the appropriate software installed at their site(s) prior to performing testing with MassHealth.
6. Identify the functions you will be testing.
 - Health Care Eligibility/Benefit Inquiry and Information Response (270/271)
 - Health Care Claim Status Request and Response (276/277)
 - Health Care Payment/Advice (835)
 - Health Care Claim: Institutional (837I)
 - Health Care Claim: Professional (837P)
 - Crossover/COB Claims
7. Confirm you have reported all the NPIs you will be using by validating them with MassHealth. Make sure your claim(s) successfully pays to your correct Provider ID if you have associated multiple MassHealth provider IDs to one NPI and/or taxonomy code.
 - If the entity is a billing intermediary or software vendor, they should use the provider's identifiers on the transaction.
8. When submitting files, make sure the members/claims you submit are representative of the type of service(s) you provide to MassHealth members.
9. If you determine that you will test the transaction, or testing is mandated by MassHealth
 - Schedule a tentative week for the initial test; and
 - Confirm the name, email, and phone number of the primary testing contact.

Appendix B. Business Scenarios

This appendix contains typical business scenarios for exchanging transactions with MassHealth. Samples of the actual data streams linked to these scenarios are included in [Appendix C](#).

1. Examples of segments within 835 transactions

A. 2100 AMT Coverage Amount

The sample 835 shows the new AMT*AU coverage amount posted only for information.

Note: AMT*AU is not part balancing.

B. 2100 DTM Claim Date Coverage Expiration Date

Sample denied ICN where denial is for member's coverage ended. The 835 displays the member's coverage end date in the DTM*036 line resulting in member denying for no open coverage on service date billed.

2. 2100 CLP samples

A. 2100 CLP Sample #1

Sample denied claim where the CLP02 / claim status = 1

Prior to 5010, the CLP02 status would equal 4 for all denied claim records.

B. 2100 CLP Sample #2

Sample denied claim for edit 2001/member not on file, where CLP02/claim status = 4

This is the only denial edit reason that will result in a CLP02 status of '4'.

C. 2100 CLP Sample #3

Sample paid claim where CLP02/ claim status = 1.

3. Examples of Claim Adjustment Reason Code (CARC) reported on denied claims with TPL amount

A. Sample Denied claim with TPL < Billed Amount and edits cross-walked to multiple CARCs

Billed amount = \$100.00

Other paid amount = \$80.00

Denied edit codes cross-walked to adjustment reason codes AA and BB

Adjustments

Other paid amount = \$80.00

AA = \$10.00

BB = \$10.00

B. Sample Denied claim with TPL = Billed amount and edits cross-walked to multiple CARCs

Billed amount = \$100.00

Other paid amount = \$100.00

Denied edit codes cross-walked to adjustment reason codes AA and BB

Adjustments

AA = \$50.00

BB = \$50.00

C. Sample Denied claim with TPL > Billed amount and edits cross-walked to multiple CARCs.

Billed amount = \$100.00

Other paid amount = \$120.00

Denied edit codes cross-walked to adjustment reason codes AA and BB

Adjustments

Other paid amount = \$120.00

AA = -\$10.00

BB = -\$10.00

4. Examples of Adjustment Amounts distributed amongst CARCs – Denied Claims

The difference between SVC03 and SVC02, divided by the number of Claim Adjustment Reason Codes (CARC) associated with the claim after specific TPL or PR CARCs are subtracted, is returned in Adjustment Amounts.

SVC02 = \$330.30

SVC03 = \$0

Other paid amount = \$30.00

The MMIS edits 2529, 814, 1055, 2507 (and 5008 are generated for this claim (see the cross walk from the edits to CARC in the table below)).

The Adjustment Amount for CARC 23 (TPL) would be subtracted from the \$330.30, leaving \$300.30, the remaining amount is divided by 3, each of the unique non-TPL CARCs, will be reported with the same dollar amount.

Sample of MassHealth Edit Code Crosswalks

Current MassHealth Edit Code	Claim Adjustment Reason Code (CARC)	Claim Adjustment Group Code	Remark Code
2529	23 (TPL)	OA	N379
814	16	CO	N382
1055	183	CO	N286
2507	16	CO	N245

Current MassHealth Edit Code	Claim Adjustment Reason Code (CARC)	Claim Adjustment Group Code	Remark Code
5008	97	CO	M86

5. Examples of multiple Remark Codes reported in LQ segment

The MMIS edits 2529, 814, 1055, 2507 and 5008 are generated for a claim (see the crosswalk from the edits to Remark Codes in the table above). Five unique remark codes will be reported in five LQ segments. Edit codes 814 and 2507 share the same CARC (16). However, they have different remark codes that are reported in LQ segments.

6. Examples of paid claim adjudicated using APR-DRG pricing methodology

A. 2100 CLP segment will contain APR-DRG information

CLP11 = DRG and CLP12 = DRG weight

7. Examples of paid or denied claims reported at the header only (i.e., claim type 'T') for all payment methodologies. The MIA segment will report up to five remark codes in MIA05, MIA20-MIA23.

A. 2100 MIA segment for claims types 'A', 'T' and 'L'

Applies to all payment methodologies

The MIA segment will report up to five remark codes in MIA05, MIA20-MIA23.

B. 2100 MIA segment for paid claims adjudicated using APR-DRG pricing methodology

The MIA segment in addition to the remark codes will include APR-DRG information.

MIA02 = outlier amount;

MIA04 = Claim DRG Amount;

MIA10 = hospital-specific capital amount

8. Examples of 835 transaction coding for paid acute outpatient hospital claims paying with the new APEC pricing methodology

A. 2110 REF segment for service loops where the APEC pricing method was applied

This segment will contain the Adjusted EAPG value returned from 3M for this detail.

Only APEC paid details will have this segment.

B. When an outlier amount is present for an episode there will be a 2110: CAS segment with a CARC of 70 on the first paid APEC detail in the episode. This CAS segment will contain the outlier amount (as a negative number). The outlier amount is calculated per episode on the claim.

C. When packaging, discounting, or other specific flags are returned to MMIS from 3M, they are mapped to MMIS EOBs, which in turn are mapped to CARCs and remark codes. The remark codes will appear in the 2110: LQ segments.

Appendix C. Transmission Examples

This appendix contains actual data streams. The business scenarios linked to the data streams are included in [Appendix B](#).

1. Examples of segments within 835 transactions

A. 2100 AMT Coverage Amount

The sample 837I EDI shows the new AMT*AU coverage amount posted only for information.

Note: AMT*AU is not part balancing.

```
LX*1-  
CLP*26010*4*1000*0*0*MC*2211219000001-  
CAS*CO*45*1000-  
NM1*QC*1* LASTNAME*FIRSTNAME****MR*999999999999-  
NM1*74*1* CORRECTEDLASTNAME*CORRECTEDFIRSTNAME-  
DTM*232*20110601-  
DTM*233*20110604-  
AMT*AU*8145.63-
```

B. 2100 DTM Claim Date Coverage Expiration Date

Sample denied ICN where denial is for member's coverage ended. The 835 displays the member's coverage end date in the DTM*036 line resulting in member denying for no open coverage on service date billed.

```
CLP*24622*4*155*0*0*MC*2011201700001-  
NM1*QC*1*LASTNAME*FIRSTNAME****MR*999999999999-  
NM1*74*1* CORRECTEDLASTNAME*CORRECTEDFIRSTNAME-  
REF*EA*125-  
DTM*232*20110712-  
DTM*233*20110712-  
DTM*036*19791231-  
SVC*HC:99214*150*0**0**1-  
DTM*472*20110712-  
CAS*CO*31*150-  
REF*6R*321-  
REF*HPI*1821017195-  
LQ*HE*N30-
```

2. 2100 CLP samples

A. 2100 CLP Sample #1

Sample denied claim where the CLP02 / claim status = 1.

```
CLP*TEST WI 26768*1*155*0*0*MC*201128070999*11*1-
```

NM1*QC*1*LASTNAME *FIRSTNAME *****MR*999999999999-
 REF*EA*125-
 DTM*232*20110822-
 DTM*233*20110822-
 DTM*036*19791231-
 SVC*HC:99214*150*0**0**1-
 DTM*472*20110822-
 CAS*CO*31*150-
 REF*6R*321-
 REF*HPI*1821017195-
 LQ*HE*N30-
 SVC*HC:82270*5*0**0**1-
 DTM*472*20110822-
 CAS*CO*31*5-
 REF*6R*322-
 REF*HPI*1821017195-
 LQ*HE*N30-
 SE*58*28001-
 GE*1*28-
 IEA*1*000000396-

B. 2100 CLP Sample #2

Sample denied claim for edit 2001 / member not on file.

CLP*TEST WI 26768*4*155*0*0*MC*201128070999*11*1-
 CAS*CO*31*155-
 NM1*QC*1*LASTNAME *FIRSTNAME *****MR*999999999999-
 REF*EA*125-
 DTM*232*20110811-
 DTM*233*20110811-

C. 2100 CLP Sample #3

Sample paid claim where CLP02 / claim status = 1.

CLP*Defect 26686*1*155*77.1*0*MC*201128570999*11*1-
 NM1*QC*1*D*Evelyn*****MR*999999999999-
 NM1*74*1*LASTNAME *FIRSTNAME-
 REF*EA*125-
 DTM*232*20110902-
 DTM*233*20110902-
 SVC*HC:99214*150*73.71**1-
 DTM*472*20110902-
 CAS*CO*45*76.29-
 REF*6R*321-
 REF*HPI*1821017195-
 AMT*B6*73.71-
 LQ*HE*N419-
 SVC*HC:82270*5*3.39**1-
 DTM*472*20110902-
 CAS*CO*45*1.61-
 REF*6R*322-
 REF*HPI*1821017195-
 AMT*B6*3.39-
 LQ*HE*N419-

3. 2100 Claim Adjustments for denied claims

A. 2100 CAS Sample #1

Sample denied claim with TPL < Billed Amount

LX*1-
CLP*26010*2*100*0*0*MC*2211219000001-
CAS*OA*23*80-
CAS*CO*16*10**183*10-

B. 2100 CAS Sample #2

Sample denied claim with TPL = Billed Amount

LX*1-
CLP*26010*2*100*0*0*MC*2211219000001-
CAS*CO*16*50**183*50-

C. 2100 CAS Sample #3

Sample denied claim with TPL > Billed Amount

LX*1-
CLP*26010*2*100*0*0*MC*2211219000001-
CAS*OA*23*120-
CAS*CO*16*-10**183*-10-

4. 2110 Claim Adjustment amounts for denied claims

A. 2110 CAS Sample #1

Sample denied claim - Adjustment amounts distributed amongst CARCs

CLP*24622*2*330.30*0*0*MC*2011201700001-
NM1*QC*1*LASTNAME*FIRSTNAME****MR*999999999999-
NM1*74*1* CORRECTEDLASTNAME*CORRECTEDFIRSTNAME-
REF*EA*125-
DTM*232*20110712-
DTM*233*20110712-
DTM*036*19791231-
SVC*HC:99214*330.30*0**0**1-
DTM*472*20110712-
CAS*OA*23*30.00-
CAS*CO*16*100.10**183*100.10**97*100.10-
REF*6R*321-
REF*HPI*1821017195-

5. 2110 LQ segments

A. 2110 LQ Sample #1

Sample service line with multiple Remark Codes reported in LQ segments

```
CLP*24622*2*330.30*0*MC*2011201700001-  
NMI*QC*1*LASTNAME*FIRSTNAME****MR*999999999999-  
NMI*74*1* CORRECTEDLASTNAME*CORRECTEDFIRSTNAME-  
REF*EA*125-  
DTM*232*20110712-  
DTM*233*20110712-  
DTM*036*19791231-  
SVC*HC:99214*330.30*0**0**1-  
DTM*472*20110712-  
CAS*OA*23*30.00-  
CAS*CO*16*100.10**183*100.10**97*100.10-  
REF*6R*321-  
REF*HPI*1821017195-  
LQ*HE*N379-  
LQ*HE*N382-  
LQ*HE*N286-  
LQ*HE*N245-  
LQ*HE*M86-
```

6. 2100 CLP segments

A. 2100 CLP Sample #1

Sample paid claim adjudicated using APR-DRG pricing methodology

```
CLP*100009240118*2*5988*202.6*0*MC*2214153000001*11*1**0115*.4421-  
CAS*CO*96*1049.56-  
CAS*OA*23*4735.84-  
NMI*QC*1*LAST NAME*FIRST NAME****MR*999999999999-  
NMI*74*1***A-
```

7. 2100 MIA segments

A. 2100 MIA Sample #1

Sample for claims paid at the header not using APR-DRG pricing methodology, or all denied claims reported at the header (i.e., Claim type 'I')

```
CLP*TEST not DRG*3*12900*12652.07*0*MC*2014150301112*11*1-  
CAS*CO*96*-552.07-  
CAS*OA*23*800-  
NMI*QC*1*LAST NAME*FIRST NAME****MR*999999999999-  
NMI*74*1***H-  
MIA*0***N245*****N419*N647*N419*N30-
```

B. 2100 MIA Sample #2

Sample for paid claims using APR-DRG pricing methodology

```
CLP*TEST 2 REPL*3*512900*112652.07*0*MC*2014150300002*11*1**0445*1.3413-
CAS*CO*96*-552.07-
CAS*OA*23*800-
NM1*QC*1*LAST NAME*FIRST NAME****MR*999999999999-
NM1*74*1***H-
MIA*0*50000**13452.07*N245*****780.31*****N419*N647-
```

8. 2110 CAS and new REF segments for APEC pricing

A. The new 2110:REF segment on APEC details

```
SVC*HC:19125:50:RT*1500*742.32*0761*1-
DTM*472*20160606- Each DOS is an episode, all services with the same DOS are in the same episode
CAS*CO*45*757.68-
REF*IS*20- The new segment posting the adjusted EAPG value for this service line(20)
AMT*B6*742.32-
LQ*HE*N701- EOB 9850 (BILATERAL DISCOUNTING APPLIES) maps to remark code N701
```

B. APEC paid details with an Outlier payment applied

The CO*45 is the APEC adjustment (billed amount – the EAPG payment).

The CARC 70 has the outlier payment amount (it will post as a negative number).

The outlier CARC payment will always post on the first paid detail of an episode.

```
SVC*HC:99283*50000*11747.77*0450*1-
DTM*472*20160509-
CAS*CO*45*49946.4**70*-11694.17- EAPG adjustment (45) AND outlier payment (70)
REF*IS*565- EAPG new segment
AMT*B6*11747.77-
SVC*HC:70481*1400*52.29*0350*1-
DTM*472*20160510-
CAS*CO*45*1347.71-
REF*IS*301- EAPG new segment
AMT*B6*52.29-
```

C. EAPG

Consolidation, discounting, etc. that have been applied by 3M and returned as flags, will be mapped to MMIS EOBs and the EOBs will map to a CARC and remark code. The remark codes will be posted in the 2110:LQ segments. The following example shows a 2110 loop with a \$0.00 payment and two remark codes that were mapped from the 3M consolidation flags that set on the detail.

```
SVC*HC:71020*100*0*0322*1-
DTM*472*20160726-
CAS*CO*45*100-
REF*IS*471- EAPG
LQ*HE*M15- 3M returned a consolidation flag for this detail
LQ*HE*N381- 3M returned a consolidation flag for this detail
```

Appendix D. Frequently Asked Questions

This appendix contains a compilation of questions and answers related to MassHealth and its providers. Typical questions would involve a discussion about code sets and their effective dates.

Q: Do I have to receive an 835 remittance response if I submit my claims electronically?

A: No. You can submit an 837 transaction, but elect not to receive the 835 response. You will still receive the PDF remittance advice. A provider's receipt of an 835 will not be automatic. Trading Partners must complete the ERA Enrollment /Modification Form to identify the 835 receiver.

Q: Will any paper claims I submit also appear on the 835?

A: Yes. All paid and denied claims adjudicated in the weekly cycle will appear, regardless of how the claims were submitted.

Q: Will suspended and pended claims appear on the 835?

A: No. Suspended and pended claims will appear only in the MassHealth proprietary PDF remittance advice.

Q: Can I have my billing intermediary receive my 835?

A: Yes. You can have your billing intermediary receive your 835 as long as you indicate that in your Trading Partner panel (TPP) information by submitting an ERA Enrollment/Modification Form.

Q: Do I need a valid electronic funds transfer (EFT) form on file in order to receive the 835 electronic remittance advice (ERA) file?

A: Yes. MassHealth requires that all Trading Partners that wish to receive an 835 ERA file or authorize a vendor to receive it on their behalf, must have a valid EFT form on file.

Q: How do I become enrolled for an 835 ERA file?

A: You may submit an ERA form or send the request on your letterhead to edi@mahealth.net or fax it to (617) 988-8971. Please note that it may take up to 3 weeks for an ERA change to take effect.

Q: Where do I find my remittance advice?

A: MassHealth makes available the 835 ERA file and the PDF RA available to download from the Provider Online Service Center (POSC). They are usually available on Mondays.

Q: Why are some of my payments missing from my recent remittance advice?

A: Payments are reported on your remittance advice within three to four weeks after adjudication. This is due to the MMIS financial payment cycle. If payments were not for MassHealth claims, this payment would not be on a MassHealth remittance advice. To verify a payment, MassHealth recommends checking the "vendor web" website at <https://massfinance.state.ma.us/VendorWeb/vendor.asp>.

Q: I can't find the exact payment amount in the 835 file.

A: When searching the 835 file, exclude the dollar sign (\$) and drop the "0" after the decimal point. For example, if searching for \$1.50, search by "1.5".

Q: How do I get older remittance advices reposted?

A: MassHealth cannot repost RAs. Please contact MassHealth Customer Service to request PDF remittance advice reports that are older than six months.

Q: Are retail pharmacy claims included in the MassHealth remittance advice?

A: Yes. Adjudicated retail pharmacy claims are included in the remittance advice and the provider will receive payment from MassHealth. The MMIS system receives pharmacy claims from the Pharmacy Online Processing System (POPS) and is included in the MassHealth financial process. If you have any questions about pharmacy claims, please call the MassHealth Pharmacy Technical Help Desk at (866) 246-8503.

Q: Are dental claims included in the MassHealth remittance advice?

A: Yes. Adjudicated dental claims are included in the remittance advice. You will receive payment from MassHealth if you submit both medical and dental claims. We receive adjudicated dental claims from DentaQuest and these claims are included in the MassHealth financial process. For providers that submit only dental claims (and not medical claims), you will not receive a remittance advice or payment from MassHealth. You should contact DentaQuest directly at (800) 207-5019.

Q: Where can I find a full list of CARCs/RARCs?

A: The claim adjustment reason codes (CARC) and remittance advice remark codes (RARC) are listed on the Washington Publishing Corporation at www.wpc-edi.com. MassHealth posts its CARC/RARC crosswalk to MassHealth-specific EOB codes on mass.gov for reference.

Appendix E. Change Summary

The *MassHealth Companion Guide* has been updated to comply with MassHealth's Technical Refresh Initiative, which requires the replacement of the MassHealth EDI HIPAA translator. This version of the *MassHealth Companion Guide* follows the CAQH CORE V5010 Companion Guide template. All references to the ASCX12 Implementation Guide are necessary to convey MassHealth's specific usage of the data elements to support electronic processing of the transaction with its Trading Partners, including codes and specific program instructions.

The following changes have been incorporated into this Companion Guide.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
95	1000A	PER03	Communication Number Qualifier	EM	
95	1000A	PER04	Payer Contact Communication Number		hipaasupport@mahealth.net The phone number on the 835 will be that of MassHealth Customer Service. However, if the questions are about a pharmacy claim, use the MassHealth Pharmacy Technical Help Desk at (866) 246-8503. If questions are about a dental claim, use the DentaQuest phone number (800) 207-5019.
96	1000A	PER05	Communication Number Qualifier	UR	
96	1000A	PER06	Payer Contact Communication Number		www.mass.gov/masshealth The email address on the 835 will be for MassHealth Customer Service: edi@mahealth.net For DentaQuest, email: www.masshealth-dental.net
98	1000A	PER02	Payer Technical Contact Name		EOHHS Customer Service
98	1000A	PER03	Communication Number Qualifier	EM	
98	1000A	PER04	Payer Contact Communication Number		hipaasupport@mahealth.net
99	1000A	PER06	Payer Contact Communication Number		www.mass.gov/masshealth
101	1000A	PER04	Communication Number		hipaasupport@mahealth.net

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