State of Missouri

Missouri Department of Mental Health

HIPAA Transaction X12N 835 Claim Payment / Advice
Companion Guide for CIMOR Implementation

Refers to the Implementation Guides
Based on X12 version 005010(Errata)

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MO Department of Mental Health
835 Claim Payment/Advice Companion Guide

Disclosure Statement

This document is intended for the billing and technical staff of the providers who exchange electronic transactions with the Missouri Department of Mental Health. Used along with the ASC X12 Implementation Guide, it will clarify the particular remittance information that DMH will return in the X12N 835 transaction set. Changes to this document will be published on the DMH Online Internet web site, along with other companion guides for DMH trading partners.

Preface

The Health Insurance Portability and Accountability Act (HIPAA) requires that the State of Missouri, Department of Mental Health (DMH) comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N 835 Implementation Guide has been established as the standard for compliance of payment transactions.

This is a Companion Document to the ANSI X12N 835 Implementation Guide. It specifies the data content when exchanging electronically with DMH. Transmissions based on this document, used in tandem with the X12N Implementation Guides, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ANSI X12N 835 Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

Additions/Changes in the Companion Guide

Starting with Version 1.1, changes to this Companion Guide will be highlighted. The color of the highlight will denote additions/changes for the four most recent versions. The key to the highlighting will be documented in this section.

Highlight Color	Version Number Reference	Version Date

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1 Introduction

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1966 (HIPAA) include requirements that national standards be established for electronic health care transactions, and national identifiers for providers, health plans, and employees. These standards are being adopted to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

1.1 Scope

This companion Guide contains the Missouri Department of Mental Health's specific instructions for receiving, reading, and interpreting the X12N 835 Claim Payment / Advice transaction

1.2 Overview of Guide

- **Getting Started** describes interacting with DMH Information Technology Services Division (ITSD) for EDI transactions.
- **Connectivity with DMH and Communications** provides information on process flows.
- **DMH Contact Information** contains the DMH contact phone numbers and the DMH ITSD Customer Support Center e-mail address.
- **DMH Specific Definitions, Business Rules and Limitations** contains terminology and instructions for specific data elements.
- **External Code Sets needed for the 835** is a list of the external code sets needed for transactions. These code sets and values are available in the Implementation Guide Code Sets document.

1.3 Intended Audience

The intended audience for this document is the technical staff responsible for programming to receive files and post electronic claim payment advices. This information should be coordinated with the Trading Partner's Accounts Receivable Office to ensure that payments are interpreted and posted correctly.

1.4 References

Implementation guides for all transactions are available electronically at www.wpc-edi.com. This Companion Guide is intended to serve only as a Companion Document to the HIPAA ANSI X12N 835 Implementation Guide.

2 Getting Started

2.1 Working with the Department of Mental Health

The following are DMH contact numbers:

Customer Support Center at 573-526-5888 (toll-free 888-601-4779)
Fax Number: 573-522-4242

2.2 Provider Registration

Prior to submitting / receiving test EDI transactions, a Provider with DMH must have a current contract with DMH and possess a valid network Userid and Password. Network Userid and Password are established after the Provider obtains a contract to provide services for DMH.

A Provider in active status (has a current contract with DMH) may contact the DMH Customer Support Center to request a trading partner identifier. A date and time will be scheduled for testing transactions.

2.3 ProviderTesting with DMH

Each Provider must successfully complete transaction testing with DMH. All batch providers will need to conduct a separate test cycle even if they are currently batching to DMH. This testing will involve the Provider sending DMH test batch files. The test files should represent a sample of typical claims. File sizes should be close to average for the range of files typically submitted. DMH will be accepting files by File Transfer Protocol (FTP) only. An FTP site is available for Providers to send and retrieve files for testing purposes. Each Provider is provided with a secure FTP folder structure for downloading and retrieving batch files and reports. Procedures for using the FTP site will be provided when testing is scheduled.

Providers must successfully complete all required testing prior to submitting production-ready transactions.

3 Connectivity with DMH and Communications

3.1 Process Flows

- Providers contacts DMH
- Provider identifiers are assigned and FTP information is provided Trading Provider sends test 837 Professional transaction(s) to DMH
    - DMH will accept for test adjudication an ASCII text file with an *.EDI* extension.

- Once successful testing is completed, DMH notifies Provider of the completion and informs them of the necessary changes to be made for sending production transactions, if any.

3.2 Transmission Administrative Procedures

- The transaction file must be a text file with an .EDI extension. Compression of files is not allowed.
- We suggest retrieval of the file on the first business day after the transaction file was submitted, but no later than seven days after the file submission.

3.3 Communication Protocol Specifications

- Instructions for receiving 835 files via secure FTP will be provided at the time the test is scheduled with DMH.

3.4 Software Requirements

- A passive FTP client that supports SSL (secure sockets layer) connection is required for securely submitting and receiving EDI documents.
- The product FTP Voyager Secure is currently supported by DMH. It is available at http://www.ftpvoyager.com.
- If you currently have a different FTP client, you may experience problems transferring files to DMH.

3.5 Passwords

- Userids and Passwords will be the DMH Network Userid and Password.
- DMH Userid and Password can be assigned to active providers by the DMH Customer Support Center.

4 DMH Contact Information

4.1 EDI Customer Service/Technical Assistance

If you need to contact DMH concerning an EDI transmission, you may call or email the ITSD Customer Support Center. The telephone number is: 573-526-5888 or toll-free 888-601-4779. The Customer Support Center's email address is: csc@dmh.mo.gov. Your inquiry will be assigned to an available EDI staff person.

5 DMH Specific Definitions, Business Rules and Limitations

1. The 835 transaction will replace all existing remittance advices.

2. One 835 transaction reflects a single payment (check or EFT). However, you may receive multiple 835 for one service, if payment is from multiple funding sources.

3. Not all of the situational segments of the 835 are used by DMH. See data clarifications listed in section 7 for details.

4. Both paid and denied claims will be reported in the Remittance Information Only 835.

5. Suspended claims will be reported using Informational 835s. The X12N U277 Unsolicited Claim Status Notification is not yet implemented.

6. Since CIMOR is based on a claim line processor design, each service will be reported in the 835 as a claim.

7. DMH may use multiple 835 transactions to fulfill the payment obligation.

8. 835 files will be available in a Provider's FTP folder for 60 days. Files may be downloaded more then once if required. It is the responsibility of the Provider to retrieve their file within 60 days. After 60 days, 835 files cannot be recreated.

9. The 835 will not show industry standard Service Adjustment Reason Codes. Section 6 contains a complete list of the DMH Service Adjustment Reason Codes.

10. Adjustments made by Payers other than DMH will be shown.

11. The CIMOR "Payer Plan" will be returned in the TRN04 Reference Identification segment in the 835 header.

12. DMH will not respond to 999s sent to acknowledge an 835.

13. All dates are in the CCYYMMDD format

14. All date/times are in the CCYYMMDDHHMM format

15. Valid EDI Delimiters for the Department of Mental Health

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	~	126	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

6 External Code Sets Needed for the 835

Code sets used for: Zip Code, State, Place of Service, ICD9 Diagnosis, and HCPCS can be found at http://www.claredi.com/hipaa/codesets.php.

Service Adjustment Reason Codes are non-standard, DMH specific codes that more accurately reflect conditions/errors in the DMH adjudication process. The DMH Service Adjustment Reason Codes conform to the 3 digit standard and do not overlap Industry Standard Codes. The following is a list of these codes. These can also be downloaded from the DMH CIMOR web site.

Code	Department of Mental Health - Service Adjustment Reason Codes
E56	ENCOUNTER DENIED, consumer is not assigned to a CPS Adult Program
E57	ENCOUNTER DENIED, consumer is not assigned to a CPS Program
E58	ENCOUNTER DENIED, consumer is not assigned to a CPS Youth Children's System of Care
E59	ENCOUNTER DENIED, consumer is not assigned to a CPS Youth Program
E60	ENCOUNTER DENIED, consumer is not assigned to this program
E55	ENCOUNTER DENIED, diagnosis does not exist for both ADA and CPS
E61	ENCOUNTER DENIED, procedure code not valid for program level
E62	ENCOUNTER DENIED, program level not defined
E64	ENCOUNTER DENIED, service must be authorized
E63	ENCOUNTER DENIED, service must be non-consumer specific
E33	REJECT, 42 hours maximum allowed in one calendar week
E46	REJECT, 8 hours maximum for one day
E32	REJECT, 8 units maximum allowed in one calendar week
E37	REJECT, cannot enter services for this service category
E66	REJECT, cannot receive more than 6 hours of service in a day
E67	REJECT, cannot receive more than 8 hours of service in a day
E17	REJECT, consumer does not have valid diagnosis for this service
E19	REJECT, consumer does not have valid ME code for this service
E18	REJECT, consumer exceeds age limit
E1	REJECT, consumer is not assigned this program
E43	REJECT, consumer is not assigned to a CPS program in the same EOC

Code	Department of Mental Health - Service Adjustment Reason Codes
E41	REJECT, consumer is not assigned to a CPS program with pay-to provider
E25	REJECT, consumer is not assigned to an ADA program
E44	REJECT, consumer is not assigned to both ADA and CPS program in the same EOC
E42	REJECT, consumer is not assigned to CPS Youth Children's System of Care program in the same EOC
E5	REJECT, consumer must be designated as co-dependent
E23	REJECT, consumer must be in SCL program
E4	REJECT, consumer's program level must be co-dependent
E26	REJECT, consumer's primary language indicates interpreting services are not needed
E3	REJECT, full assessment must be performed H0001
E12	REJECT, maximum limit for program limit is exceeded
E28	REJECT, maximum units for program is exceeded
E30	REJECT, needs ADA SATOP Administration Group approval
E7	REJECT, needs authorization
E49	REJECT, needs to be entered under the CPR service category to bill to Medicaid
E51	REJECT, Not a valid procedure code for Medication Administration
E14	REJECT, nursing service not valid for this program
E54	REJECT, Only 2 units of ADA Drug Testing per consumer per 30 days (month)
E2	REJECT, only one claim for H0001 is allowed in a 180 day period
E65	REJECT, only one intake evaluation allowed in the last 355 days
E8	REJECT, primary abuser does not have room and board service for same date of service
E13	REJECT, primary abuser does not have service for same date of service
E6	REJECT, primary abuser must be entered in program
E47	REJECT, procedure code invalid for consumer's assigned program
E34	REJECT, procedure code is in error for non-consumer specific encounter
E35	REJECT, procedure code is invalid for non-consumer specific category
E38	REJECT, procedure code not valid for Rehabilitation program level
E10	REJECT, provider needs to move consumer to Authorized Program level and authorize the additional units
E9	REJECT, provider needs to move consumer to Extended Program level
E50	REJECT, Rehabilitation & Maintenance are the only 2 program levels for CPR
E48	REJECT, service category is in error on the service matrix
E27	REJECT, service is not allowed for SATOP programs
E53	REJECT, service is not billable to Medicaid
E22	REJECT, service is not billed. This procedure code should be marked "non-billable" on the service matrix
E11	REJECT, service is not valid for consumer's program level
E20	REJECT, service must be billed to First Steps program
E29	REJECT, service not allowable for program phase
E39	REJECT, service not allowed for Intensive program level
E40	REJECT, service not allowed for Maintenance program level
E31	REJECT, the service is invalid for non-treatment consumer
E24	REJECT. only allowed one service for ADA drug testing in a calendar week

7 835 Data Clarifications

This companion guide for the ANSI ASC X12N 835 Health Care Claim Payment /Advice transaction has been created for use in conjunction with the standard Implementation Guide. It should not be considered a replacement for the Implementation Guide, but rather used as an additional source of information. The data clarifications are derived from specific business rules that apply exclusively to the Missouri Department of Mental Health claim adjudication process.

The following table contains data clarifications for the ANSI ASC X12N 835 transaction. Please note that not every field is listed. Only the fields requiring specific data clarifications or containing hard coded values are shown.

Please see the ANSI ASC X12N 835 Implementation Guide for complete details on the ANSI ASC X12N 835 transaction.

Loop	Segment	Data Element	Required	Comment
Header Detail				
Header	ISA	06	R	Interchange Sender ID MoDMH Federal Tax ID
Header	ISA	13	R	Interchange Control Number
Header	ST	02	R	Transaction Set Control Number
Header	BPR	01	R	Transaction Handling Code 'I' = Remittance Information Only 'H' = Notification Only
Header	BPR	02	R	Total Actual Provider Payment Amount The total payment amount cannot exceed eleven characters, including decimal. Although the value can be zero, the 835 cannot be issued for less than zero dollars.
Header	BPR	04	R	Payment Method Code 'CHK' = Check This code Is used when the Transaction Handling Code (BPR01) = 'I'. 'NON' = Non-Payment data. This code Is used when the Transaction Handling Code (BPR01) = 'H'.
Header	BRP	16	R	Check Issue or EFT Effective Date. {format CCYYMMDD}

Loop	Segment	Data Element	Required	Comment
				If BPR04 = 'CHK' then this code is the check issuance date.
Header	TRN	02	R	Check or EFT Trace Number If BPR02 is greater than zero, this field is populated with the number of the check or with the EFT Trace Number associated with this transfer of funds.
Header	TRN	03	R	Originating Company Identifier This is the Payer Identifier: the Federal Tax ID proceeded by a '1'.
Header	TRN	04	R	Reference Identification DMH CIMOR Payer Plan Code
Header	REF	01	S	Reference Identification Qualifier Used only when the receiver of the transaction is other than the payee (e.g., Clearing House or Billing Service ID) 'EV' = when dealing with clearing house
Header	REF	02	S	Reference Identification or Receiver identifier Clearing House or Billing Service ID
Header	DTM	01	R	Data/Time Qualifier '405' = Production Date SAM II check date
Header	DTM	02	R	Date of Claim Adjudication Data expressed as CCYYMMDD format
Payer Information				
1000A	N1	02	R	Payer Name "Missouri Department of Mental Health"
1000A	N1	03	R	Payer Identification Code Qualifier 'XV'
1000A	N1	04	R	Payer Identification Code '446000987' = Federal Tax ID
1000A	N3	01	R	Payer Address "1706 East Elm Street"
1000A	N4	01	R	Payer City Name "Jefferson City"
1000A	N4	02	R	Payer State Code 'MO'
1000A	N4	03	R	Payer Postal Code

Loop	Segment	Data Element	Required	Comment
				'65101'
Payee Information				
1000B	N1	01	R	Entity Identifier Code 'PE' = Payee
1000B	N1	02	R	Payee Name Provider Name on record at MODMH
1000B	N1	03	R	Payee Identification Code XX=NPI
1000B	N1	04	R	Identification Code
1000B	N3	01	S	Payee Address
1000B	N4	01	S	Payee City Name
1000B	N4	02	S	Payee State Code
1000B	N4	03	S	Payee Postal Code
1000B	REF	01	S	Reference Identification Qualifier 'PQ' = Payee Identification
1000B	REF	02	S	Reference Identification Facility Service Location Number
Claim Detail				
2100	CLP	01	R	Patient Control Number or Payee Claim Control Number This is the patient control number assigned by the provider.
2100	CLP	02	R	Claim Status Code Code identifying the status of an entire claim assigned by the payer '1' = Processed as Primary '4' = Denied ''22' = Reversal of Previous Payment
2100	CLP	03	R	Total Claim Charge Amount
2100	CLP	04	R	Claim Payment Amount
2100	CLP	05	R	Patient Responsibility Amount
2100	CLP	06	R	Claim Filing Indicator Code '13' = Point of Service (POS)
2100	CLP	07	R	Payer Claim Control Number MODMH Internal Control Number that applies to the entire claim
2100	CAS	01	S	Claim Adjustment Group Code 'CO' = Contractual Obligations 'OA' = Other Adjustments 'PI' = Payer Initiated Reductions 'PR' = Patient Responsibility

Loop	Segment	Data Element	Required	Comment
2100	CAS	02	S	Claim Adjustment Reason Code The detail reason adjustment was made.
2100	CAS	03	S	Monetary Amount The monetary amount for the adjustment reason. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04
2100	CAS	04	S	Quantity or Adjustment Quantity Used only when the units of service are being adjusted. A positive value decreases the paid units of service, and a negative number increases the paid units of service.
2100	CAS	05	S	Claim Adjustment Reason Code The detail reason adjustment was made.
2100	CAS	06	S	Monetary Amount The monetary amount for the adjustment reason. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04
2100	CAS	07	S	Quantity or Adjustment Quantity Used only when the units of service are being adjusted. A positive value decreases the paid units of service, and a negative number increases the paid units of service.
2100	CAS	08	S	Claim Adjustment Reason Code The detail reason adjustment was made.
2100	CAS	09	S	Monetary Amount The monetary amount for the adjustment reason. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04
2100	CAS	10	S	Quantity or Adjustment Quantity Used only when the units of service are being adjusted. A positive value decreases the paid units of service, and a negative number increases the paid units of service.
2100	CAS	11	S	Claim Adjustment Reason Code The detail reason adjustment was made.
2100	CAS	12	S	Monetary Amount The monetary amount for the adjustment reason. A negative amount increases the payment, and a

Loop	Segment	Data Element	Required	Comment
				positive amount decreases the payment contained in CLP04
2100	CAS	13	S	Quantity or Adjustment Quantity Used only when the units of service are being adjusted. A positive value decreases the paid units of service, and a negative number increases the paid units of service.
2100	CAS	14	S	Claim Adjustment Reason Code The detail reason adjustment was made.
2100	CAS	15	S	Monetary Amount The monetary amount for the adjustment reason. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04
2100	CAS	16	S	Quantity or Adjustment Quantity Used only when the units of service are being adjusted. A positive value decreases the paid units of service, and a negative number increases the paid units of service.
2100	CAS	17	S	Claim Adjustment Reason Code The detail reason adjustment was made.
2100	CAS	18	S	Monetary Amount The monetary amount for the adjustment reason. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04
2100	CAS	19	S	Quantity or Adjustment Quantity Used only when the units of service are being adjusted. A positive value decreases the paid units of service, and a negative number increases the paid units of service.
2100	NM1	01	R	Entity Identifier Code 'QC' = Patient
2100	NM1	02	R	Entity Type Qualifier '1' = Person
2100	NM1	03	R	Patient Last Name Recipient's last name
2100	NM1	04	R	Patient First Name Recipient's first name
2100	NM1	05	O	Patient Middle Name

Loop	Segment	Data Element	Required	Comment
				Recipient's middle name
2100	NM1	08	R	Identification Code Qualifier This is a required field if the patient identifier is known or was reported on the claim. 'MI' = Member Identification Number
2100	NM1	09	R	Identification Code or Patient Identifier Recipient's MODMH State ID
2100	DTM	01	S	Data/Time Qualifier '050' = Received – used to convey the date that the claim was received by MODMH
2100	DTM	02	S	Date Data expressed as CCYYMMDD format
2100	PER	01	R	Contact Function Code 'CX' = Payers Claim Office
2100	PER	02	S	Claim Contact Name "Help Desk"
2100	PER	04	S	Claim Contact Email 'csc@MoDMH.mo.gov'
2100	PER	05	S	Claim Contact Phone "(888) 601-4779"
2100	PER	06	S	Claim Contact Fax "(573) 526-6033"
Service Payment Detail				
2110	SVC	01-1	R	Product/Service ID Qualifier 'HC' = Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
2110	SVC	01-2	R	Product/Service ID or Procedure Code
2110	SVC	01-3	S	Procedure Modifier
2110	SVC	01-4	S	Procedure Modifier
2110	SVC	01-5	S	Procedure Modifier
2110	SVC	01-6	S	Procedure Modifier
2110	SVC	02	R	Monetary Amount or Line Item Charge Amount
2110	SVC	03	R	Monetary Amount or Line Item Provider Payment Amount
2110	SVC	04	S	Product/Service ID or National Uniform Billing Committee Revenue (NUBC) Code Required when an NUBC revenue code was considered during adjudication in addition to the procedure code.

Loop	Segment	Data Element	Required	Comment
2110	SVC	05	S	Units of Service Paid Count The number of paid units of service.
2110	DTM	01	S	Data/Time Qualifier '472' = Service Date – indicates a single day of Service
2110	DTM	02	S	Date Data expressed as CCYYMMDD format
2110	REF	01	R	Reference Identification Qualifier '6R' = Provider Control Number – This is the Line Control Number submitted in the 837, which is used by the provider for tracking.
2110	REF	02	R	Line Control Number
NOTE: *The following CAS segment will be used to reflect reductions in payment due to adjustments particular to a specific service in the claim.*				
2110	CAS	01	S	Claim Adjustment Group Code 'CO' = Contractual Obligations 'OA' = Other Adjustments 'PI' = Payer Initiated Reductions 'PR' = Patient Responsibility
2110	CAS	02	S	Claim Adjustment Reason Code The detail reason adjustment was made.
2110	CAS	03	S	Monetary Amount The monetary amount for the adjustment reason. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04
2110	CAS	04	S	Quantity or Adjustment Quantity Used only when the units of service are being adjusted. A positive value decreases the paid units of service, and a negative number increases the paid units of service.
2110	CAS segments 05-13 are not used in the MoDMH adjudication process, but will be used if Medicaid provides additional adjustment data that needs to be conveyed to the payee.			
2110	REF	01	R	Line Item Control Number '6R' = Provider Control Number – This is the Line Control Number submitted in the 837, which is used by the provider for tracking.
2110	REF	02	R	Line Control Number
2110	LQ	01	S	Code List Qualifier Code

Loop	Segment	Data Element	Required	Comment
				'HE' = Claims Payment Remark Codes
2110	LQ	02	S	Industry Code or Remark Code
Provider Level Adjustments				
Summary	PLB	01	S	Reference Identification or Provider Identifier XX – NPI
Summary	PLB	02	S	Date or Fiscal Period Date The last day of the provider's fiscal year. If the end of the provider's fiscal year is not known by the payer (MoDMH), December 31st of the current year is used.
Summary	PLB	03	S	Adjustment Identifier or Adjustment Reason Codes See pages 219 - 222 of the Implementation Guide for a complete listing of all Adjustment Reason Codes Typical Values: 'WO' – Overpayment Recovery 'FB' – Forward Balance 'LS' – Lump Sum
Summary	PLB	04	S	Monetary Amount or Provider Adjustment Amount This is the adjustment amount for the preceding adjustment reason.
Summary	SE	01	R	Number of Included Segments
Summary	SE	02	R	Transaction Set Control Number This is the same identifier as the Header's ST02