MassHealth
Standard Companion Guide
837 Post-adjudicated Claims Data Reporting: Professional

Refers to the Implementation Guides Based on ASC X12N Version 005010X298A1

March 2026

Disclosure Statement

This *MassHealth Standard Companion Guide* ("Companion Guide") serves as a companion document to the corresponding ASC X12N/005010X298 837 Post-adjudicated Claims Data Reporting: Professional and its related Addenda (005010X298A1). 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.

This document supplements but does not contradict, disagree, oppose, or otherwise modify the 005010X298A1 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.

MassHealth's Standardized Encounter Data Program (SENDPro)

MassHealth requires that Managed Care Entities (MCE)s submit encounter data to the agency on a bi-weekly basis through its SENDPro solution, with plans to move to weekly in the future. See Encounter Submission Guidelines in Section 7 for additional details on submission frequency. SENDPro manages trading partner information, facilitates the exchange of HIPAA ASC X12 and NCPDP transactions, validates HIPAA compliance, and produces acknowledgments for each submitted file. Additional details about SENDPro are detailed below.

Contact for Additional Information

Please note: Updates will be included in future versions of the Companion Guide.

MassHealth Encounter Data Support Services
Email: TBD
Phone Number: TBD

MassHealth Data Warehouse
XXXXX

Preface

This *MassHealth Standard Companion Guide* to the *005010 ASC X12N Technical Report Type 3 Implementation Guide* and associated addenda adopted under Health Insurance Portability and Accountability Act (HIPAA) 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 uses 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, or 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 healthcare 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 healthcare transactions.

This document is intended to provide information from MassHealth to its Trading Partners that provides the information necessary to exchange Electronic Data Interchange (EDI) X12 transactions with the agency. This includes information about specific data requirements, registration, testing, and support.

SCOPE

The standard adopted by Health & Human Services (HHS) for electronic healthcare transactions is ASC X12N Version 005010, which became effective January 1, 2012. Although HHS did not mandate the adoption of the Post-Adjudicated Claims Data Reporting transaction, EOHHS has adopted the transaction set to support its encounter data submissions from MassHealth Managed Care Entities (MCE)s. The unique version/release/industry identifier code for the Post-adjudicated Claims Data Reporting: Professional (837) transactions is 005010X298A1.

This Companion Guide assumes compliance with all loops, segments, and data elements contained in the 005010X298A1. It defines the requirements for HIPAA transactions submitted to and/or received from MassHealth.

OVERVIEW

MassHealth created this Companion Guide for MassHealth Managed Care Entities (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 electronic transaction
- Technical requirements and transmission options
- Information on testing procedures that each Trading Partner must complete before transmitting electronic transactions

The information in this document outlines MassHealth's requirements for HIPAA standard electronic encounter data reporting. The following standards are in addition to those outlined in the MassHealth provider manuals. These standards in no way supersede MassHealth regulations.

Where applicable, trading partners must use this guide in conjunction with the information available in your MassHealth provider manual.

REFERENCES

The Implementation Guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, healthcare payer, or government agency. The Implementation Guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all healthcare providers and their Trading Partners. It is critical that your IT staff 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. Information about the X12 Licensing Program can be found at x12.org/products/licensing-program.

ADDITIONAL INFORMATION

The intended audience for this document is the technical and operational staff responsible for generating, submitting, receiving, and reviewing electronic healthcare transactions.

2. Getting Started

WORKING WITH MASSHEALTH

Managed Care Entity (MCE) Trading Partners can exchange electronic healthcare transactions with MassHealth by directly uploading and downloading transactions via the SENDPro portal, Secure File Transfer Protocol (SFTP), or system-to-system using the SENDPro's connectivity submission method. Submitters must determine whether they will use SFTP or 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 encounter data to MassHealth.

After determining the transmission method, each Trading Partner must successfully complete testing of the connectivity protocol and the HIPAA transaction. Additional information regarding testing is noted in the next section of this companion guide. After successful completion of testing, trading partners may exchange production transactions with MassHealth.

TRADING PARTNER REGISTRATION

All MassHealth Trading Partners are required to sign a Trading Partner Agreement (TPA), as described in Section 9. If you have elected to use a third party to perform electronic transactions on your behalf, they will also be required to complete a TPA. If you or your submitter have already completed this form, you are not required to complete it again.

CERTIFICATION AND TESTING OVERVIEW

All MCE Trading Partners that exchange electronic batch transactions with MassHealth must complete Trading-Partner testing. At the completion of testing, Trading Partners will receive approval from MassHealth to submit transactions in the production environment.

Test transactions exchanged with MassHealth should include a representative sample of the various types of encounter scenarios that Managed Care Entities would normally submit to MassHealth. This includes typical transactions received from enrolled health plan providers that were then adjudicated by your organization. The size of each test file should be between 25 and 50 transactions.

3. Testing with SENDPro

Each MCE Trading Partner must complete testing. Trading Partner testing includes HIPAA compliance testing, as well as validating the use of conditional, optional, and mutually defined components of the transaction.

SENDPro will process de-identified transactions in a test environment to verify that the file structure and content meet HIPAA standards and MassHealth-specific data and business requirements. MassHealth will also verify the quality of the data submitted within the test files. MCEs will receive responses for every test file submitted. MCEs should review the 999 Implementation Acknowledgement and 277 Data Reporting Acknowledgement (277DRA) reports for errors, make the appropriate corrections, and resubmit updated test files. Section 8 of this Companion Guide provides a brief description of the 999 and 277DRA reports.

Please note: Trading partners will not be allowed to submit encounter data transactions in the production environment until they have successfully passed both data quality validation and HIPAA standards testing. Once this testing and certification is complete and approved by MassHealth, the Trading Partner may submit transactions to MassHealth's SENDPro for processing. For the purposes of SENDPro implementation, please refer to discussions with MassHealth MCE Communications group for further details.

PRE-TESTING ACTIVITIES

In order for MCEs to submit/receive EDI files, access the SENDPro Portal, and access reports, they will need to be onboarded into the Commonwealth of Massachusetts' Virtual Gateway (VG) and MOVEit applications.

Virtual Gateway Onboarding

The Virtual Gateway (VG) is used to access the SENDPro Portal and reports. MCEs can submit EDI files via the SENDPro Portal. MCEs will need to establish a VG organization ID in the VG. Once a VG organization ID is established, MCE-designated users will be able to be onboarded.

MOVEit Onboarding

MOVEit is used to submit EDI files to MassHealth/SENDPro and also to deliver EDI response messages from MassHealth/SENDPro. Files can be sent through SFTP in MOVEit via a service account or manually through individual user accounts. MassHealth will reach out to MCEs 30-60 days prior to trading partner testing to request business, technical, and test user contact information as part of the Testing Team Roster spreadsheet. Once this information is provided to MassHealth, it is submitted to create a service account and individual user accounts.

File Encryption Key Exchange

EDI files exchanged to and from SENDPro must be PGP encrypted. MassHealth will reach out to MCEs to exchange keys to encrypt/decrypt files submitted to and received from SENDPro.

TRADING PARTNER TESTING

MassHealth has specified testing scenarios that are required to be passed prior to MCEs being certified to submit encounters to SENDPro in production. MCEs are required to submit test files in multiple submissions for every MCE product – one set for MCO/ACO, one set for SCO, and one set for One Care (when applicable). Paid, partially denied, and fully denied files are expected to be submitted independently for each submission, except for the error test file submission.

During testing, MCEs are expected to provide claims associated with select test scenarios for each claim type (837P fully paid, partially denied, and fully denied) to evaluate the readiness of MCEs to submit data in Production. The suggested lookback period for providing scenario examples is two years prior to the testing period. However, if no

claims can be found within this period, it is highly recommended to look back five years, rather than mocking up the data to meet the scenario. If needed, please consult the SENDPro team if unable to source data for certain scenarios for further guidance.

Note that a submission is considered a failure in the following scenarios. The MCE would need to resubmit the file(s) in order to proceed.

(1) The full file is rejected

(2) All records are rejected, or

(3) Fewer than 50% of records are accepted (with the exception of the first Submission of TPT1)

Please contact MassHealth for full details on Trading Partner Testing scenarios.

4. Connectivity with SENDPro/Communications

This section outlines how MCE Trading Partners may connect and communicate with MassHealth to exchange ASC X12N-formatted batch transactions via SENDPro.

TRANSMISSION ADMINISTRATIVE PROCEDURES

System Availability

While the system is typically available 24 hours a day, seven days a week, except for scheduled maintenance windows, please ensure that files are submitted only from 8 a.m. ET Monday 8 to 6 p.m. ET Friday. Files submitted after 6 p.m. ET Friday will undergo processing once SENDPro completes its maintenance window.

Transmission File Size

Transmission sizes are defined based on the following factors.

- Number of segments/records allowed by HIPAA Standards
- HIPAA-standard ST-SE envelope transaction size limitations
  - File size limitations – assumes each MCE will be assigned a designated weekday for file submissions in the PROD environment post SENDPro go-live after TPT2 completion.
    - Maximum of 85,000 claims in each file submission
    - Per the 837 Implementation Guide, a maximum of 5,000 claims is permitted in each transaction set (ST/SE) within an EDI file. Note that in the scenario where an MCE has multiple claims to submit, MassHealth expects ST/SE segments to contain more than a single claim in each, unless otherwise agreed upon. ST/SE segments should be constructed to contain as close to 5,000 claims as possible
    - No additional rule on max lines per claim beyond those in 837 Implementation Guide

MassHealth expects that the files will only have one ISA/IEA and one GS/GE per EDI file.

Please note that the SENDPro does not unzip or decompress files. Transmit all files in an unzipped or uncompressed format. Due to stated file size limitations, MCEs may need to break their encounters into multiple files. Please note that file sequencing is not preserved in MassHealth's processing, and that files submitted in a specific order by the MCE may be processed in parallel or out of order by MassHealth. This may cause cascading errors as later versions

of claims are rejected because the original claim is in a file that is taking longer to process. Therefore, MassHealth recommends that MCEs group related claims in the same file, to reduce this risk.

Transmission Errors

Upon the submission of the file by the trading partner and its successful reception by SENDPro, responses in the form of TA1 and 999 acknowledgment transactions are generated within one hour of file ingestion. These generated responses will be deposited into the relevant folder on the trading partner's SFTP server.

SENDPro generates positive 999 acknowledgements if the submitted file meets HIPAA standards related to syntax and data integrity. For files that do not meet the HIPAA standards, trading partners are sent a negative TA1 and/or negative 999 describing the validation error(s).

Production File-naming Convention

For Inbound transactions, use the below naming convention.

senderid_transtype_datetime_env_adj_{suff}.ext

- **senderid** is the PID/SL of the trading partner who is sending or receiving the file, in lower case.
- **transtype** is pacdrp.
- **datetime** is the datetime of the file submission, in MMDDYYYYhhmmss format, using 24-hour format in Eastern time (GMT-5).
- **env** is the environment in which the file is to be processed. Allowable values include the following.
    - prod
    - test
- **adj** is the adjudication type for the files. Allowable values include the following.
    - pd (for files containing only claims with Paid adjudication status)
    - fd (for files containing only claims with Fully Denied adjudication status)
    - pa (for files containing only claims with Partially Denied adjudication status)
- **ext** is the extension for the file. Allowable values are:
    - .edi
    - .pgp
    - .edi.pgp
- **suff** is the optional suffix. See more detail below.

For example, a paid production 837P file submitted on January 4, 2024, at 2:30 p.m. ET, by a Trading Partner with a ten-digit PID/SL: of “110025617d” might be named the following.

110025617d_pacdrp_01042024143000_prod_pd.edi

If a file is intended for a specific request, it is essential to include this specificity in the naming convention to facilitate easy identification of the file, by using an alpha suffix. This is only to be used for applicable pre-approved MassHealth defined projects and will be communicated directly to MCEs. Files submitted in this format without MassHealth's preapproval will be rejected. In the case of this process, the naming convention is as follows.

senderid_transtype_datetime_env_adj_xxx

The three-character alpha suffix *xxx* defines the exception when needed. For example, a paid production 837I file submitted on January 4, 2024, at 2:30 p.m. EST, by a Trading Partner with a ten-digit PID/SL: of "110025617D", for special project "XYZ", might be named the following.

110025617d_pacdri_01042024143000_prod_pd_xyz.edi

For outbound response files, the following convention is used

senderid_transtype_datetime_env_adj_{suff}_transactionid_resp.ext

- **senderid** is the PID/SL of the trading partner who is sending or receiving the file, in lower case.
- **transtype** is pacdri.
- **datetime** is the datetime of the file submission, in MMDDYYYYhhmmss format, using 24-hour format in Eastern time (GMT-5).
- **env** is the environment in which the file is to be processed. Allowable values include the following.
    - prod
    - test
- **adj** is the adjudication type for the files. Allowable values are:
    - pd (for files containing only claims with Paid adjudication status)
    - fd (for files containing only claims with Fully Denied adjudication status)
    - pa (for files containing only claims with Partially Denied adjudication status)
- **transactionid** is the unique identifier given to the file during processing
- **resp** is the type of response file
    - 277dra
    - ta1
    - 999
    - ack
- **ext** is the extension for the file. Allowable values include the following.
    - .json
    - .edi

- **suff** is the optional suffix. See more detail below.

For example, the 277 DRA from a paid production 837I file submitted on January 4, 2024, at 2:30 p.m. EST, by a Trading Partner with a ten-digit PID/SL: of "110025617D" might be named the following.

110025617d_pacdri_01042024143000_prod_pd_6f8792a6-1546-4729-b6ff-f2efd0b22ae9_277dra.edi

If a file is intended for a specific request, it is essential to include this specificity in the naming convention to facilitate easy identification of the file, by using an alpha suffix. This is only to be used for applicable pre-approved MassHealth defined projects and will be communicated directly to MCEs. Files submitted in this format without MassHealth's preapproval will be rejected. In the case of this process, the naming convention is as follows.

senderid_transtype_datetime_env_adj_xxx_transactionid_resp.ext

The three-character alpha suffix *xxx* defines the exception when needed. For example, the 277 DRA from a paid production 837I file submitted on January 4, 2024, at 2:30 p.m. EST, by a Trading Partner with a ten-digit PID/SL: of "110025617D", for special project "XYZ", might be named the following.

110025617d_pacdri_01042024143000_prod_pd_xyz_6f8792a6-1546-4729-b6ff-f2efd0b22ae9_277dra.edi

RETRANSMISSION PROCEDURE

SENDPro does not require any identification of a previous transmission of a file. SENDPro processes each file independently of other files; therefore, all files sent should be marked as original transmissions.

COMMUNICATION PROTOCOL SPECIFICATIONS

SENDPro offers Council for Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE) connectivity submission methods using one of the two Envelope Standards: HTTP MIME Multipart or Simple Object Access Protocol (SOAP)/Web Services Description Language (WSDL). However, this rule is not intended to require trading partners to remove existing connections that do not match the rule, nor is it intended to require that all CAQH CORE trading partners must use one of these methods for all new connections. SENDPro provides the following methods for submitting batch EDI transaction files.

CONNECTIVITY SUBMISSION METHOD

MCE trading partners can send 837 Encounters Transactions to MassHealth using one or both of the following methods.

- Batch using Secure File Transfer Protocol (SFTP): MCEs submit files directly to MOVEit folders via a MOVEit service account.
- SENDPro Web Portal (MFTP - MOVEit File Transfer protocol): MCE users log in to the Virtual Gateway (VG) and navigate to the SENDPro Portal to access MOVEit through their user account to manually upload or download files.

Please refer to communications from MassHealth MCE Communications for additional details.

5. Contact Information

EDI CUSTOMER SERVICE

MassHealth Encounter Data Support Services

Days Available: Monday through Friday
Time Available: TBD
Email: TBD
Phone: TBD
Fax: TBD

EDI TECHNICAL ASSISTANCE

MassHealth Encounter Data Technical Support Services

Days Available: Monday through Friday
Time Available: TBD
Email: TBD
Phone: TBD
Fax: TBD

Please note: Support for Trading Partner Testing will be communicated by MassHealth prior to testing commencement. Further details will be provided in the next version of the Companion Guide.

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 electronic Health Care Transactions and Code Sets Model Compliance Plan. See https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.

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)

- CAQH is a nonprofit alliance of health plans and trade associations working to simplify healthcare 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 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.

National Council of Prescription Drug Programs (NCPDP)

- The NCPDP is the standards and codes development organization for pharmacy. See www.ncpdp.org.

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. All ISA segments within a single file must be consistent with the exception of the date/time and control # data elements. The chart 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.3	----	ISA	Interchange Control Header		
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		Trading Partner ID assigned by MassHealth (10-character MMIS PID/SL - provider ID/service location). See Section 7 for additional guidance for parent/affiliate MCEs.
C.5	-----	ISA07	Interchange ID Qualifier	ZZ	
C.5	-----	ISA08	Interchange Receiver ID	DMA7384	Post-adjudicated claims from MassHealth Managed Care Entities

GS (FUNCTIONAL GROUP HEADER)

This section describes MassHealth's use of the functional group control segments. It includes the expected application sender and receiver codes. All GS segments within a single file must be consistent.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	-----	GS02	Application Sender's Code		Trading Partner ID assigned by MassHealth (10-character MMIS PID/SL - provider ID/service location). See Section 7 for additional guidance for parent/affiliate MCEs.
C.7	-----	GS03	Application Receiver's Code	DMA7384	Post-adjudicated claims from MassHealth Managed Care Entities

7. MassHealth-Specific Business Rules and Limitations

This section describes MassHealth's business rules, including for the following examples.

- Reporting specific scenarios, such as coordination of benefits (COB), amounts paid, durable medical equipment (DME), ambulance, and home health services
- Communicating MassHealth-specific edits

MCEs must comply with industry-standard Implementation Guides (IGs), specifications governing healthcare administrative transactions. MassHealth Companion Guides supplement IGs with MassHealth Medicaid–specific business rules and requirements, including those needed to meet state and federal reporting requirements and related regulatory obligations. Unless the MassHealth Companion Guide explicitly states that situational fields are not required, MassHealth requires MCEs to submit all situational-field information in the IG when covered services are rendered to MassHealth members.

Before submitting encounter claims to MassHealth, please review the appropriate HIPAA implementation guide and MassHealth companion guide to ensure the X12 transaction will comply with MassHealth's requirements.

The following sections outline recommendations, instructions, and conditional data requirements for claims submitted to MassHealth. This information is designed to help Trading Partners construct transactions in a manner that will allow MassHealth to efficiently process claims.

ENCOUNTER-SUBMISSION GUIDELINES

ST/SE segments within transactions submitted to MassHealth must not contain more than 5,000 encounters. Submissions larger than 5,000 will be rejected.

In steady state, MCEs will submit on a weekly basis. With MassHealth permission, MCEs may enter production on bi-weekly cadence. MCEs submitting on a bi-weekly basis will be given at least six months' notice of requirement to move to weekly submission cadence. If for any reason (including special projects) the MCE needs to submit off-cycle EDI files, they must first consult with MassHealth to determine what day they can submit these file(s). MCEs should never submit EDI files, other than on the designated submission days, without first receiving permission from MassHealth.

In order to balance the load for SENDPro processing MassHealth is asking MCEs to only submit EDI files on assigned days. Staggering submissions will reduce the risk of overload to the system that could cause issues and potentially rework. MCEs will be assigned a specific day of the week to submit their standard encounters file (original, adjustment, and voids) to SENDPro.

When constructing the file, submitters should order encounters by their adjudication dates. Encounters must be sorted chronologically by the adjudication date in the DTP segment – Claim Check or Remittance Date under loop 2330B, as failure to do so may lead to rejections due to void and adjustment sequencing within the same file. Note that duplicate claims submitted to MassHealth, in the same or in separate files, will result in rejections.

If for any reason (including special projects) the MCE needs to submit off-cycle EDI files, they must first consult with MassHealth to determine what day they can submit these file(s). MCEs should never submit EDI files, other than on the designated submission days, without first receiving permission from MassHealth.

MassHealth will accept EDI files submitted within the bi-weekly period only for submissions of claims that were previously rejected by MassHealth.

Transactions should be submitted to MassHealth only to directly support services that have or will be provided directly to MassHealth members. MassHealth strongly encourages all submitters to ensure that redundant or excessive transactions are not submitted for processing.

MassHealth will require all MCEs to merge ancillary vendor encounter data into their EDI transaction files (837 I and 837 P) at a future date after SENDPro Go-Live. Our intention is to:

- Allow MCEs more time to establish procedures and operations to manage merge process.
- Allow MassHealth additional time to monitor and measure the volume of third-party vendor files and better understand their impact.
- Allow MassHealth and MCEs time to create solution to identify third-party vendor encounters that are merged into EDI Transaction files, in order to better track this data going forward.

The effective date will be no earlier than 6 months after full go-live for SENDPro.

ERROR THRESHOLD SPECIFICATIONS

Within SENDPro, there is an error threshold pertaining to the upfront edits and validations conducted by the SENDPro EDI application. This limitation has been implemented to address situations involving significant issues that may lead to an unusually high volume of errors. Details are below:

- When an error response 999 file exceeds 9,999 lines for a ST/SE segment the entire ST/SE segment is rejected
- There is **no** limit on claim failures per file. The 9,999 error limit applies to each ST/SE segment, not the entire file. If one ST/SE reaches the threshold and is rejected, SENDPro continues processing the remaining ST/SEs in the file.
- Within SENDPro, there is a limit of 9,999 segments (text lines in the file) that can be reported in 999 for a given Transaction Set (ST/SE). If this max 9,999 segments is reached within a given ST/SE, SENDPro will abort processing further claims in the ST/SE and fail all the claims in that ST/SE
- Claims not processed due to exceeding the 9,999 segment limit are marked as failed without detailed error information; only claims before the threshold receive specific reject reasons in the 999/JSON/Cognos.
- Note that SENDPro adds BUID (L2100 CTX segment) to the 999 after generation, which can increase the segment count beyond 9,999 within the ST/SE, typically by the number of IK3 segments in the EDI.
- If needed, MCEs can decrease the number of claims in the ST/SE to reduce the risk of this happening. Or, they can fix the known errors in the ST/SE and resubmit the claims.
- We have observed that in the high error scenarios, there tends to be just a few unique errors that are repeated across claims and driving the high volume of errors. Fixing these known errors often resolves other errors and helps achieve the MH 97% threshold through resubmissions.

ENCOUNTER SENDER/SUBMITTER IDS

For Encounter submissions, SENDPro supports the following three approaches.

- Parent organizations submitting on their own behalf
- Parent organizations submitting files on behalf of their affiliates

All alpha characters in the PID/SL of sender and submitter IDs within the EDI file must be uppercase.
See Appendix C for detailed examples of all three options.

TRANSFORMED MEDICAID STATISTICAL INFORMATION SYSTEM (TMSIS)

MassHealth is required to submit TMSIS information to the Centers for Medicare & Medicaid Services (CMS) on a monthly basis. That information includes both medical and pharmacy managed care encounter data. The encounter data that MCEs submit to MassHealth is integral to the completeness and accuracy of that information. Furthermore, CMS requires and assesses completeness and accuracy of a number of critical data elements that must be included in every relevant encounter when applicable. MCEs must submit any/all federally required TMSIS data within the transaction in order to ensure compliance. However, it's especially important that the following data elements are included in every applicable encounter data submission to MassHealth:

Data Element	Notes
Provider ID/Service Location (PID/SL)	For Billing, Ordering, Referring, and Rendering
Detail and Total Medicaid Paid Amounts	For all claim types
Detail and Total Allowed Amounts	For all claim types
Detail and Total Billed Amounts	For all claim types
Provider Taxonomy	For Billing on all claim types except Pharmacy
Medicare Paid, Deductible, Copay, and Coinsurance Amounts	For all claim types
Present and Valid NPI values	All provider types (Billing, Ordering, Referring, Rendering, etc.)

NATIONAL PROVIDER IDENTIFIER (NPI) AND TAXONOMY CODE

MassHealth expects the provider's National Provider Identifier (NPI) in the appropriate NM109 data element, and the taxonomy code in the appropriate PRV data element. Trading partners are required to populate all NPIs and taxonomy codes when known and within IG standards. This is true for all provider loops that are utilized within the transaction, except for in the Service Facility Location loop (L2310E) where NM108 and NM109 remain situational in alignment with Implementation Guide standards and as specified in this MassHealth Companion Guide. SENDPro validates that taxonomy is valid as per National Uniform Claim Committee (NUCC) source.

If you are an atypical provider and do not have an NPI, submit your 15-character internal provider ID (G2) and MassHealth provided PID/SL in the appropriate Reference Identification (REF) segment according to the rules below.

Note that Provider Social Security Numbers (SSNs) should never be submitted to MassHealth.

SECONDARY PROVIDER IDENTIFIERS

In addition to the NPI, MassHealth expects Managed Care Entities to populate all secondary provider identifiers in the allowable and appropriate REF segments to include the following:

Qualifier	IG Definition	MassHealth Description
G2	Provider Commercial Number	**Internal Provider Number** MCEs must populate G2 with the Internal Provider number, Internal Provider Location ID, and the MassHealth PID/SL in the event the LU qualifier is not available within a segment and the PID/SL is known. A description of how to populate the date element is as shown below. Internal Provider Number<space>Internal Provider Location ID<space>PID/SL In SENDPro, the Internal Provider Number is validated against MCE PROVIDER ID (Field 2) in the Enhanced Provider File, in combination with the ENTITY PIDSL (Field 18) in 1000A NM109 Submitter ID . In SENDPro, the Internal Provider Location ID is validated against the MCE PROVIDER ID LOCATION CODE (Field 3) in the Enhanced Provider File, in combination with the ENTITY PIDSL (Field 18) in 1000A NM109 Submitter ID. Include PID/SL when known and in accordance with the CMS Medicaid and CHIP Managed Care Final Rule. All alpha characters in the PID/SL must be uppercase. Note that the maximum length for the entire REF02 field is 50 characters, including spaces. In SENDPro, the provider PID/SL is validated against the list of valid PID/SLs from the MassHealth Medicaid Management Information System (MMIS). ***Details are specified in each Provider ID data element in the Section 10 table.***
LU	Location Number	**PID/SL** MCEs must populate LU with the MassHealth PID/SL when known. In the event the LU qualifier is not available within a segment, MCEs must populate G2 with the Internal Provider Number, the Internal Provider Location ID, and the MassHealth PID/SL (if known) as described above. Note that the maximum length for the entire REF02 field is 50 characters, including spaces. All alpha characters in the PID/SL must be uppercase. ***Details are specified in each Provider ID data element in the Section 10 table.***

0B	State License Number	**State License Number** MCEs must populate the State License Number when known. Note that the maximum length for the entire REF02 field is 50 characters, including spaces. ***Details are specified in each Provider ID data element in the Section 10 table.***

ORIGINAL, VOID, AND ADJUSTMENT/REPLACEMENT TRANSACTIONS – OVERPAYMENT RECOVERIES

MassHealth requires MCEs to clearly document adjustments, overpayments, and recoveries by submitting void and adjustment/replacement encounter data transactions. MassHealth strongly recommends that MCEs submit voids to document a full recovery of a paid transaction and adjustments to document a partial recovery of a paid transaction.

VOID AND ADJUSTMENT/REPLACEMENT TRANSACTIONS

MassHealth strongly recommends that MCEs follow the approach below to report adjustments, overpayments, and recoveries. Note that failure to follow these instructions by attempting to void/adjust a claim with no original or by attempting to adjust the same original more than once will result in rejections.

Void Transactions: to be used for a full recovery

- Use Claim Frequency Type "8" in Loop 2300 CLM05-03 to completely void/cancel the paid or partially paid transaction. This will ensure a complete void of a previously submitted claim.

Adjustment/Replacement Transactions: to be used for a partial recovery

- Use Claim Frequency Type "7" in Loop 2300 CLM05-03 to adjust or modify a previously paid or partially paid transaction.

Guidance for populating claims for voids and adjustments can be found in the "SENDPro 837 Voids and Adjustments Approach" documented below.

Upon receipt of a void or replacement transaction, MassHealth will validate the following.

- The adjustments/voids are linked to the original claim.
- The appropriate Adjustment Reason Codes are used in Provider Overpayment Scenarios.
- The adjustments are properly updated across header and detail lines to maintain overall claim integrity.

Please note: All validations will occur at the time of 837 encounter claims intake, and post-837 intake at the MassHealth Data Warehouse.

Follow guidance in Appendix B. Business Scenarios and Appendix C. Transmission Examples to construct adjustments and voids. This guidance reflects the daisy chain process and how to reference and tie back to a previous submission. SENDPro only expects to receive the PACDR 837 from MCEs and will return the corresponding

277DRA.

For adjustments (Frequency Code = 7), MassHealth has revised the original restriction of having same number of lines in the daisy chain and will now accept claims submitted (in daisy chain) with different number of lines.

Note that for Voids (Frequency code = 8), they should still have the same number of lines as the original/adjusted claims that they are voiding.

In SENDPro, there are two ways to process "Paid" and "Partially Denied" amendments.

- Submit an amendment as an adjustment with Frequency code 7 (with correct daisy chain).
- Submit a void to the claim that is being corrected by the amendment claim and then submit an original claim with the amended information. (Note that amendments to denied claims are not accepted.)

COORDINATION OF BENEFITS

COB Claims

MCE trading partners should report all instances of COB scenarios received by providers in their encounter submissions in the 2320 loop. Information such as the other payer's adjudication amounts and details, subscriber/patient details, line- item details, and adjustment reason codes (using standard claim adjustment reason codes – CARCs) must be reported in the appropriate data elements . It is important to note that the Submitter ID/PIDSL in 1000A NM109 must match the MCE adjudication information under 2330B NM109. Appendices B and C provide business scenario examples for reporting COB.

COB Claims with Medicare

MCE trading partners should report all instances of Medicare COB scenarios received by providers in their encounter submissions. It is important to note that Medicare information must be reported even when Medicare has paid in full and the MCE to-be-paid balance is zero. In addition, Medicare adjudication must be reported even when Medicare does not pay. Appendices B and C provide business scenario examples for reporting COB from Medicare.

DENIED AND PARTIALLY DENIED CLAIMS

MassHealth requires denied and partially denied claims to be submitted in two separate file from paid claims.

Denied claims should be populated where 2300 CN104 Contract Code = D and CAS02 Claim Adjustment Reason Codes populated appropriately. For denied claims files, SENDPro validates Strategic National Implementation Process (SNIP) 1 and 2, and that the claim was paid at $0.

Partially denied claims should be populated where 2300 CN104 Contract Code = R and CAS02 Claim Adjustment Reason Codes populated appropriately for denied lines, as well as for paid lines where appropriate. SENDPro validates SNIP 1 and 2 of denied claim lines, and SNIP 1, 2, 5, and 7 of paid claim lines.

CLAIM ADJUSTMENT REASON CODES (CARCs)

MassHealth/SENDPro will be using active standard Claim Adjustment Reason Codes (CARCs) from X12 External Codes Source 139. The assumption is that all MCEs follow industry and X12 validation standards and produce appropriate denials from their respective adjudication systems. MassHealth expects MCEs to adhere to the

guidelines for populating CARCs referenced in the MassHealth CARC Memo published on the MassHealth site: MassHealth Managed Care Encounter Data Companion Guides | Mass.gov.

BUNDLED CLAIMS

Managed Care Entities must appropriately identify and populate all data elements on their encounter submissions when reporting bundled payments:

- When the claim is fully bundled, MCEs should use Contract Type = 4 or 9 at the header, Pricing Methodology = 4 at the header and line level, and CARC per standard or MassHealth guidance at the header and line level. If the claim is Professional (P), MCEs should use Contract Type = 4 or 9 at the line level as well.
- When the claim has a mix of bundled lines and non-bundled lines, MCEs should populate Contract type = 9 at the header.
    - When the claim has a mix of bundled and Sub-Cap or APM lines, MCEs should populate Pricing Methodology and CARC at the header and line level per Sub-Cap or APM policy. If the claim is professional (P), MCEs should also populate Contract Type at the line level per Sub-Cap or APM policy.
    - When the claim has a mix of bundled lines and payment arrangements other than Sub-Cap or APM, MCEs should use Pricing Methodology = 10 at the header and the appropriate Pricing Methodology for bundled lines (Pricing Methodology = 4) or non-bundled lines (Pricing Methodology = per standard) at the line level. MCEs should populate CARC at the header and line level per standard or MassHealth guidance.

- Include the LX Assigned Number of the service line in which the service line was bundled in SVD06
- For Enhanced Ambulatory Patient Grouping (EAPG) Claims - Claim lines that have been processed through Solventum's (formerly 3M Corporation) EAPG Grouper that has been configured for the MassHealth APEC methodology
- The Solventum EAPG Grouper assigns 'Visit IDs' to lines on the claim, and these 'Visit IDs' should be used to identify discrete bundles
- Within each bundle with a shared EAPG 'Visit ID', the lowest enumerated line should be treated as the line under which the services are bundled. The line number of the lowest enumerated line in the bundle should be populated in the LX Assigned Number field for all other claim lines within that same bundle.
- Any and all outlier payments should be attributed to the lowest enumerated EAPG line on the claim
- Example: A submitted claim has 4 lines (1-4) under Visit ID 1, and 3 lines (5-7) under Visit ID 2. For Visit ID 1, line 1 is treated as the bundled line, and the LX Assigned Number on lines 2-4 should be 1. For Visit ID 2, line 5 is treated as the bundled line, and the LX Assigned Number on lines 6 and 7 should be 5.
- Non-bundled claim lines should be differentiated from EAPG lines by using Pricing Methodology = per standard or MassHealth guidance and not including an LX Assigned Number.
- If an MCE does not currently receive Visit ID information from their vendor(s), they should notify MassHealth and work with their vendor(s) to ensure this information is available to the MCE by September 1, 2026. In the interim, MCEs who do not have accurate Visit ID information should not include an LX Assigned Number on EAPG claims. MassHealth expects that these claims will be coded accurately using Visit ID information starting on September 1, 2026.

- For Ambulatory Payment Classification (APC) claims, MCEs should use the Medicare Payment Status field or another APC indicator field to determine which claim lines are bundled and which are paid at the standard fee schedule.
- For claim lines marked as APC, the lowest enumerated APC claim line should be treated as the line in which the services are bundled. The line number of this first bundled line should be populated in the LX Assigned Number field for all other APC claim lines.
- Example: If claim lines 3-7 are marked as APC, line 3 is treated as the bundled line, and the LX Assigned Number on lines 4-7 should be 3.
- Non-APC claim lines should be differentiated from APC claim lines by using Pricing Methodology = per standard or MassHealth guidance and not including an LX Assigned Number.

Table 6: Mapping for Bundled Pricing in PACDR Format

Payment Arrangement	Multiple Arrangements[1]	Line Type	Contract Type[2]	Pricing Methodology[3]	CARC[4]
Bundled Pricing	No	Header	4 or 9	4	Per Standard or MassHealth Guidance
Bundled Pricing	No	Line	N/A (I) or 4/9 (P)	4	Per Standard or MassHealth Guidance
Bundled Pricing	Yes	Header	9	10	Per Standard or MassHealth Guidance
Bundled Pricing	Yes	Line	N/A (I) or Per Standard or MassHealth Guidance (P)	Per Standard or MassHealth Guidance	Per Standard or MassHealth Guidance

RECORD INDICATORS IN PACDR FORMAT FOR 837I AND P

Below is guidance for translating Record Indicators from the proprietary format to the PACDR-Professional standard.

Fee-for-Service (FFS)

- When the claim is fully Fee-for-Service (FFS), MCEs should use Contract Type = 04 at the header, Pricing Methodology per standard at the header and line level, CARC per standard or MassHealth guidance at the header and line level, and Contract Type = 04 at the line level as well.

[1] "Multiple arrangements" refers to a claim that contains lines representing more than one payment arrangement.
[2] See Table I-A for Contract Type (CN101) values.
[3] See Table I-B for Pricing Methodology (HCP01) values.
[4] See https://x12.org/codes/claim-adjustment-reason-codes for full list of CARC (CAS02) values.

- When the claim has a mix of FFS and other payment arrangements, MCEs should populate Contract Type = 09 at the header.
    - When the claim has a mix of FFS and Primary Care Sub-Capitation (Sub-Cap) or Alternative Payment Methodology (APM) lines, MCEs should populate Pricing Methodology, CARC at the header and line level per Sub-Cap or APM policy, and Contract Type at the line level per Sub-Cap or APM policy.
    - When the claim has a mix of FFS and payment arrangements other than Sub-Cap or APM, MCEs should populate Pricing Methodology, CARC at the header and line level as applicable in their system, and Contract Type at the line level per standard or MassHealth guidance.
- All amounts will be submitted in their corresponding fields per X12 Implementation Guide (IG).

Payment Arrangement	Multiple Arrangements[5]	Line Type	Contract Type	Pricing Methodology	CARC[6]
FFS	No	Header	04	Per Standard	Per Standard or MassHealth Guidance
FFS	No	Line	04	Per Standard	Per Standard or MassHealth Guidance
FFS	Yes	Header	09	Per Standard or MassHealth Guidance	Per Standard or MassHealth Guidance
FFS	Yes	Line	Per Standard or MassHealth Guidance	Per Standard or MassHealth Guidance	Per Standard or MassHealth Guidance

Per Diem

- When the claim is fully Per Diem, MCEs should use Contract Type = 02 at the header, Pricing Methodology per standard at the header and line level, CARC per standard or MassHealth guidance at the header and line level, and Contract Type = 02 at the line level as well.
- When the claim has a mix of Per Diem and other payment arrangements, MCEs should populate Contract Type = 09 at the header.
    - When the claim has a mix of Per Diem and Sub-Cap or APM lines, MCEs should populate Pricing Methodology, CARC at the header and line level per Sub-Cap or APM policy, and Contract Type at the line level per Sub-Cap or APM policy.
    - When the claim has a mix of Per Diem and payment arrangements other than Sub-Cap or APM, MCEs should populate Pricing Methodology, CARC at the header and line level as applicable in their system, and Contract Type at the line level per standard or MassHealth guidance.
- All amounts will be submitted in their corresponding fields per X12 IG.

Payment Arrangement	Multiple Arrangements[1]	Line Type	Contract Type	Pricing Methodology	CARC[2]
Per Diem	No	Header	02	Per Standard	Per Standard or MassHealth Guidance
Per Diem	No	Line	02	Per Standard	Per Standard or MassHealth Guidance

[5] "Multiple arrangements" refers to a claim that contains lines representing more than one payment arrangement.
[6] See https://x12.org/codes/claim-adjustment-reason-codes for full list of CARC (CAS02) values.

Per Diem	Yes	Header	09	Per Standard or MassHealth Guidance	Per Standard or MassHealth Guidance
Per Diem	Yes	Line	Per Standard or MassHealth Guidance	Per Standard or MassHealth Guidance	Per Standard or MassHealth Guidance

Diagnosis Related Group (DRG)

- When the claim is fully DRG, MCEs should use Contract Type = 01 at the header, Pricing Methodology per standard at the header and line level, CARC per standard or MassHealth guidance at the header and line level, and Contract Type = 01 at the line level as well.
- When the claim has a mix of DRG and other payment arrangements, MCEs should populate Contract Type = 09 at the header.
    - When the claim has a mix of DRG and Sub-Cap or APM lines, MCEs should populate Pricing Methodology, CARC at the header and line level per Sub-Cap or APM policy, and Contract Type at the line level per Sub-Cap or APM policy.
    - When the claim has a mix of DRG and payment arrangements other than Sub-Cap or APM, MCEs should populate Pricing Methodology, CARC at the header and line Level as applicable in their system, and Contract Type at the line level per standard or MassHealth guidance.
- All amounts will be submitted in their corresponding fields per X12 IG.

Payment Arrangement	Multiple Arrangements[1]	Line Type	Contract Type	Pricing Methodology	CARC[2]
Diagnosis Related Group (DRG)	No	Header	01	Per Standard	Per Standard or MassHealth Guidance
Diagnosis Related Group (DRG)	No	Line	01	Per Standard	Per Standard or MassHealth Guidance
Diagnosis Related Group (DRG)	Yes	Header	09	Per Standard or MassHealth Guidance	Per Standard or MassHealth Guidance
Diagnosis Related Group (DRG)	Yes	Line	Per Standard or MassHealth Guidance	Per Standard or MassHealth Guidance	Per Standard or MassHealth Guidance

Alternative Payment Methodology (APM)

Please note that MassHealth approval is required to implement an Alternative Payment Methodology (APM) arrangement.

The cost of approved APMs should be spread across relevant claims for the performance period in the "Amount Paid" field.

- When the claim is fully APM, MCEs should use Contract Type = 05 at the header, Pricing Methodology = 10 at the header and line level, CARC = 24 at the header and line level, and Contract Type = 05 at the line level as well.
- When the claim has a mix of APM and Sub-Cap lines only:

    - MCEs should use Contract Type = 05 at the header and Contract Type = 05 at the line level.
    - MCEs should use Pricing Methodology = 10 at the header and the appropriate Pricing Methodology for APM (Pricing Methodology = 10) or Sub-Cap (Pricing Methodology = 07) at the line level.
    - MCEs should use CARC = 24 at the header and line level.
- When the claim has a mix of APM and at least one or more non-Sub-Cap lines:
    - MCEs should populate Contract Type = 09 at the header and Contract Type at the line level per standard or MassHealth guidance.
    - MCEs should populate Pricing Methodology = 10 at the header and the appropriate Pricing Methodology for APM (Pricing Methodology = 10), Sub-Cap (Pricing Methodology = 07), or other payment arrangement (per standard) at the line level.
    - MCEs should populate CARC at the header per standard or MassHealth guidance. Populate the appropriate CARC for APM (CAS02 = 24), Sub-Cap (CAS02 = 24), or other payment arrangement (per standard or MassHealth guidance) at the line level.
- All amounts will be submitted in their corresponding fields per X12 IG.

Payment Arrangement	Multiple Arrangements[1]	Line Type	Contract Type	Pricing Methodology	CARC[2]
Alternative Payment Methodology (APM)	No	Header	05	10	24
Alternative Payment Methodology (APM)	No	Line	05	10	24
Alternative Payment Methodology (APM)	Yes (with Sub-Cap only)	Header	05	10	24
Alternative Payment Methodology (APM)	Yes (with Sub-Cap only)	Line	05	Per MassHealth Guidance	24
Alternative Payment Methodology (APM)	Yes (with 1 or more non-Sub-Cap lines)	Header	09	10	Per Standard or MassHealth Guidance
Alternative Payment Methodology (APM)	Yes (with 1 or more non-Sub-Cap lines)	Line	Per Standard or MassHealth Guidance	Per Standard or MassHealth Guidance	Per Standard or MassHealth Guidance

Note: Multiple CARCs can be submitted at both the header and line levels; however, if CARC 24 is indicated, it must be included on at least one of the lines.

Primary Care Sub-Capitation

Please note that Primary Care Sub-Capitation detail lines must meet the zero-pay criteria of the Primary Care Sub-Capitation program. MCEs must report $0 in “Amount Paid” and the value in “Amount Allowable” that is applicable in their systems for these detail lines.

- When the claim is fully Sub-Cap, the MCE should use Contract Type = 05 at the header, Pricing Methodology = 07 at the header and line level, CARC = 24 at the header and line level, and Contract Type = 05 at the line level as well.
- When the claim has a mix of Sub-Cap and APM lines only:
    - MCEs should use Contract Type = 05 at the header and Contract Type = 05 at the line level.
    - MCEs should use Pricing Methodology = 10 at the header and the appropriate Pricing Methodology for APM (Pricing Methodology = 10) or Sub-Cap (Pricing Methodology = 07) at the line level.
    - MCEs should use CARC = 24 at the header and line level.
- When the claim has a mix of Sub-Cap and one or more non-APM lines:
    - MCEs should populate Contract Type = 09 at the header and Contract Type at the line level per standard or MassHealth guidance.
    - MCEs should populate Pricing Methodology = 10 at the header and the appropriate Pricing Methodology for Sub-Cap (Pricing Methodology = 07), APM (Pricing Methodology = 10), or other payment arrangement (per standard) at the line level.
    - MCEs should populate CARC at the header per standard or MassHealth guidance. Populate the appropriate CARC for Sub-Cap (CAS02 = 24), APM (CAS02 = 24), or other payment arrangement (per standard or MassHealth guidance) at the line level.
- All amounts will be submitted in their corresponding fields per X12 IG.

Payment Arrangement	Multiple Arrangements[1]	Line Type	Contract Type	Pricing Methodology	CARC[2]
Primary Care Sub-Capitation (Sub-Cap)	No	Header	05	07	24
Primary Care Sub-Capitation (Sub-Cap)	No	Line	05	07	24
Primary Care Sub-Capitation (Sub-Cap)	Yes (with APM only)	Header	05	10	24
Primary Care Sub-Capitation (Sub-Cap)	Yes (with APM only)	Line	05	Per MassHealth Guidance	24
Primary Care Sub-Capitation (Sub-Cap)	Yes (with 1 or more non-APM lines)	Header	09	10	Per Standard or MassHealth Guidance
Primary Care Sub-Capitation (Sub-Cap)	Yes (with 1 or more non-APM lines)	Line	Per Standard or MassHealth Guidance	Per Standard or MassHealth Guidance	Per Standard or MassHealth Guidance

Note: Multiple CARCs can be submitted at both the header and line levels; however, if CARC 24 is indicated, it must be included on at least one of the lines.

SERVICE CATEGORY CODE

Follow the guidance below for submitting the service category code.

1. Submit Service Category code based on the proprietary format tables I-A and I-B listed below.
2. Service category is not needed on Dental and Pharmacy claims.

3. **For Professional claims**:
    a. Enter the service category at the line level only as follows (*do **not** enter NTE in loop 2300*):
        Loop: 2400
        Segment: NTE – LINE NOTE
        Data Element: NTE01= ADD and enter service category value in **NTE02** for each line
        i.

See Appendix B and C for an example.

Service Category Using the 4B Reporting Groups

Value	Description
1	Capitated Physician Services
2	Fee For Service Physician Services
3	Behavioral Health – Inpatient Services
4	Behavioral Health – Diversionary Services *
5	Behavioral Health – Emergency Services Program (ESP) Services
6	Behavioral Health – Mental Health Outpatient Services *
7	Behavioral Health – Substance Abuse Outpatient Services *
8	Behavioral Health – Other Outpatient Services *
9	Facility- Medical/Surgical
10	Facility- Pediatric/Sick Newborns
11	Facility- Obstetrics
12	Facility- Skilled Nursing Facility/Rehab
13	Facility- Other Inpatient
14	Facility- Emergency Room
15	Facility- Ambulatory Care
16	Prescription Drug
17	Laboratory
18	Radiology
19	Home Health
20	Durable Medical Equipment
21	Emergency Transportation
22	Therapies
23	Other (Please use this for Vision and Dental claims)
24	Other Alternative Care
25	Mental Health and Substance Abuse Outpatient Services (*MBHP Only)
26	Outpatient Day Services (*MBHP Only)
27	Non-ESP Emergency Services (*MBHP Only)
28	Behavioral Health –Diversionary Services – 24-Hour
29	Behavioral Health – Diversionary Services – Non-24-Hour
30	Behavioral Health –Standard Outpatient Services
31	Behavioral Health –Other Services
32	Behavioral Health – Intensive Home or Community Based Outpatient Services for Youth

Value	Description
	(Please note this new category is where all CBHI services, except youth mobile crisis intervention would be listed. Youth mobile crisis intervention would be considered part of the Emergency Services Program Services.)

*Note: Use these categories only for the claims with Dates of Service before 07/01/2010.

Service Category Using SCO and One Care reporting groups

Value	Description	SCO	One Care
301	Hospital Inpatient	Yes	Yes
302	Behavioral Health (BH) Hospital Inpatient	Yes	Yes
303	Hospital Outpatient	Yes	Yes
304	Behavioral Health (BH) Hospital Outpatient	Yes	Yes
305	Professional	Yes	Yes
306	Vision	Yes	Yes
307	Dental	Yes	Yes
308	Therapy	Yes	Yes
309	Pharmacy/Drugs	Yes	Yes
309B	Pharmacy/Drugs (non-Part D) GROSS	Yes	Yes
310	Laboratory, Radiology, Testing	Yes	Yes
311	Institutional Long-Term Care	Yes	Yes
314	Transportation	Yes	Yes
315	Medical Equipment	Yes	Yes
316	Hospice	Yes	Yes
317	Case Management	Yes	Yes
318	Other Miscellaneous	Yes	Yes
320	Personal Care Attendant (PCA)	Yes	Yes
325	Home Health	Yes	Yes
330	Adult Foster Care (Including GAFC)	Yes	Yes
335	Adult Day Health	Yes	Yes
340	Day Habilitation	Yes	Yes
345	Frail Elder Waiver (FEW) Services	Yes	No
347	All Other Community LTC	Yes	Yes
350	ASAPs	Yes	Yes

ADDITIONAL COMMERCIAL STANDARD CODE SET VALIDATIONS

SENDPro validates values populated for the following code sets within the EDI files, where applicable.

Code	Name	Validation Type
CS-130-P	HCPCS Procedure	Dictionary Lookup based on Date of Service; at least 7 years of history is supported
CS-130-Q	HCPCS Modifier	Dictionary Lookup; at least 7 years of history is supported
CS-132-T	NUBC Occurrence	Dictionary Lookup based on Date of Service

CS-132-U	NUBC Occurrence Span	Dictionary Lookup
CS-132-R	NUBC Revenue	Dictionary Lookup based on Date of Service
CS-132-V	NUBC Value	Dictionary Lookup based on Date of Service
CS-133-P	CPT-4 Procedure	Dictionary Lookup based on Date of Service
CS-133-Q	CPT-4 Modifier	Dictionary Lookup
CS-135-U	ADA CDT Oral Cavity	Dictionary Lookup based on Date of Service; at least 7 years of history is supported
CS-135-P	ADA CDT Procedure	Dictionary Lookup based on Date of Service
CS-135-T	ADA CDT Tooth Number	Dictionary Lookup based on Date of Service; at least 7 years of history is supported
CS-139	Claim Adjustment Reason Code (CARC)	Dictionary Lookup
CS-230	NUBC Point of Origin	Dictionary Lookup
CS-231	NUBC Priority of Admission	Dictionary Lookup
CS-235	NUBC Claim Freq Type	Dictionary Lookup
CS-236	NUBC Uniform Billing Code (UBC)	Dictionary Lookup
CS-237	Place of Service	Dictionary Lookup; at least 7 years of history is supported
CS-239	NUBC Patient Status	Dictionary Lookup
CS-641	NUBC Condition	Dictionary Lookup based on Date of Service
CS-682	Taxonomy	Dictionary Lookup; at least 7 years of history is supported
CS-716	HIPSS Procedure	Dictionary Lookup based on Date of Service; at least 7 years of history is supported
CS-896	ICD-10 Proc	Dictionary Lookup based on Date of Service; at least 7 years of history is supported
CS-897-A	ICD-10 Diag A	Dictionary Lookup based on Date of Service; at least 7 years of history is supported
CS-897-B	ICD-10 Diag B	Dictionary Lookup based on Date of Service; at least 7 years of history is supported
CS-897-E	ICD-10 Diag E	Dictionary Lookup based on Date of Service; at least 7 years of history is supported

8. Acknowledgements and Reports

MassHealth has adopted three acknowledgement transactions with the 837 Post-Adjudicated Claims Data Reporting Version 005010 transaction: the TA1, 999, and 277DRA. These acknowledgments will replace any/all proprietary reports issued by MassHealth in response to proprietary encounter data submissions.

REPORT INVENTORY

THE TA1 INTERCHANGE ACKNOWLEDGEMENT

TA1 allows the receiver of a file to notify the sender that an invalid interchange structure was received or that problems were encountered. The TA1 verifies only the interchange header (ISA/GS) and trailer (IEA/GE) segments of the file envelope. If ISA or GS errors were encountered, then the generated TA1 report with the Interchange Header errors will be returned.

THE 999 IMPLEMENTATION ACKNOWLEDGEMENT

Each submission of an ASC X12 V5010 file to MassHealth generates a 999 Implementation acknowledgement and is sent to the submitter within one business day.

THE 999 JSON ACKNOWLEDGEMENT

Each submission of an ASC X12 V5010 file to MassHealth generates a 999 JSON acknowledgement error file and is sent to the submitter within one business day.

For general layout of this acknowledgement, see Appendix D: 999 JSON Scenarios.

THE 277 DATA REPORTING ACKNOWLEDGEMENT (277DRA)

This report acknowledges the validity and acceptability of data reporting claim submissions at the pre-processing stage and identifies encounter claims that are accepted as well as those that are not accepted. Please review the 277DRA Companion Guide for MassHealth specific instructions and information.

9. Trading Partner Agreements

MCEs that intend to conduct electronic transactions with MassHealth must sign the MassHealth Trading Partner Agreement (TPA). A copy of the agreement is available for download (www.mass.gov) or by contacting MassHealth Encounter Data Support services at (email address TBD, targeting to be provided after Design phase) if you have any questions.

TRADING PARTNERS

MassHealth defines a Trading Partner as any entity (provider, billing service, software vendor, employer group, financial institution, etc.) that exchanges 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.

10. Transaction-Specific Information

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with 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 do the following.

- 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.
- 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 deepest 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.

The following table references columns from the published and corresponding ASC X12 Implementation Guide. Each row provides additional information on MassHealth's specific business requirements and includes Notes/Comments to clarify intent and usage.

STANDARD CLAIMS

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
41	1000A	NM103	Submitter Name		The organization name must be consistent with the MassHealth-assigned Trading Partner ID (PID/SL).
41	1000A	NM109	Submitter Identifier		Trading Partner ID (PID/SL) assigned by MassHealth (the 10-character MassHealth MMIS provider number including service location)
43	1000A	PER03	Communication Number Qualifier	EM	MassHealth allows only the contact's email address.
46	1000B	NM103	Receiver Name	MassHealth	
46	1000B	NM109	Receiver Primary Identifier	DMA7384	
49	2000A	PRV01	Provider Taxonomy Code	BI	
56	2010AA	NM109	Billing Provider Identifier		If you are an atypical provider and do not have an NPI, populate Internal ID in REF02 and PID/SL, if known, using G2 qualifier; otherwise enter the billing provider NPI.
60	2010AA	REF01	Billing Provider Tax Identification Qualifier	EI	
62	2010AA	REF01	Billing Provider License Information	0B	
63	2010AA	REF01	Billing Provider Secondary ID Qualifier	G2 LU	Internal Provider ID<space>Internal Provider Location ID PID/SL
65	2000B	HL04	Subscriber Hierarchical Level	0	Subscriber is always the patient in Medicaid.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
69	2010BA	NM102	Entity Type	1	The Subscriber must always be a person.
69	2010BA	NM104	Name First		
70	2010BA	NM109	Subscriber Primary Identifier		12-character MassHealth member ID. This field is always required when NM102 = 1 except when L1000A NM103 = "MASSACHUSETTS BEH HLTH PRT" and L2320 SBR03 in (840003, 840046, 841003, 841046
80	2010BB	NM103	Data Receiver Name	MassHealth	
98	2300	CLM05-03	Claim Frequency Code	1-5, 7, 8	Indicate the claim frequency using the following codes. 1 = Original; Admit through Discharge 2 = Original; Interim – First Claim 3 = Original; Interim – Continuing Claims 4 = Original; Interim – Last Claim 5 = Original; Late Charge Only 7 = Adjustment/Replacement of Prior Claim 8 = Void/Cancel of Prior Claim Former claim number must be populated in L2330B REF*BP when CLM05-03 = 7 or 8. This field value should be 1-5 only when 2300 CN104 = D
125	2300	CN101	Contract Type Code		Adhere to guidance in Section 7 for populating Contract Type Code in relation to Record Indicator.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
125	2300	CN102	Monetary Amount		Populate when Contract Type code in CN101 is any value other than 06
126	2300	CN103	Allow Charge Percent		Populate when Contract Type Code in CN101 = 06
126	2300	CN104	Contract Code	P, R, D	Indicate if a claim is paid, partially paid, or denied using the following codes. P = Paid R = Partially Denied D = Denied
133	2300	REF01	Payer Claim Control Qualifier	F8	
162	2300	HI01-01	Principal Diagnosis Type Code	ABK	The ICD10 Principal Diagnosis Codes report in Cognos defines the ICD-10 codes used to validate that principal diagnosis codes populated are accurate and accepted.
163	2300	HI02-01	Diagnosis Type Code	ABF	
164	2300	HI03-01	Diagnosis Type Code	ABF	Populate when this data element is applicable.
165	2300	HI04-01	Diagnosis Type Code	ABF	Populate when this data element is applicable.
166	2300	HI05-01	Diagnosis Type Code	ABF	Populate when this data element is applicable.
166	2300	HI06-01	Diagnosis Type Code	ABF	Populate when this data element is applicable.
167	2300	HI07-01	Diagnosis Type Code	ABF	Populate when this data element is applicable.
168	2300	HI08-01	Diagnosis Type Code	ABF	Populate when this data element is applicable.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
169	2300	HI09-01	Diagnosis Type Code	ABF	Populate when this data element is applicable.
170	2300	HI10-01	Diagnosis Type Code	ABF	Populate when this data element is applicable.
170	2300	HI11-01	Diagnosis Type Code	ABF	Populate when this data element is applicable.
171	2300	HI12-01	Diagnosis Type Code	ABF	Populate when this data element is applicable.
186	2300	HCP02	Reprised Allowed Amount		Populate the maximum amount determined by the payer as being allowable under the provision of the contract prior to the determination of actual payment. It represents the maximum payer liability for a given service and is what the payer would pay if there was no patient liability.
191	2310A	NM109	Referring Provider Identifier		
192	2310A	REF01	Referring Provider Secondary ID Qualifier	G2 0B	Populate with the "Internal Provider Number<space>Internal Provider Location ID <space>PID/SL" (when known). If the PID/SL is unknown, use Internal Provider Number<space>Internal Provider Location ID only. State License Number
196	2310B	NM109	Rendering Provider Identifier		MassHealth expects Rendering Provider information to only be populated when different from the Billing Provider.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
197	2310B	PRV01	Rendering Provider Taxonomy Code	PE	
199	2310B	REF01	Rendering Provider Secondary ID Qualifier	G2 LU 0B	Internal Provider Number<space>Internal Provider Location ID PID/SL State License Number
203	2310C	NM109	Laboratory or Facility Primary Identifier		In accordance with the Implementation Guide, this field should be populated unless the Service Facility NPI is the same as the Billing Provider NPI. If services were performed on an Indian reservation, use the NPI of the Indian Health Services.
207	2310C	REF01	Service Facility Location Secondary ID Qualifier	G2 LU 0B	Internal Provider Number<space>Internal Provider Location ID PID/SL State License Number
211	2310D	NM109	Supervising Provider Identifier		
212	2310D	REF01	Supervising Provider Secondary ID Qualifier	G2 LU 0B	Internal Provider Number<space>Internal Provider Location ID PID/SL State License Number
222	2320	SBR09	Claim Filing Indicator Code		Use MC when reporting MCE claim adjudication data. Use MA, MB, or OF for reporting Medicare.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					Use other designations as appropriate.
225	2320	CAS02	Claim Adjustment Reason Code		Adhere to guidance in Section 7 for populating CARCs.
225	2320	CAS04	Adjustment Quantity		Populate this data element when the number of service units has been adjusted in (CAS03) is greater than 0.
226	2320	CAS07	Adjustment Quantity		Populate this data element when CAS05 is present and related to units of service.
226	2320	CAS10	Adjustment Quantity		Populate this data element when CAS08 is present and related to units of service adjustment.
227	2320	CAS13	Adjustment Quantity		Populate this data element when CAS11 is present and related to units of service adjustment.
227	2320	CAS16	Adjustment Quantity		Populate this data element when CAS14 is present and related to units of service adjustment.
228	2320	CAS19	Adjustment Quantity		Populate this data element when CAS17 is present and related to units of service adjustment.
244	2330B	NM109	Other Payer Primary Identifier		At least one 2330 should have a payer who is consistent with the submitter in 1000A NM109.
250	2330B	REF02	Other Payer's Adjusted Claim Control Number		The 2330 for the payer who is the submitter must be populated with the former claim number for all voids and adjustments.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
261	2400	SV101-01	Product/Service ID Qualifier	HC	Allowable qualifier in this field
299	2400	CN101	Contract Type Code		Use Contract Type 05 to report Medicaid Fee for Service Equivalent Amount when other code types are not applicable.
299	2400	CN102	Monetary Amount		
300	2400	CN104	Contract Code	P, D	Indicate if a claim is paid, partially paid, or denied using the following codes. P = Paid D = Denied
318	2400	HCP02	Repriced Allowed Amount		
319	2400	HCP09	Product/Service ID Qualifier	HC	Allowable qualifier in this field
320	2400	HCP11	Unit Or Basis of Measure Code	DA or UN	MassHealth expects this field to be populated to describe HCP12.
320	2400	HCP12	Repriced Approved Service Unit Count		Populate the number of days or units corresponding to the code populated in HCP11.
332	2420A	NM109	Rendering Provider Identifier		
333	2420A	PRV01	Provider Taxonomy Code	PE	
335	2420A	REF01	Rendering Provider Secondary ID Qualifier	G2 LU 0B	Internal Provider Number<space>Internal Provider Location ID PID/SL State License Number

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
338	2420B	NM109	Purchased Service Provider Identifier		
340	2420B	REF01	Purchased Service Provider Secondary ID Qualifier	G2 0B	Populate with the "Internal Provider Number<space><space >Internal Provider Location ID PID/SL" (when known). If the PID/SL is unknown, use Internal Provider Number<space>Interna l Provider Location ID only. State License Number
343	2420C	NM109	Service Facility Primary Identifier		In accordance with the Implementation Guide, should be populated unless Service Facility NPI is not different from Billing Provider NPI. If services were performed on an Indian reservation, use the NPI of the Indian Health Services.
347	2420C	REF01	Service Facility Location Secondary ID Qualifier	G2	Populate with the "Internal Provider Number<space>Interna l Provider Location ID <space>PID/SL" (when known). If the PID/SL is unknown, use Internal Provider Number<space>Interna l Provider Location ID only.
350	2420D	NM109	Supervising Provider Identifier		
351	2420D	REF01	Supervising Provider Secondary ID Qualifier	G2 LU	Internal Provider Number<space>Internal Provider Location ID PID/SL

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
				0B	State License Number
355	2420E	NM109	Ordering Provider Identifier		
359	2420E	REF01	Ordering Provider Secondary ID Qualifier	G2 0B	Populate with the "Internal Provider Number<space>Internal Provider Location ID <space>PID/SL" (when known). If the PID/SL is unknown, use Internal Provider Number<space>Internal Provider Location ID only. State License Number
365	2420F	NM109	Referring Provider Identifier		
366	2420F	REF01	Referring Provider Secondary ID Qualifier	G2 0B	Populate with the "Internal Provider Number<space>Internal Provider Location ID <space>PID/SL" (when known). If the PID/SL is unknown, use Internal Provider Number<space>Internal Provider Location ID only. State License Number
368	2430	SVD03-01	Product/Service ID Qualifier	HC	Allowable qualifier in this field, when SVD segment is populated
373	2430	CAS02	Claim Adjustment Reason Code		Adhere to guidance in Section 7 for populating CARCs.
373	2430	CAS04	Adjustment Quantity		Populate this data element when the number of service units has been adjusted.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
373	2430	CAS07	Adjustment Quantity		Populate this data element CAS05 is present and related to units of service.
374	2430	CAS10	Adjustment Quantity		Populate this data element when CAS08 is present and related to units of service adjustment.
375	2430	CAS13	Adjustment Quantity		Populate this data element when CAS11 is present and related to units of service adjustment.
375	2430	CAS16	Adjustment Quantity		Populate this data element when CAS14 is present and related to units of service adjustment.
376	2430	CAS19	Adjustment Quantity		Populate this data element when CAS17 is present and related to units of service adjustment.

APPENDICES

Appendix A. Implementation Checklist

This appendix contains all necessary steps for implementing the transactions with MassHealth. More details are defined in the MCE User Guide.

- Develop your system to comply with ACS X12N v5010 Technical Reports 3/Implementation Guides.
    - Develop your system to comply with X12 837 Post Adjudicated Claims Data Reporting (PACDR) Technical Reports 3/Implementation Guide
- Review MassHealth SENDPro Companion Guides to identify and implement necessary changes to your system.
    - Develop your system to comply with additional requirements as defined in this guide.
- Complete the SENDPro onboarding activities. A summary is listed below:
    - Complete MOVEit service account setup to exchange EDI files with MassHealth.
    - Complete MOVEit user account setup to exchange EDI files with MassHealth.
    - Complete setup of encryption keys to securely exchange EDI files with MassHealth.
    - Complete VG account setup to access the SENDPro Portal and reports.
- Test connectivity.
    - Perform a connectivity test with MassHealth to confirm EDI files are able to be securely sent to MassHealth and securely received by MCEs.
- Participate in all trading partner testing activities.
    - Successfully complete testing activities based on testing scenarios provided by MassHealth.
- Utilize various and real case business scenarios during testing.
    - Successfully complete testing of MassHealth-defined business scenarios as part of testing activities.

Appendix B. Business Scenarios

This appendix contains typical business scenarios. The actual data streams linked to these scenarios are included in Appendix C.

1. MCEs have the option to submit PACDR files as described below.
    a. Parent submitting for themselves
    b. Parent submitting on behalf of their affiliate
    c. MCE submitting for themselves
2. PACDR Professional containing a denied encounter
3. PACDR Professional with COB payer
4. PACDR Professional with COB Medicare
5. PACDR Professional with Void
6. PACDR Professional with replacement
7. PACDR Original, Adjustment, Subsequent Adjustment, and Void
8. PACDR Initial Fully Denied Encounter then Subsequently Fully Paid in MCE Claims System
9. PACDR Initial Fully Denied Encounter then Subsequently Partially Denied in MCE Claims System
10. PACDR Initial Partially Denied Encounter then Subsequently Fully Paid in MCE Claims System

Appendix C. Transmission Examples

Below are examples of how MCEs should submit PACDR files as described in Appendix B. Note that these are snippets of EDI messages that are included to illustrate the respective scenarios as per MassHealth requirements; they are not intended to be fully formed EDI messages.

1. If **Parent**-Tufts Health Together TPID/PIDSL = 110088791A and their **Affiliate** is Tuft's Health Together with CHA: TPID/PIDSL =110088791E, it would look like this.

    a. Tufts submitting as **Parent** for themselves

ISA*00* *00* *ZZ*11008791A *ZZ*DMA7384 *230809*0813*^*00501*000000954*0*P*:
GS*HC*110088791A *DMA7384*20230809*081356*954*X*005010X299A1
ST*837*0954*005010X299A1
BHT*0019*00*20230809081347003*20230809*081239*RP
NM1*41*2*TUFTS HEALTH TOGETHER*****46*110088791A

    b. Tufts submitting as a **Parent** on behalf of their **Affiliate** Tuft's Health Together

ISA*00* *00* *ZZ*110088791A *ZZ*DMA7384 *230809*0813*^*00501*000000954*0*P*:
GS*HC*110088791A *DMA7384*20230809*081356*954*X*005010X299A1
ST*837*0954*005010X299A1
BHT*0019*00*20230809081347003*20230809*081239*RP
NM1*41*2*TUFTS HEALTH TOGETHER WITH CHA*****46*110088791E

2. **PACDR Professional containing a denied encounter**

CLM*755555M*110***11:B:1*Y*A*Y*1~
DTP*484*D8*20231019~
CL1*1*7*3~
CN1*02*110**D~ **(CN104 – D(Denied))**
HI*ABK:V723*ABF:4660~
SBR*P*18*G00786***6***MC~
CAS*CO*39*110~ **(Denied CARC)**
AMT*D*0~
LX*1~
SV1*HC:99396*110*UN*1~
SVD*P*0*HC:99396*0510*1~
CAS*CO***39***110~ **(Denied CARC)**
DTP*573*D8*20231103

3. PACDR Professional with COB payer

SBR*S*18*0077186***6***MC ~
AMT*D*5577.18~
NM1*IL*1*ROSSITER*WESTON****MI*9999999~
N3*6272 PERRY RD~
N4*BOSTON*MA*457010000~
NM1*PR*2*MCE*****PI*0077186~

DTP*573*D8*20230808~
REF*F8*23216211156~
SBR*P*18* ***1***CI~ (*SBR06=1 COB)*
AMT*D*0~
NM1*IL*1*ROSSITER*WESTON****MI*9999999~
N3*6272 PERRY RD~
N4*BOSTON*MA*457010000~
NM1*PR*2*BLUE CROSS BLUE SHIELD*****PI*L01733M001~

4. PACDR Professional with COB Medicare

SBR*S*18*0077186***6*MC~
AMT*D*5577.18~
NM1*IL*1*MEDYUM*WAYNE*M***MI*102200221B1~
N3*1010 THOUSAND OAK LANE~
N4*BOSTON*MA*45701~
NM1*PR*2*MCE*****PI*0077186~
DTP*573*d8*20230808~
REF*F8*23216211156~
SBR*P*18** **1***MB~
AMT*D*80~
AMT*A8*15~
NM1*IL*1*MEDYUM* WAYNE*M***MI*102200221B1~
N3*1010 THOUSAND OAK LANE~
N4*BOSTON*MA*45701~
NM1*PR*2*MEDICARE*****PI*59999~

5. **PACDR Professional with Void**
    1. **See scenario examples 7-10 below for further elaboration on voids**

CLM*26463774*100***13:B: **8 ~ (CLM05-03 = 8 (Void))**

6. **PACDR Professional with Replacement**
    1. **See scenario examples in 7-10 below for further elaboration on replacements**

CLM*26463774*100***13:B: **7 ~ (CLM05-03 = 7 (Replacement))**

7. **PACDR Original, Adjustment, Subsequent Adjustment, and Void**

Provider to MCE	Value	Payer (MCE)	Value	Encounter From MCE to Medicaid	Value	SENDPro to MCE	Value
Original Claim - 837		**ERA - 835**		**PACDR**		**277DRA**	
2300 CLM05-3 (Frequency Code)	1	2100 CLP01 (Patient Control Number)	P1	2300 CLM05-3 (Frequency Code)	1	2200D TRN02	C1
2300 CLM01 (Patient Control Number)	P1	2100 CLP07 (Payer Claim Control Number)	C1	2300 CLM01 (MCE Claim Number)	C1	2200D REF01 (Payer's Claim Number)	1K
		2100 CLP09 (Frequency Code)	1	2300 REF*F8 (Payer Claim Control Number)	Not sent	2200D REF02	C1
				2330B REF01 (Original Reference Number)	F8		
				2330B REF02	C1		
				2330B REF01			
				2330B REF02			
Adjustment		**Adjusted ERA - 835**		**Adjusted PACDR**		**Adjusted 277DRA**	
2300 CLM05-3 (Frequency Code)	7	2100 CLP01 (Patient Control Number)	P2	2300 CLM05-3 (Frequency Code)	7	2200D TRN02	C2
2300 CLM01 (Patient Control Number)	P2	2100 CLP07 (Payer Claim Control Number)	C2	2300 CLM01 (MCE Claim Number)	C2	2200D REF01 (Payer's Claim Number)	1K
2300 REF*F8 (Payer Claim Control Number)	C1	2100 CLP09 (Frequency Code)	7	2300 REF*F8 (Payer Claim Control Number)	Not sent	2200D REF02	C2
				2330B REF01 (Signal Code)	T4		

Provider to MCE	Value	Payer (MCE)	Value	Encounter From MCE to Medicaid	Value	SENDPro to MCE	Value
				2330B REF02	Y		
				2330B REF01 (Original Reference Number)	F8		
				2330B REF02	C2		
				2330B REF01 (Adjustment Control Number)	BP		
				2330B REF02	C1		
Subsequent Adjustment		**Subsequent Adjusted ERA - 835**		**Subsequent Adjusted PACDR**		**Subsequent Adjusted 277DRA**	
2300 CLM05-3 (Frequency Code)	7	2100 CLP01 (Patient Control Number)	P3	2300 CLM05-3 (Frequency Code)	7	2200D TRN02	C3
2300 CLM01 (Patient Control Number)	P3	2100 CLP07 (Payer Claim Control Number)	C3	2300 CLM01 (MCE Claim Number)	C3	2200D REF01 (Payer's Claim Number)	1K
2300 REF*F8 (Payer Claim Control Number)	C2	2100 CLP09 (Frequency Code)	7	2300 REF*F8 (Payer Claim Control Number)	Not sent	2200D REF02	C3
				2330B REF01 (Signal Code)	T4		
				2330B REF02	Y		
				2330B REF01 (Original Reference Number)	F8		
				2330B REF02	C3		
				2330B REF01 (Adjustment Control Number)	BP		
				2330B REF02	C2		
Second Subsequent Adjustment		**Second Subsequent Adjusted ERA - 835**		**Second Subsequent Adjusted PACDR**		**Second Subsequent Adjusted 277DRA**	
2300 CLM05-3 (Frequency Code)	7	2100 CLP01 (Patient Control Number)	P4	2300 CLM05-3 (Frequency Code)	7	2200D TRN02	C4
2300 CLM01 (Patient Control Number)	P4	2100 CLP07 (Payer Claim Control Number)	C4	2300 CLM01 (MCE Claim Number)	C4	2200D REF01 (Payer's Claim Number)	1K

Provider to MCE	Value	Payer (MCE)	Value	Encounter From MCE to Medicaid	Value	SENDPro to MCE	Value
2300 REF*F8 (Payer Claim Control Number)	C3	2100 CLP09 (Frequency Code)	7	2300 REF*F8 (Payer Claim Control Number)	Not sent	2200D REF02	C4
				2330B REF01 (Signal Code)	T4		
				2330B REF02	Y		
				2330B REF01 (Original Reference Number)	F8		
				2330B REF02	C4		
				2330B REF01 (Adjustment Control Number)	BP		
				2330B REF02	C3		
Subsequent Void		**Subsequent Void ERA - 835**		**Subsequent Void PACDR**		**Subsequent Void 277DRA**	
2300 CLM05-3 (Frequency Code)	8	2100 CLP01 (Patient Control Number)	P5	2300 CLM05-3 (Frequency Code)	8	2200D TRN02	C5
2300 CLM01 (Patient Control Number)	P5	2100 CLP07 (Payer Claim Control Number)	C5	2300 CLM01 (MCE Claim Number)	C5	2200D REF01 (Payer's Claim Number)	1K
2300 REF*F8 (Payer Claim Control Number)	C4	2100 CLP09 (Frequency Code)	8	2300 REF*F8 (Payer Claim Control Number)	Not sent	2200D REF02	C5
				2330B REF01 (Signal Code)	T4		
				2330B REF02	Y		
				2330B REF01 (Original Reference Number)	F8		
				2330B REF02	C5		
				2330B REF01 (Adjustment Control Number)	BP		
				2330B REF02	C4		

8. PACDR Initial Fully Denied Encounter and then Subsequently Fully Paid in MCE Claims System

Claims submitted as shown below would be accepted by MassHealth using either Scenario 1A or Scenario 1B.

Scenario 1A (Denied then Paid)	Value	SENDPro to MCE 277 DRA	Value
Initially Submitted DENIED Claim			

Scenario 1A (Denied then Paid)	Value	SENDPro to MCE 277 DRA	Value
2300 CLM05-3 (Frequency Code)	1	2200D TRN02	C1
2300 CLM01 (MCE Claim Number)	C1	2200D REF01 (Payer's Claim Number)	1K
2300 CN104	D	2200D REF02	C1
2320 CAS	Populate valid X12 CARC - Send header CAS as applicable		
2300 REF*F8 (Payer Claim Control Number)	Not sent		
2330B REF01 (Original Reference Number)	F8		
2330B REF02	C1		
2330B REF01			
2330B REF02			
2420 CAS	Populate valid X12 CARC at line level		
PAID Claim Submitted as an Adjustment to the Above DENIED Claim			
2300 CLM05-3 (Frequency Code)	7	2200D TRN02	C2
2300 CLM01 (MCE Claim Number)	C2	2200D REF01 (Payer's Claim Number)	1K
2300 CN104	P	2200D REF02	C2
2320 CAS	Populate valid X12 CARC - Send header CAS as applicable		
2300 REF*F8 (Payer Claim Control Number)	Not sent		
2330B REF01 (Signal Code)	T4		
2330B REF02	Y		
2330B REF01 (Original Reference Number)	F8		
2330B REF02	C2		
2330B REF01 (Adjustment Control Number)	BP		
2330B REF02	C1		
2420 CAS	Populate valid X12 CARC at line level		

Scenario 1B (Denied then Paid)	Value	SENDPro to MCE 277 DRA	Value
Initially Submitted DENIED Claim			
2300 CLM05-3 (Frequency Code)	1	2200D TRN02	C1
2300 CLM01 (MCE Claim Number)	C1	2200D REF01 (Payer's Claim Number)	1K
2300 CN104	D	2200D REF02	C1

Scenario 1B (Denied then Paid)	Value	SENDPro to MCE 277 DRA	Value
2320 CAS	Populate valid X12 CARC - Send header CAS as applicable		
2300 REF*F8 (Payer Claim Control Number)	Not sent		
2330B REF01 (Original Reference Number)	F8		
2330B REF02	C1		
2330B REF01			
2330B REF02			
2420 CAS	Populate valid X12 CARC at line level		
PAID Claim Submitted as an Original to the Above Claim			
2300 CLM05-3 (Frequency Code)	1	2200D TRN02	C2
2300 CLM01 (MCE Claim Number)	C2	2200D REF01 (Payer's Claim Number)	1K
2300 CN104	P	2200D REF02	C2
2320 CAS	Populate valid X12 CARC - Send header CAS as applicable		
2300 REF*F8 (Payer Claim Control Number)	Not sent		
2330B REF01 (Original Reference Number)	F8		
2330B REF02	C2		
2330B REF01			
2330B REF02			
2420 CAS	Populate valid X12 CARC at line level		

9. PACDR Initial Fully Denied Encounter then Subsequently Partially Denied in MCE Claims System

Claims submitted as shown below would NOT be accepted by MassHealth Scenario 2A.

Scenario 2A (Denied then Partially Denied)	Value	SENDPro to MCE 277 DRA	Value
Initially Submitted DENIED Claim			
2300 CLM05-3 (Frequency Code)	1	2200D TRN02	C5
2300 CLM01 (MCE Claim Number)	C5	2200D REF01 (Payer's Claim Number)	1K
2300 CN104	D	2200D REF02	C5
2320 CAS	Populate valid X12 CARC - Send header CAS as applicable		

Scenario 2A (Denied then Partially Denied)	Value	SENDPro to MCE 277 DRA	Value
2300 REF*F8 (Payer Claim Control Number)	Not sent		
2330B REF01 (Original Reference Number)	F8		
2330B REF02	C5		
2330B REF01			
2330B REF02			
2420 CAS	Populate valid X12 CARC at line level		
PARTIALLY DENIED Claim Submitted as an Adjustment to the Above DENIED Claim – NOT ACCEPTED			
2300 CLM05-3 (Frequency Code)	7	2200D TRN02	C6
2300 CLM01 (MCE Claim Number)	C6	2200D REF01 (Payer's Claim Number)	1K
2300 CN104	R	2200D REF02	C6
2320 CAS	Populate valid X12 CARC - Send header CAS as applicable		
2300 REF*F8 (Payer Claim Control Number)	Not sent		
2330B REF01 (Signal Code)	T4		
2330B REF02	Y		
2330B REF01 (Original Reference Number)	F8		
2330B REF02	C6		
2330B REF01 (Adjustment Control Number)	BP		
2330B REF02	C5		
2420 CAS	Populate appropriate line level CARC as per MH instruction		

Rather, they should be submitted as shown below in Scenario 2B.

Scenario 2B (Denied then Partially Denied)	Value	SENDPro to MCE 277 DRA	Value
Initially Submitted DENIED Claim			
2300 CLM05-3 (Frequency Code)	1	2200D TRN02	C5
2300 CLM01 (MCE Claim Number)	C5	2200D REF01 (Payer's Claim Number)	1K
2300 CN104	D	2200D REF02	C5
2320 CAS	Populate valid X12 CARC - Send header CAS as applicable		
2300 REF*F8 (Payer Claim Control Number)	Not sent		
2330B REF01 (Original Reference Number)	F8		

2330B REF02	C5		
2330B REF01			
2330B REF02			
2420 CAS	Populate valid X12 CARC at line level		
PARTIALLY DENIED Claim Submitted as an Original to the Above Claim			
2300 CLM05-3 (Frequency Code)	1	2200D TRN02	C6
2300 CLM01 (MCE Claim Number)	C6	2200D REF01 (Payer's Claim Number)	1K
2300 CN104	R	2200D REF02	C6
2320 CAS	Populate valid X12 CARC - Send header CAS as applicable		
2300 REF*F8 (Payer Claim Control Number)	Not sent		
2330B REF01 (Original Reference Number)	F8		
2330B REF02	C6		
2330B REF01			
2330B REF02			
2420 CAS	Populate appropriate line level CARC as per MH instruction		

10. PACDR Initial Partially Denied Encounter then Subsequently Fully Paid in MCE Claims System

Claims submitted as shown below would be accepted by MassHealth using either Scenario 3A or Scenario 3B.

Scenario 3A (Partially Denied then Paid)	Value	SENDPro to MCE 277 DRA	Value
Initially Submitted PARTIALLY DENIED Claim			
2300 CLM05-3 (Frequency Code)	1	2200D TRN02	C3
2300 CLM01 (MCE Claim Number)	C3	2200D REF01 (Payer's Claim Number)	1K
2300 CN104	R	2200D REF02	C3
2320 CAS	Populate valid X12 CARC - Send header CAS as applicable		
2300 REF*F8 (Payer Claim Control Number)	Not sent		
2330B REF01 (Original Reference Number)	F8		
2330B REF02	C3		
2330B REF01			
2330B REF02			

Scenario 3A (Partially Denied then Paid)	Value	SENDPro to MCE 277 DRA	Value
2420 CAS	Populate appropriate line level CARC as per MH instruction		
PAID Claim Submitted as an Adjustment to the Above PARTIALLY DENIED Claim			
2300 CLM05-3 (Frequency Code)	7	2200D TRN02	C4
2300 CLM01 (MCE Claim Number)	C4	2200D REF01 (Payer's Claim Number)	1K
2300 CN104	P	2200D REF02	C4
2320 CAS	Populate valid X12 CARC - Send header CAS as applicable		
2300 REF*F8 (Payer Claim Control Number)	Not sent		
2330B REF01 (Signal Code)	T4		
2330B REF02	Y		
2330B REF01 (Original Reference Number)	F8		
2330B REF02	C4		
2330B REF01 (Adjustment Control Number)	BP		
2330B REF02	C3		
2420 CAS	Populate valid X12 CARC at line level		

Scenario 3B (Partially Denied then Paid)	Value	SENDPro to MCE 277 DRA	Value
Initially Submitted PARTIALLY DENIED Claim			
2300 CLM05-3 (Frequency Code)	1	2200D TRN02	C3
2300 CLM01 (MCE Claim Number)	C3	2200D REF01 (Payer's Claim Number)	1K
2300 CN104	R	2200D REF02	C3
2320 CAS	Populate valid X12 CARC - Send header CAS as applicable		
2300 REF*F8 (Payer Claim Control Number)	Not sent		
2330B REF01 (Original Reference Number)	F8		
2330B REF02	C3		
2330B REF01			
2330B REF02			
2420 CAS	Populate appropriate line level CARC as per MH instruction		

Scenario 3B (Partially Denied then Paid)	Value	SENDPro to MCE 277 DRA	Value
PAID Claim Submitted as a Void to the Above Claim			
2300 CLM05-3 (Frequency Code)	8	2200D TRN02	C4
2300 CLM01 (MCE Claim Number)	C4	2200D REF01 (Payer's Claim Number)	1K
2300 CN104	R	2200D REF02	C4
2320 CAS	Populate valid X12 CARC - Send header CAS as applicable		
2300 REF*F8 (Payer Claim Control Number)	Not sent		
2330B REF01 (Signal Code)	T4		
2330B REF02	Y		
2330B REF01 (Original Reference Number)	F8		
2330B REF02	C4		
2330B REF01 (Adjustment Control Number)	BP		
2330B REF02	C3		
2420 CAS	Populate appropriate line level CARC as per MH instruction		
PAID Claim Submitted as an Original to the Above Claim			
2300 CLM05-3 (Frequency Code)	1	2200D TRN02	C7
2300 CLM01 (MCE Claim Number)	C7	2200D REF01 (Payer's Claim Number)	1K
2300 CN104	P	2200D REF02	C7
2320 CAS	Populate valid X12 CARC - Send header CAS as applicable		
2300 REF*F8 (Payer Claim Control Number)	Not sent		
2330B REF01 (Original Reference Number)	F8		
2330B REF02	C7		
2330B REF01			
2330B REF02			
2420 CAS	Populate valid X12 CARC at line level		

11. Service Category Code in PACDR

Example of a claim with 22 lines:

NTE01=UPI NTE02=318 318 318 318 318 318 318 318 318 318 318 318 318 315 310 315 315 310 310 310

NTE01=UPI NTE02=310 303

The example above will be read by SENDPro as:

Claim Line Number	Service Category
1	318
2	318
3	318
4	318
5	318
6	318
7	318
8	318
9	318
10	318
11	318
12	318
13	318
14	315
15	310
16	315
17	315
18	310
19	310
20	310
21	310
22	303

Appendix D. 999 JSON Layout

This section outlines the 837 JSON error report and the accompanying documentation for HIPAA data compliance validation, specifically as processed by SENDPro. The report is based on an 837 EDI transmission and is designed to assist technical analysts, compliance officers, and EDI implementers. It provides guidance on interpreting validation errors and warnings that may arise during HIPAA transaction processing. The following is the 837 JSON schema and the section that follows provides detail on the JSON tags and fields.

999 JSON Schema

```
{
        "TRANSMISSION" : "string",
        "Status" : {
                "Type2" : "string",
                "Type3" : "string",
                "Type4" : "string",
                "Type5" : "string",
                "Type7" : "string"
        },
        "INTERCHANGE" : [
        {
                "Sequence" : "string",
                "Control Number" : "string",
                "Status" : {
                        "Type2" : "string",
                        "Type3" : "string",
                        "Type4" : "string",
                        "Type5" : "string",
                        "Type7" : "string"
                },
                "FUNCTIONAL GROUP" : [
                {
                        "Sequence" : "string",
                        "Functional GroupID" : "string",
                        "Control Number" : "string",
                        "Status" : {
                                "Type2" : "string",
                                "Type3" : "string",
                                "Type4" : "string",
                                "Type5" : "string",
                                "Type7" : "string"
                        },
                        "TRANSACTION SET" : [
                        {
                                "Sequence" : "string",
                                "Transaction SetID" : "string",
                                "Control Number" : "string",
                                "Status" : {
                                        "Type2" : "string",
                                        "Type3" : "string",
                                        "Type4" : "string",
                                        "Type5" : "string",
                                        "Type7" : "string"
                                },
                                "ErrorDetails" : [
                                {
                                        "ErrorType" : "string",
                                        "SEGMENT" : [
                                        {
                                                "ErrorLevel" : "string",
                                                "SegmentPosition" : "string",
                                                "SegmentID" : "string",
                                                "SegmentDesc" : "string",
                                                "Loop" : "string",
                                                "SegErrorCode" : "string",
                                                "SegErrorCodeDesc" : "string",
                                                "BUId" : "string",
                                                "ELEMENT" : [
                                                {
                                                        "ElementID" : "string",
                                                        "ElementDesc" : "string",
                                                        "ElementErrorCode" : "string",
                                                        "ElementErrorCodeDesc" : "string"
                                                },
                                                {
                                                        "ElementID" : "string",
                                                        "ElementDesc" : "string",
                                                        "ElementErrorCode" : "string",
                                                        "ElementErrorCodeDesc" : "string"
                                                }
                                                ]
                                        }
                                }
                        }
                }
        }
}
```

Error Report Structure

This section provides detailed information at the JSON tag and field level detail.

Transmission Level

- TRANSMISSION: Contains file and transmission identifiers. Example: File: 110031467g_pacdrp_19032025103007_sit_pd.edi
- Status: Provides a summary of error types (e.g., Type2, Type3, etc.). "ERRORS NOTED" indicates errors detected at this level.

Interchange Level

- INTERCHANGE: An array of interchange objects (ISA/IEA envelope).
- Sequence: Numeric sequence of the interchange.
- Control Number: Interchange control number for tracking purposes.
- Status: Summary of compliance at the interchange level, including types of errors

Functional Group Level

- FUNCTIONAL GROUP: An array of functional group objects (GS/GE envelope).
- Sequence: Numeric sequence of the functional group.
- Functional Group ID: Identifier such as HC for Health Care Claim.
- Control Number: Functional group control number.
- Status: Error summary for the group

Transaction Set Level

- TRANSACTION SET: Each transaction set (ST/SE envelope) includes:
- Sequence: Order of the transaction set.
- Transaction Set ID: EDI type, such as 837.
- Control Number: Transaction set control number.
- Status: Indicates pass or fail for each error type.
- ErrorDetails: Array of detailed errors, including error type and segment/element information

Segment And Data Element Errors

Each error in ErrorDetails contains:

- ErrorType: The HIPAA validation rule type (e.g., Type3, Type4, Type7).

Segment

This provides a list of affected segments, with the following detail:

- ErrorLevel: Severity, e.g., Error.
- SegmentPosition: Position in the transaction set.
- SegmentID: EDI segment identifier (e.g., AMT, PER, NM1, PRV, REF).
- SegmentDesc: Description of the segment.
- Loop: The loop in which the segment appears.
- SegErrorCode and SegErrorCodeDesc: Error codes and descriptions at the segment level.
- BUId: Business Unit ID populated for errors at Provider level with L2010AA NM109, for errors at Subscriber level with L2010BA NM109, and for errors at Claim/Line level with L2300 CLM01 value.

Element

This is an array of data element errors, including:

- ElementID: Data element reference (e.g., AMT02).
- ElementDesc: Description of the data element.
- ElementErrorCode and ElementErrorCodeDesc: Data element error codes and descriptions.
- ElementErrorDesc: Human-readable explanation of the error.
- ElementDataContent: The problematic data content.

SUBELEMENT

This is an array of sub-element errors, including:

- SubElementPos: Data sub-element reference (e.g., CLM05:01).
- SubElementDesc: Description of the data sub-element.
- SubElementErrorCode and SubElementErrorCodeDesc: Data sub-element error codes and descriptions.
- SubElementErrorDesc: Human-readable explanation of the error.
- SubElementDataContent: The problematic data content.

Appendix E. Frequently Asked Questions

This appendix contains a link to the FAQ document published on mass.gov.

Appendix F. Change Summary

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 were made to this MassHealth Companion Guide.

Date	Page Number	Section	Notes/Comments
April 2024	4	Section 3: Testing with SENDPro	Updated document contents to include additional details.
April 2024	10	Section 7: MassHealth Specific Business Rules and Limitations	Updated document contents to include additional details.
April 2024	21	Section 10: Transaction-Specific Information	Added notes including descriptions for codes to be populated in CLM05-03.
April 2024	25	Section 10: Transaction-Specific Information	Updated CN104 to remove 'R = for Partially Paid' as an accepted adjudication status at the line level. Note that 'R' is still an accepted status at the claim header level.
April 2024	App-3	Appendix B: Business Scenarios	Updated with scenarios for which examples have been provided, identified in Section 7.
April 2024	App-4	Appendix C: Transmission Examples	Updated with example EDI files based on scenarios identified in Section 7.
November 2024	5	Section 4: Connectivity with SENDPro/Communications	Updated file naming convention and example.
November 2024	10	Section 7: MassHealth Specific Business Rules and Limitations	Updated submission frequency and file construction guidelines.
November 2024	12	Section 7: MassHealth Specific Business Rules and Limitations	Updated TMSIS providers.
November 2024	12–13	Section 7: MassHealth Specific Business Rules and Limitations	Updated Provider ID guidelines.
November 2024	14	Section 7: MassHealth Specific Business Rules and Limitations	Updated guidance on voids and adjustments.
November 2024	15	Section 7: MassHealth Specific Business Rules and Limitations	Updated guidance for denied claims submissions.
November 2024	15	Section 7: MassHealth Specific Business Rules and Limitations	Updated guidance for bundled claims submissions.
November 2024	19–26	Section 10: Transaction-Specific Information	Updated guidance for populating Provider IDs in segments 2010AA, 2310A, 2310B, 2310C, 2310D, 2420A, 2420B, 2420C, 2420D, 2420E, and 2420F

Date	Page Number	Section	Notes/Comments
November 2024	20 and 24	Section 10: Transaction-Specific Information	Updated guidance for populating former claim number based on frequency in CLM05-03.
November 2024	22 and 24	Section 10: Transaction-Specific Information	Updated guidance for Laboratory or Service Facility Primary Identifier.
November 2024	24 and 26	Section 10: Transaction-Specific Information	Updated allowable qualifiers for Product/Service ID
November 2024	App-4–7	Appendix C: Transmission Examples	Updated example EDI.
February 2025	14–16	Section 7: MassHealth Specific Business Rules and Limitations	Updated guidance for submission of voids and adjustments.
February 2025	16	Section 7: MassHealth Specific Business Rules and Limitations	Added guidance for population of Claim Adjustment Reason Codes.
February 2025	16–19	Section 7: MassHealth Specific Business Rules and Limitations	Added guidance for population of Record Indicators.
February 2025	19–22	Section 7: MassHealth Specific Business Rules and Limitations	Added guidance for population of Service Category Codes.
February 2025	27	Section 10: Transaction-Specific Information	Updated guidance for diagnosis segments HI*ABK and HI*ABN.
February 2025	30 and 33	Section 10: Transaction-Specific Information	Updated guidance for population of CARCs in CAS02.
February 2025	App-2	Appendix B: Business Scenarios	Added examples for submission of voids and adjustments and examples for population of service category code.
February 2025	App-10–18	Appendix C: Transmission Examples	Added examples for submission of voids and adjustments.
August 2025	4-5	Section 3: Testing with SENDPro	Added guidance for Pre-Testing Activities and Trading Partner Testing
August 2025	5	Section 4: Connectivity with SENDPro/Communications	Added guidance for ISA per file.
August 2025	5-6	Section 4: Connectivity with SENDPro/Communications	Added guidance about file naming in alignment with Partially Denied/Denied Claims File Split Memo

Date	Page Number	Section	Notes/Comments
August 2025	12	Section 7: MassHealth Specific Business Rules and Limitations	Added guidance about bi-weekly submission cadence
August 2025	12-14	Section 7: MassHealth Specific Business Rules and Limitations	Added PIDSL Guidance
August 2025	23-24	Section 7: MassHealth Specific Business Rules and Limitations	Updated to include Code Set Validations
August 2025	28	Section 10: Transaction-Specific Information	Updated to clarify language in guidance on L1000a PER segment
August 2025	29-30	Section 10: Transaction-Specific Information	Added additional guidance for CN102 and CN103
August 2025	33	Section 10: Transaction-Specific Information	Added guidance for to CAS07,10, 13, 16, & 19 for segments 2320 and 2430
August 2025	34	Section 10: Transaction-Specific Information	Added guidance or HCP02 and HCP12
August 2025	App-3-5	Appendix C: Transmission Examples	Added updated examples
August 2025	App-15	Appendix D: Frequently Asked Questions	Updated to include link to a newly created external FAQ document
March 2026	4-5	Section 3: Testing with SENDPro	Added guidance for Trading Partner Testing activities.
March 2026	5	Section 4: Connectivity with SENDPro/Communications	Added guidance from File Size Limitations Memo.
March 2026	6-7	Section 4: Connectivity with SENDPro/Communications	Added guidance on suffix and outbound file specifications.
March 2026	13	Section 7:MassHealth-Specific Business Rules and Limitations	Added guidance on Managing MCE transitions from bi-weekly to weekly.
March 2026	13	Section 7:MassHealth-Specific Business Rules and Limitations	Added guidance on ancillary vendor expectations.
March 2026	14	Section 7:MassHealth-Specific Business Rules and Limitations	Added guidance on Error Threshold Specifications.

Date	Page Number	Section	Notes/Comments
March 2026	17	Section 7:MassHealth-Specific Business Rules and Limitations	Added guidance on Secondary Provider Identifiers, G2.
March 2026	20	Section 7:MassHealth-Specific Business Rules and Limitations	Added guidance on bundled claims per Pricing Methodology Memo.
March 2026	27-28	Section 7: MassHealth-Specific Business Rules and Limitations	Added guidance on code set history details.
March 2026	28	Section 7:MassHealth-Specific Business Rules and Limitations	Removed row for CS-897-D as this code set is no longer used.
March 2026	30	Section 8: Acknowledgements and Reports	Added guidance on new 999 JSON Acknowledgment sent for 837.
March 2026	34	Section 10: Transaction-Specific Information	Added validation exceptions for MBHP Subscriber Primary Identifier.
March 2026	33	Section 10: Transaction-Specific Information	Added guidance for claim frequency code.
March 2026	38	Section 10: Transaction-Specific Information	Added guidance for HCP11.
March 2026	App-3	Appendix C: Transmission Examples	Removed example 1c.
March 2026	App-15	Appendix D: 999 JSON Layout	Added general layout for 999 JSON Acknowledgement.

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