New Mexico Health Care Authority
Medical Assistance Division
Conduent State Healthcare, LLC

CONDUENT

HEALTH CARE AUTHORITY

5010 PACDR I Companion Guide

New Mexico Health Care Authority
MMISR Financial Services Project

Version 2.0

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Preface

This companion guide to the *Version 5010 ASC X12N Implementation Guides* and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Conduent EDI Solutions. Transmissions based on this companion guide, used in tandem with the *Version 5010 ANSI ASC 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 *ASC X12N Implementation Guides* adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the implementation guides.

Disclaimer

This companion guide is for use along with the *ANSI ASC X12N 5010 Health Care Claim: 837 Institutional Post Adjudicated Claims Data Reporting Implementation Guide*. It should not be considered a replacement for the implementation guide but rather used as an additional source of information. The companion guide contains data clarifications derived from specific business rules that apply exclusively to claims processing for the New Mexico Medicaid program. The guide also includes useful information about sending and receiving data to and from Conduent EDI Solutions, Inc.

Submitters are therefore encouraged to check the New Mexico Health Care Authority (HCA) Medical Assistance Division website periodically for updates to the companion guides at the following website: https://www.hca.nm.gov/providers/hipaa-standard-companion-guides/.

Please note that acceptance into the payer system does not guarantee claim payment.

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1. Introduction

Conduent EDI Solutions, Inc., a leader in healthcare technology, provides Electronic Data Interchange (EDI) clearing house services to provider enrolled with various insurance companies and in contracted healthcare plans. This document outlines the procedures necessary for engaging EDI with Conduent EDI and provides specific data clarifications where applicable. Our electronic transactions acquisition services provide an array of tools that allow you to:

- Easily submit all your transactions to one source.
- Submit transactions twenty-four hours a day, seven days a week.
- Receive confirmation of receipt of each file transferred.
- Receive remittance notification from health care plans on a regular basis.

As an EDI Gateway Service, we provide connectivity to various healthcare plans and states where Conduent is the fiscal agent, third-party administrator, or contracted clearinghouse. Healthcare plans that participate with Conduent EDI Solutions, Inc. are referred to as payers. Transactions are accepted electronically into our data center and are processed through the Conduent State Healthcare Clearinghouse (SHCH).

The Conduent SHCH provides connectivity for the flow of medical information and data between medical providers, facilities, vendors, claim payment agencies, and other clearinghouses and the Front-end Online Transaction Processor (OLTP). Beyond the receipt and delivery of this data, Conduent SHCH provides translation to and from ANSI ASC X12N standard formats.

The 837 Institutional Post Adjudicated Claims Data Reporting transaction data will be submitted to the Conduent SHCH for processing. Conduent SHCH validates submission of ANSI X12N format(s). TA1 report is generated to verify data at the interchange level and confirms whether the envelope has been accepted or rejected due to issues such as corrupt or invalid data. If the file contains syntactical error(s), the segment(s) and elements(s) where the error(s) occurred will be reported in a X12 N 999 acknowledgement.

1.1. Scope

This companion guide is intended to be used by trading partners for the submission of the X12N 837 Institutional Post Adjudicated Claims Data Reporting transaction to Conduent EDI Solutions. This guide is to be used in conjunction with the *ANSI ASC X12N 5010 National Implementation Guide*. The companion guide contains data clarifications derived from specific business rules that apply exclusively to claims processing for NM Medicaid. This companion guide is subject to change.

1.2. Overview

This document provides the following information for NM Medicaid trading partners:

- Testing expectations

- Connectivity methods for transaction transmission and associated security standards
- NM Medicaid data requirements
- Details on responses/acknowledgements
- X12 transaction data clarifications

1.3. References

This companion guide is intended for trading partner use in conjunction with the *ANSI ASC X12N National Consolidated Guides (TR3)*, as adopted under HIPAA. These are available at: https://x12.org/products/technical-reports

Table 1: Reference Materials

ANSI ASC 5010 Implementation Guides	
EDI Online	https://edionline.portal.conduent.com/EDIOnline/redirect.action
HCA FAQ's	https://www.hca.nm.gov/providers/hipaa-standard-companion-guides/
NM Helpdesk	HIPAA.DeskNM@hca.nm.gov
NM MOVEit	https://pbmazuremoveit.services.conduent.com
Trading Partner Agreement Form	https://www.hca.nm.gov/providers/hipaa-standard-companion-guides/

2. Getting Started

2.1. Working with New Mexico Medicaid

Any entity sending electronic transmissions to Conduent EDI Solutions for processing where reports and responses will be delivered must complete an EDI enrollment package. This package provides Conduent EDI Solutions with the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic transmissions.

2.2. Trading Partner Registration

- HCA requires any provider exchanging electronic data with New Mexico Medicaid to be enrolled in the program and should be approved for the submission of X12 transaction sets.
- New Mexico Medicaid Enrollment Forms and instructions are available at: https://www.hca.nm.gov/providers/hipaa-standard-companion-guides/
- Successful enrollment in New Mexico Medicaid is required before proceeding with Conduent EDI. HCA makes available companion guides and enrollment packages for download via the web at: https://www.hca.nm.gov/providers/hipaa-standard-companion-guides/.

2.3. Certification and Testing Overview

Conduent EDI Solutions does not require certification of submitters and their transactions; however, we do require some minimal transaction testing.

Completion of the testing process must occur prior to electronic submission of production data to Conduent EDI Solutions. Assistance from Conduent EDI Business Analysts is available throughout this process. Each test transmission is inspected thoroughly to ensure no format errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, to simulate a production environment, we request that you send real transmission data. The number of test transmissions required depends on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to Conduent's system. Also, changes to the X12N formats may require additional testing.

3. Testing with the Payer

Vendors, Billing Agents, Clearinghouses, and Providers who have created their own electronic claims submission software are required to engage in testing with Conduent EDI Solutions. These entities will validate their applications using companion guides along with the national *ANSI ASC X12N Implementation Guides*. These guides ensure that the software meets X12N standards and payer business edit requirements. The test file should first be validated in UAT EDI MOVEit DMZ/Transfer. Successful completion of both testing processes is required before a submitter will be approved for production.

Each test transmission is validated to ensure no format errors are present. Testing is conducted to verify the integrity of the format not the integrity of the data. However, to simulate a production environment, we request that test files contain realistic healthcare transaction data. The number of test transmissions required depends on the number of format errors in a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to Conduent's system or HIPAA mandated changes.

3.1. Conduent EDI Trading Partner Testing Procedures

1. Complete a new Trading Partner Agreement (TPA) for 5010 transactions.
   - The form is available on the New Mexico Medicaid Website at: https://www.hca.nm.gov/providers/hipaa-standard-companion-guides/.
   - Complete the form and send toHIPAA.DeskNM@hca.nm.gov.
2. Once the New Mexico HIPAA Helpdesk receives your signed TPA, they will enter your information into our Trading Partner Management System (TPMS) and provide you details on submission of your PACDR transactions for testing.
   - You will be granted access to the UAT EDI DMZ to perform HIPAA transaction format validation on the test files.
   - EDI DMZ, an SFTP connection, which allows automated delivery and receipt of files.
3. Validate your files using UAT MOVEit DMZ/Transfer https://nonprodazuresftp.services.conduent.com.
   - Your files only need to pass SNIP levels 1 and 2 without errors. That is, if you have a SNIP level 5 error, or a SNIP level 1 warning (not error), then your file is considered passed for 5010 validations.
   - You should submit your files in UAT MOVEit DMZ/Transfer first to ensure they pass 5010 validations.
4. The submitter needs to submit three files of at least 10 valid claims each for each transaction type (PADCR I, PACDR D, PACDR P) you wish to submit in production. That is, if you are planning to submit PACDR I, D, P transactions, you need to submit nine files total.
5. Once you have submitted 3 files of at least 10 valid claims each, contact the NM HIPAA Helpdesk (HIPAA.DeskNM@hca.nm.gov) to let them know you are ready to have your files reviewed by Conduent.

6. The claims will be reviewed by the State and once approved permission will be granted to submit 5010 version PACDR claims or encounters to the production system.

3.2. Tracking Transmission/Production Problems

Please have the following information available when calling the NM HIPAA Helpdesk regarding transmission and production issues.

- **Trading Partner ID/Submitter ID**: Your Trading Partner ID is our key to accessing your trading partner information. Please have this number available each time you contact the NM HIPAA Helpdesk. Use your Conduent EDI Solutions submitter ID number in conjunction with your software application to transmit files to Conduent EDI Solutions.
- **Logon Name and Logon User ID**: These allow asynchronous trading partners access to the host system for claims submission. The NM HIPAA Helpdesk uses this information to reference your submitted data.
- **Secure file transfer ID/Password:** These are the login credentials for the Conduent DMZ site. They allow FTP trading partners to access assigned folders for file submission or to retrieve responses. The Conduent HIPAA Helpdesk also uses this secure file transfer ID to reference your DMZ data submissions.

4. Connectivity with the Payer(s)/Communications

This section describes the process to submit HIPAA X12N 837 Institutional Post Adjudicated Claims Data Reporting transactions, along with various submission methods, security requirements, and exception handling procedures.

4.1. Process Flows

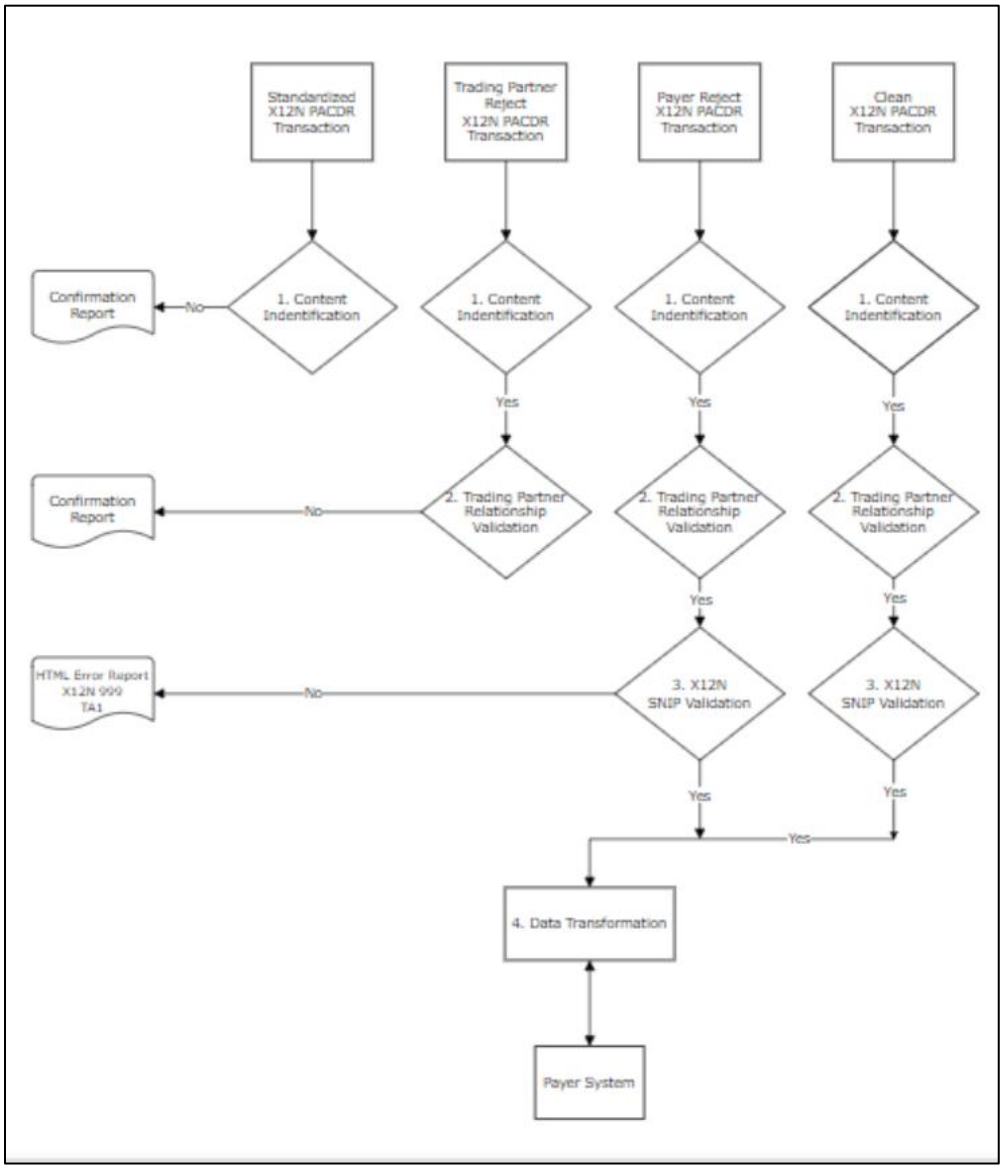


Figure 1: Editing and Validation Flow Diagram

LEGEND:

Content Identification: The process starts with four types of X12N PACDR transactions. Each type goes through a Content Identification check. If the content does not pass the identification check, a TA1 Report is generated, and the process stops for that transaction.

Standardized X12N PACDR Transaction **Trading Partner Reject X12N PACDR Transaction**	**Payer Reject X12N PADCR Transaction** **Clean X12N PACDR Transaction**

Trading Partner Relationship Validation: The trading partner information is validated. If the trading partner information is invalid, a TA1 (Interchange Acknowledgement) will be returned to the submitter. If the trading partner relationship is valid, the data will pass for X12N syntax validation.

X12N SNIP 1&2 Validation: A determination will be made as to whether the data is ANSI ASC X12N. A X12 N 999 (Implementation Acknowledgement) will be returned to the submitter. The X12 N 999 contains ACCEPT information. If the file contained syntactical errors, the segment(s) and element(s) where the error(s) occurred will be reported. If the data passes X12N SNIP 1 and 2 validations, it is then sent to the adjudication system.

4.2. Transmission Administrative Procedures

When file transmission or technical production issues occur, which could require the re-submission of files, please contact the NM HIPAA helpdesk at 1 **(800)-299-7304 or by email at HIPAA.DeskNM@hca.nm.gov**.

4.3. Communication Protocol Specifications

We offer the following transmission methods for trading partners:

EDI DMZ/Transfer (SFTP)

Transaction transmission is available twenty-four hours a day, seven days a week. This availability is subject to scheduled and unscheduled maintenance downtime. It is an operational policy to schedule preventative maintenance periods on weekends whenever possible.

EDI MOVEit DMZ/Transfer

MOVEit DMZ/Transfer is appropriate for submitters of large transaction files. MOVEit DMZ/Transfer is a software product that transports data via secure FTP across the Internet.

There are two methods for using MOVEit DMZ/Transfer:

1. Uploading files through a secure website https://pbmazuremoveit.services.conduent.com.
2. Sending and receiving files via Secure FTP client.
   Note: The inbound file name must not exceed 100 characters including file extension, spaces and underscore.

4.4. Password General Standards

Trading partners are assigned a Login Name and Login User ID during the enrollment process with NM Medicaid. Login User IDs (passwords) can be up to 50 characters.

5. Contact Information

Access to the site for New Mexico Medicaid trading partners is administered through the New Mexico NM HCA HIPAA Helpdesk (HIPAA.DeskNM@hca.nm.gov).

EDI Customer Service/Technical Assistance

The NM HIPAA Helpdesk Support Unit assists users with questions about electronic submission. The NM HIPAA Helpdesk Support Unit is available to all New Mexico Providers Monday through Friday from 8:00 a.m. to 5:00 p.m. MT at 1-800-299-7304 or by email at HIPAA.DeskNM@hca.nm.gov. The NM HIPAA Helpdesk Support Unit provides the following services:

- Information on available services,
- Enrolls users for electronic submission,
- Verifies receipt of electronic transmissions, and
- Provides technical assistance to users who are experiencing transmission difficulties.

6. Control Segments/Envelopes

This section contains data clarifications. The clarifications include:

- Identifiers to use when a national standard has not been adopted.
- Parameters in the implementation guide that provides options.

Many of the data elements included in the companion guides are business requirements and are not standardization-required elements. The inclusion of a business-required data field, as defined by this companion guide, may aid in the delivery of a positive response.

6.1. ISA-IEA

Conduent EDI Solutions will read the Interchange Control Segments to validate the Interchange Envelope of each ASC X12 file received for processing. If the Interchange Envelope is invalid, the trading partner will receive a TA1 Interchange Acknowledgement. In the event a TA1 is generated, the TA1 will be delivered to the Trading Partner Mailbox. Table 2 ISA-IEA Segment provides the sender and receiver codes, authorization, and delimiter information.

Table 2: ISA-IEA Segment

Loop	Segment	Data Element	Description
Header	ISA	01	The value to be used **00**
Header	ISA	03	The value to be used **00**
Header	ISA	05	The value to be used **ZZ** (Mutually Defined)
Header	ISA	06	You must enter the Trading Partner ID provided during the enrollment process. Example: **123456** followed by spaces to complete the15-digit element
Header	ISA	07	The value to be used **ZZ** (Mutually Defined)
Header	ISA	08	The value to be entered **100000** followed by spaces to complete the 15-digit element.
Header	ISA	09	Expected date in YYMMDD format.
Header	ISA	10	Expected time in HHMM format.

Loop	Segment	Data Element	Description
Header	ISA	15	Use one of the following values: **T=** Test data **P=** Production data

6.2. GS-GE

Conduent EDI Solutions permits trading partners to submit single or multiple functional groups within an X12 file. If the X12 file contains multiple functional groups, Conduent EDI will split a file containing multiple functional groups into several files for processing. As a result, the trading partner will receive multiple X12C 999 Implementation Acknowledgments.

Table 3: GS-GE Segment

Loop	Segment	Data Element	Description
Header	GS	02	You must enter the Trading Partner ID provided during the enrollment process. The value in this data element should mirror that of ISA06 except for the trailing spaces. Example:123456
Header	GS	03	Enter 77048
Header	GS	04	Expected date in CCYYMMDD format.
Header	GS	05	Expected time in HHMM or HHMMSS format.
Header	GS	08	The value to be used is 005010X299A1

6.3. ST-SE

Conduent EDI Solutions will require a unique Transaction Set Control Number in the ST02. The ST02 value should match the SE02 value. Should a file contain multiple ST to SE Transaction Sets, each transaction set control number may not be duplicated within the same interchange (ISA to IEA).

Table 4: ST-SE Segment

Loop	Segment	Data Element	Description
FunctionalGroup	ST	02	Refer to the X12 TR3Guide
FunctionalGroup	SE	02	Refer to the X12 TR3Guide

7. Payer-Specific Business Rules and Limitations

To promote efficient, accurate electronic transaction processing, please note:

- Each user is assigned a Conduent EDI Solutions Trading Partner ID: 6 digits long.
- Logon Name: System generated 9-12 characters.
- Logon User ID (password): System generated – can be up to 50 characters long.
- All dates are in the CCYYMMDD format.
- All date/times are in the CCYYMMDDHHMM format.
- The same phone number will be used for transmitting test and production transactions.
- New Mexico Medicaid Provider ID: 8-digits long.
- The Receiver ID for New Mexico is 100000 and the Payer ID for New Mexico is 77048.
- The Trading Partner Agreement determines where reports and responses will be delivered.

8. Acknowledgements and/or Reports

8.1. Acknowledgements

HIPAA enabled the healthcare community to standardize transactions, front-end edits, and the corresponding acceptance/rejection reports. These reports ensure precision in EDI transaction format syntax and adherence to the transaction implementation guide. The type of report generated depends on the level of the invalid edit.

Each transaction contains multiple levels where edits may occur. The level at which an error is detected determines whether an entire batch or a single claim is rejected. The following three headings explain these levels in detail:

- Interchange Level Syntax Results and TA1 Rejection Report
- Transaction Set Level Syntax Results and X12 N 999 Rejection
- Implementation guide Level Results and the Rejection Report

The levels and their affiliated acceptance/rejection reports are discussed on the following pages.

8.2. Report Inventory

8.2.1. Interchange Level Syntax Results and TA1 Rejection Report

Interchange or TA1 edits verify the ISA, GS, GE, and IEA level segments and their data content, which include header and footer batch information. Any X12 syntax error at this level will result in the entire transaction being rejected, with these rejections reported on TA1.

8.2.2. TA1-Interchange Acknowledgement

A TA1 is an Interchange Acknowledgement segment used to report receipt of individual interchange envelopes. An interchange envelope contains the sender, receiver, and data type information within the header. TA1 reports the syntactical analysis of the interchange header and trailer. If invalid (e.g., the data is corrupt or the trading partner relationship does not exist within the Conduent system) the interchange will be rejected and a TA1, along with the data, will be forwarded to the Conduent EDI Support Unit for referencing purposes.

Refer to *National Electronic Data Interchange Implementation Guide, Health Care Claim, PACDR I,* under sections “A” and “B”.

- **ISA** Interchange Control Header: contains sender information.
- **GS** Functional Group Header: starts a group of related transaction sets.
- **GE** Functional Group Trailer: ends a group of related transaction sets.
- **IEA** Interchange Control Trailer: counts total number of functional groups within a batch.

8.2.3. Transaction Set Level Syntax Results and 999 Rejection Report

This level of edits is enforced by transaction set level syntax problems for all transactions within each functional group. These edits check the ST and SE level segments and the data content within these segments. These segments consist of the entire detailed information within a transaction. Any X12 syntax error that occurs at this level will result in the entire transaction being rejected. However, if the functional group consists of additional transactions without errors, these will be processed. The rejections are reported on X12 N 999.

8.2.4. X12 N 999-Implementation Acknowledgement

Conduent SHCH validates submission of ANSI ASC X12N format(s). An X12 N 999, or Implementation Acknowledgement, is generated when an EDI file, e.g., an ANSI ASC X12N file that has passed the header and trailer check, passes through the clearinghouse. This report contains Accept or Reject information; if the file contains syntactical errors, the segment(s) and element(s) where the error(s) occurred will be reported. For an example of the values used for this report, see the *ANSI ASC X12N 837 Institutional Post Adjudicated Claims Data Reporting Implementation Guide*. This method of acknowledgement is required by the Trading Partner Agreement between Conduent EDI Solutions and the Trading Partners.

The examples below show an accepted and a rejected X12 N 999. For documentation purposes the examples below are shown using the notepad++ unwrap functionality.

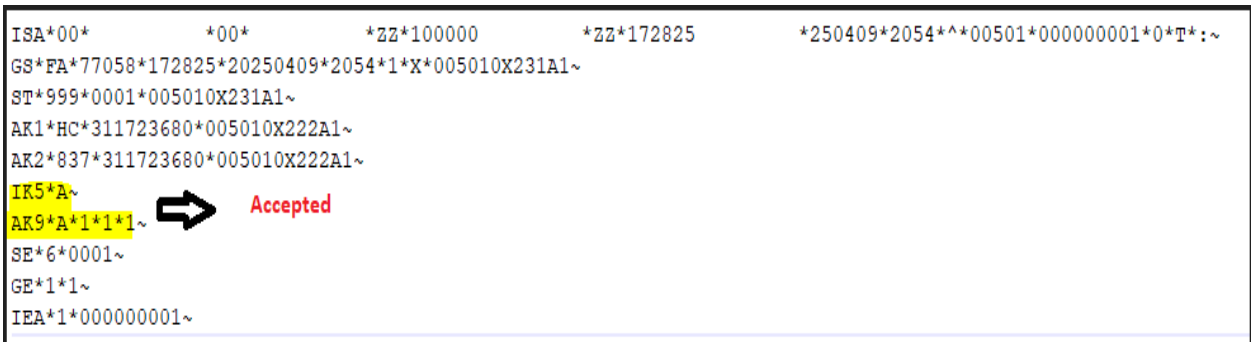


Figure 2: Accepted X12N 999 Example

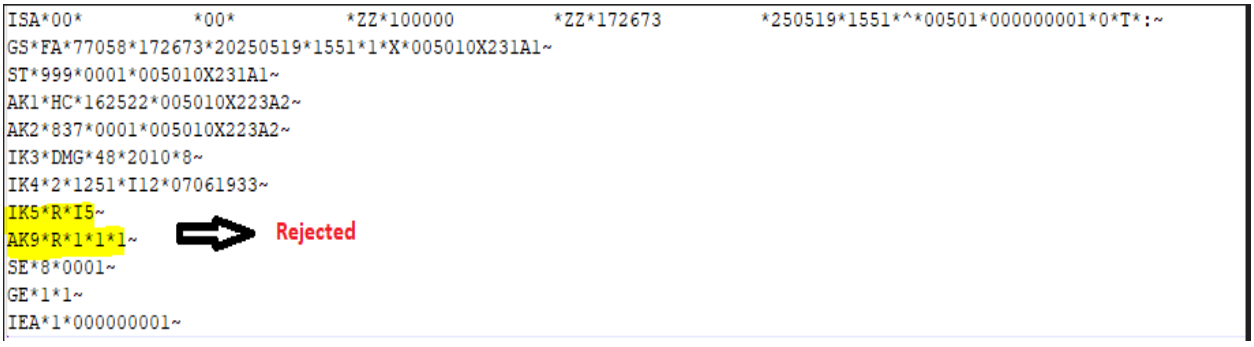


Figure 3: Rejected X12N 999 Example

Refer to *National Electronic Data Interchange Implementation Guide, Health Care Claim, PACDR I 837*, under sections “A” and “B”.

The X12 N 999 edits verify the **ST** and **SE** level segments and the segment data content within these segments.

- **ST** Transaction Set Header: starts a transaction set.
- **SE** Transaction Set Trailer: ends a transaction set.

9. Trading Partner Agreements

Conduent EDI Solutions requires trading partner enrollment, which includes a trading partner agreement, for testing and submission of X12N PACDR transactions through our processing gateway. Your trading partner agreement also determines where reports and responses will be delivered.

The NM Medicaid trading partner agreement form is available at

https://www.hca.nm.gov/providers/hipaa-standard-companion-guides/.

An EDI Trading Partner is defined as any payer customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from the payer.

10. Transaction-Specific Information (Version 5010)

This section contains data clarifications. The clarifications include:

- Identifiers to use when a national standard has not been adopted.
- Parameters in the implementation guide that provides options.

Many of the data elements included in the companion guides are business requirements and are not necessarily required per the ANSI ASC standard. The inclusion of a Business-Required data field, as defined by this companion guide, may aid in the delivery of a positive response.

CMdS TCN

- The CMdS Assigned claim number (TCN) should be returned by the MCO in **the 2300 loop**:
  - REF – Claim Identifier for Transmission Intermediaries.
    - REF*D9*52404700625000001 (must match exactly what was sent to the MCO).

- The MCO should report their own unique claim identifier (ICN/TCN) **in the 2330B**:
  - REF – Other Payer Claim Control Number.
    - REF*F8*ABC123QTY321 (this is just an example. Each MCO will have their own configuration).

Adjustment/Void Reporting

- For an Adjustment or Void **initiated by the provider**, the MCO should report the adjustment or void with the following:

In the loop 2300
  - REF – Claim Identifier for Transmission Intermediaries.
    - REF*D9*52406300690000001in the 2300 – (this would be the CMdS Assigned claim number (TCN) of the adjustment/void claim sent to the MCO)

In the loop 2330B
  - REF – Other Payer Claim Adjustment Indicator.
    - REF*T4*Y.
  - REF – Other Payer Claim Control Number
    - REF*F8*ABC123LMN001 (this would be the NEW unique claim identifier created by the MCO (ICN/TCN) when the adjustment or void was processed).
  - REF – Other Payer Adjusted Claim Control Number.
    - REF*BP*52404700625000001 (this would be the CMdS Assigned claim number (TCN) for the claim being adjusted).

- For an Adjustment or Void **initiated by the MCO**, the MCO should report the adjustment or void with the following:

In the loop 2300

- REF*D9*12A34B56C789 in the 2300 – (this would be the NEW unique claim identifier created by the MCO (ICN/TCN) when the adjustment or void was processed. The same value as in the 2330B REF*F8).

In the loop 2330B

- REF – Other Payer Claim Adjustment Indicator.
  - REF*T4*Y.
- REF – Other Payer Claim Control Number.
  - REF*F8*12A34B56C789 (this would be the NEW unique claim identifier created by the MCO (ICN/TCN) when the adjustment or void was processed).
- REF – Other Payer Claim Adjusted Claim Control Number.
  - REF*BP*52404700625000001 (this would be the CMdS Assigned claim number (TCN) for the claim being adjusted).

10.1. Data Clarifications

This companion guide for the ANSI ASC Consolidated 837 Institutional Post Adjudicated Healthcare Claim transaction has been created for use in conjunction with the combined consolidated guide. It should not be considered a replacement for the consolidated guide but rather used as an additional source of information.

10.2. 837 Institutional Post Adjudicated Claims Data Reporting

Table 5: PACDR I Transactions

Loop	Segment	Data Element		Description
Header	ST	01		Transaction Type
Header	ST	02		Transaction ID
Header	ST	03		The value to be used 005010X299A1.
	BHT	Beginning of Hierarchical Transaction		
Header	BHT	02		Please use code 00 for the original claim/encounter transmission or code 18 in case a transmission is disrupted, and the batch needs to be sent again.
Header	BHT	06		Use code RP for Reporting.
1000A	NM1	Submitter Name		
1000A	NM1	09		Please enter the Trading Partner ID provided during the enrollment process.

Loop	Segment	Data Element		Description
				The value in this data element should mirror that of ISA06.
1000B	NM1	Receiver Name		
1000B	NM1	03		The accepted value is NM Medicaid.
1000B	NM1	09		The accepted value is 77048.
2000A	HL	Billing Provider Hierarchical Level		
2000A	PRV	Billing Provider Specialty Information		
2000A	PRV	03		NM requires Taxonomy Code in this field and the taxonomy must match the allowed taxonomy for that provider type/specialty (i.e., Provider has one NPI number but has more than one provider type under which they submit claims using that NPI number). Please use the Provider Taxonomy to Provider Type table available on the MAD website. New Mexico Medicaid Portal (conduent.com).
2010AA	NM1	Billing Provider Name		
2010AA	NM1	01		85-Billing Provider Qualifier
2010AA	NM1	03		Billing Provider Name/Last name
2010AA	NM1	08		Billing Provider Qualifier and ID. XX is expected for NM1-08.
2010AA	NM1	09		Billing Provider NPI
2010AAA	N3	Billing Provider Address		
2010AA	N3	01		Billing provider's address is required.
2010AA	N4	Billing Provider city, state, ZIP code		
2010AA	N4	03		The billing provider ZIP code must be the ZIP code for the physical location which matches the Medicaid ID number for that location. There must be 9 digits

Loop	Segment	Data Element		Description
				in this field. If the last 4 digits are not known, use zeros.
2010AA	REF	Billing Provider Tax Identification		
2010AA	REF	01		EI
2010AA	REF	02		Billing Provider EIN Number
2000B	HL	Subscriber Hierarchical Level		Medicaid encounters, the patient is always the subscriber and the Patient HL in Loop 2000C is not used.
2000B	HL	04		Please use 0. The Subscriber is always the patient; therefore, the dependent level will not be utilized.
2010BA	NM1	Subscriber Name		
2010BA	NM1	08		The accepted value is MI for Member Identification Number.
2010BA	NM1	09		The New Mexico Medicaid Client ID number is required.
2010BB	NM1	Data Receiver		
2010BB	NM1	01		ZD - Party to Receive Reports
2010BB	NM1	03		The accepted value is NM Medicaid.
2300	CLM	Claim Information		
2300	CLM	01		Patient Control Number
2300	CLM	02		Total claim charges must be equal to the sum of all line-item charges. For Third Party Liability (TPL) claims total charges must balance.
2300	CLM	05-3		Claim Frequency Codes 1 = Original 2 = Beginning of Continuation Claim 3 = Iteration of Continuation Claim 4 = Final Iteration of Continuation Claim 7 = Replacement Claim 8 = Void prior-sent Claim
2300	CN1	Contract Information		

Loop	Segment	Data Element		Description
2300	CN1	02		The Total Allowed amount on the claim. This should be the sum of the Allowed amounts from the lines
2300	CN1	04		Please indicate if a claim is paid, or denied using the following 1-digit character: P = Paid D = Denied
2300	AMT	Patient Estimated Amount Due		
2300	AMT	02		For nursing facility claims where the member has a patient liability for the month of service, enter the amount to be applied to this nursing facility claim
2300	REF	Claim Identifier for Transmission Intermediaries		
2300	REF	01		D9
2300	REF	02		**For an Original claim**, enter the CMdS Assigned TCN sent on the incoming managed care claim. **If this is an adjustment claim submitted by the provider**, enter the CMdS Assigned claim number (TCN) of the adjustment/void claim sent to the MCO. **If this is an adjustment claim initiated by the MCO**, enter the unique NEW claim number created by the MCO (ICN/MCO_TCN) when the adjustment or void was processed. This should be the same value as in the 2330B REF F8 segment.
2300	HCP	Claim Pricing/Repricing Information		
2300	HCP	01		Pricing Methodology is required at the header for inpatient claims (defined as TOB 11x or 12x where billing provider is an acute care hospital or mental health hospital) and at the line for outpatient claims (anything else). For non-inpatient claims priced at the line, please include the pricing process code here. Valid

Loop	Segment	Data Element		Description
				Values are: 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14. The MCO is expected to use this segment to identify for MAD how the claim line was priced. Use value 00 to indicate line(s) not priced because service has been reimbursed through other means. Vaccines are the best example of this. They are a service rendered but may have been paid through DOH vaccines program. MCO Paid Amt will be expected to be zero on the line, but the line is not considered to be denied. Use value 04 to indicate line(s) not priced individually but included in bundled payment amount shown on another line. MCO Allowed Amt will be expected to be zero on the line, but the line is not considered to be denied. Use value 10 if MCO Allowed Amount reflects an FFS equivalent. MCO and subcontractor have not paid this amount as the service is capitated and only a PMPM has been paid for the services reflected in the claim. MCO Allowed Amount must not be 0.
2300	HCP	02		The MCO Paid Amount is required at the header for inpatient and at the line for outpatient claims (everything not defined as inpatient). If the claim is an inpatient claim, the MCO must enter a monetary amount > 0 if the value in HCP01 is anything other than 00- Zero pricing (Not Covered Under Contract) or 04 (Bundled Pricing). This amount should be the total amount paid on the claim, less any COB.
2310 A	NM1	Attending Provider Name		
2310A	NM1	08 and 09		An encounter that contains an NPI that does not pass check digit validation WILL REJECT
2310A	PRV	Attending Provider Name		
2310A	PRV	03		NM requires Taxonomy Code in this field and the taxonomy must match the allowed taxonomy for that provider type/specialty as necessary for

Loop	Segment	Data Element		Description
				adjudication of the claim when NPI is used for rendering provider (i.e., Provider has one NPI number but has more than one provider type under which they submit claims using that NPI number). Please use the Provider Taxonomy to Provider Type/Specialty table available on the MAD website New Mexico Medicaid Portal.
2310 D	NM1	Rendering Provider Name		
2310 D	NM1	08 and 09		NPI of the Rendering provider if different from Attending.
2310F	NM1	Referring Provider Name		
2310F	NM1	08 and 09		An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
2320	SBR			This loop is used to provide information about the MCO's processing of the claim and to Provide Third Party Liability (TPL) and Medicare Crossover information. Make one repeat of the loop for MCO-related information (where SBR 06 = 6) and related one repeat for each non-Medicaid payer (where SBR 06 = 1).
2320	SBR	01		When the member has third party coverage and the MCO is reporting their own claim results (SBR06 =6), the value here should be S; otherwise, the value will be P. When this loop contains third party payer information (SBR06 = 1), the third party will be reported as P.
2320	SBR	03		Enter “SC” code when SBR06=’6’ in loop 2320 for the PACDR claim that does not have corresponding 837 claim. Example: Paper claims, subcontractor claims, COBA Claims etc.,
2320	SBR	06		Values: 1 = COB claim submitted by the Provider 6 = Information related to the MCO's payment of the claim.

Loop	Segment	Data Element		Description
2320	SBR	09		SBR06 = 6, use MC (Medicaid) as the Claim Filing Indicator Code. SBR06 = 1, Use 'MB' for Medicare Part B, 'MA' for Medicare Part A or CI for Commercial Insurance.
2320	CAS	Claim Level Adjustments		MCOs must report all claim level adjustments made by any third-party payer as well as claim level adjustments made by the MCO as payer.
2320	AMT	Coordination Of Benefits (COB) Payer Paid Amount		
2320	AMT	01		D= Amount Qualifier code
2320	AMT	02		When 2320 SBR06 = 6, this field contains the total amount paid on the claim by the MCO or subcontractor less any header level adjustments; including the patient liability for a nursing facility claim reported in 2300 AMT02. When 2320 SBR06 = 1, this field contains the amount paid by the third-party payer.
2330B	NM1	09		Required MCO payer id when loop 2320 SBR06=6 and other payer id when loop 2320 SBR06=1This loop provides information about the payers identified in the 2320 loop. Must match Loop 2430 SVD01 if line information for this payer has been sent.
2330B	DTP	01		Date claim was paid by MCO DTP 01=573.
2330B	REF – Other Payer Claim Adjustment Indicator	01 and 02		T4 and Y- Required for adjustment or void claim.
2330B	REF Other Payer Claim Control Number	01		F8
2330B	REF Other Payer Claim Control Number	02		For an original claim, the MCO reports their MCO_TCN here. For an adjustment/void, The MCO must

Loop	Segment	Data Element		Description
				report their NEW unique claim identifier generated when the adjustment or void is processed.
2330B	REF – Other Payer Adjusted Claim Control Number	01		BP
2330B	REF – Other Payer Adjusted Claim Control Number	02		**If this is an adjustment claim submitted by the provider**, enter the CMdS Assigned claim number (TCN) of the original claim. **If it is the adjustment submitted by provider, enter** CMdS TCN of original claim number that was sent to the MCO. **For consecutive MCO adjustment**, enter the MCO original claim (MCO_TCN) number from the previous MCO-adjusted claim.
2400	LX	01		Service Line Number
2400	SV2	05		NM Medicaid will not accept unit values with more than two places after decimal. E.g., 1.25 is acceptable, 1.253 is not.
2400	HCP	Line-Item Pricing/Repricing Information		MCO Allowed amount at the line level.
2400	HCP	01		The Pricing Methodology is required. The MCO is expected to use this segment to identify for MAD how the claim line was priced. Use value 00 to indicate line(s) that are denied or not priced because service has been reimbursed through other means. Vaccines are the best example of this. They are a service rendered but may have been paid through DOH vaccines program. MCO Paid Amt will be expected to be zero on the line, but the line is not considered to be denied. Use value 04 to indicate line(s) not priced individually but included in bundled payment amount shown on another line. MCO Allowed Amt will be

Loop	Segment	Data Element		Description
				expected to be zero on the line, but the line is not considered to be denied. Use value 10 if MCO Allowed Amount reflects an FFS equivalent. MCO and subcontractor have not paid this amount as the service is capitated and only a PMPM has been paid for the services reflected on the claim. MCO Allowed Amount must not be 0.
2400	HCP	02		The MCO must enter a monetary amount > 0 if the value in HCP01 is anything other than 00-Zero pricing or 04-Bundled Pricing. The amount recorded must be the amount minus any patient liability, or copay, or CAS paid on that line.
2400	HCP	04		Use HCP04 segment to mention the line level status and allowed amount. Enter the contract type code followed by comma and the allowed amount for the line. Use another comma as the separator and specify the service line status (P-Paid, D-Denied) ~~R-Partially Paid (1 or more lines denied)).~~ EX: HCP*01*100**02,100, P~
2400	HCP	06		If the MCO has paid using DRG, enter the DRG code used in pricing
2420C	NM1	08-09		Rendering Provider is required if different from Billing Provider or if Billing Provider is a group practice.
2430	SVD	Line Adjudication Information		
2430	SVD	01		Required for any Payers identified in Loop 2320, must match the value in Loop 2330B, NM109.
2430	SVD	02		Report the amount paid on the line minus any patient liability or copay or CAS paid on that line.
2430	CAS			The MCO is required to report any claim line adjustment they post to the claim line as well as any third-party payments received on the claim.

Loop	Segment	Data Element		Description
2430	CAS	02 & 03		MCOs must submit all line level adjustment reasons codes (CARCs) that post to claims in the MCOs claims adjudication system in this segment. If MCOs post proprietary EOBs, these must be cross walked to the best HIPAA Compliant CARC available and submit it in the encounter data in this segment. For every Medicare claim there MUST be at least 1 of the following CAS segments and in many cases 2 CAS segments: CAS02=1 (Medicare Deductible) and CAS05=2 (Medicare Coinsurance). Another frequent CAS segment used is CAS05= 122, Medicare psych amount. ANY CAS SEGMENT REPORTED MUST HAVE AN ASSOCIATED CAS AMOUNT. The MCO will continue to report the total allowed amount on 2300 CN1 segment.
2430	DTP	Line Check or Remittance Date		
2430	DTP	01		Date claim was paid by MCO DTP 01=573.
2430	DTP	02		D8
2430	DTP	03		Date expressed in Format CCYYMMDD.

11. Appendices

11.1. Implementation Checklist

Conduent EDI offers a high-level onboarding checklist on request.

11.2. Business Scenarios

Please contact the NM HIPAA Helpdesk to discuss your specific business needs.

11.3. PACDR Adjustments/Voids Submitted After Go Live

The image below presents the various 837 scenarios along with their corresponding PACDR's and provides guidance on the specific segments where the CMdS TCN and MCO TCN should be reported in the PACDR claims.

837 Location	837 Description	837 Value	PACDR Location	PACDR Description	PACDR value
Scenario	***837 Original Submitted by Provider***				
2300 REF*D9	CMdS TCN	22030IGC0000005	2300 REF*D9	CMdS Tracking ID	22030IGC0000005
			2330B REF*F8	MCO assigned claim ID	MCO12345
Scenario:	***837 Adjustment /Void Submitted by Provider***				
2300 REF*D9	CMdS TCN for adjustment/void	22030IGC0000022	2300 REF*D9	CMdS TCN for adjustment/Void	22030IGC0000022
2300 REF*F8	MCO assigned claim ID to adjust/void	MCO12345	2330B REF*F8	MCO assigned claim ID for adjusted claim	MCO56789
			2330B REF*BP	CMdS TCN ID for claim being adjusted	22030IGC0000005
Scenario:	***Subsequent 837 Adjustment/Void submitted by Provider***				
2300 REF*D9	CMdS TCN for adjustment/void	22030IGC0000033	2300 REF*D9	CMdS TCN for adjustment/Void	22030IGC0000033
2300 REF*F8	MCO assigned claim ID to adjust/void	MCO56789	2330B REF*F8	MCO assigned claim ID for adjusted claim	MCO98989
			2330B REF*BP	CMdS TCN ID for claim being adjusted	22030IGC0000022
Scenario:	***Subsequent 837 Adjustment/Void initiated by MCO***				
N/A	*N/A*	*N/A*	2300 REF*D9	MCO assigned cliam ID for adjusted claim	MCO98765
N/A	*N/A*	*N/A*	2330B REF*F8	MCO assigned claim ID for adjusted claim	MCO98765
			2330B REF*BP	CMdS TCN for claim being adjusted	22030IGC0000033
Scenario:	***Subsequent 837 Adjustment/Void initiated by Provider***				
2300 REF*D9	CMdS TCN for adjustment/void	22030IGC0000044	2300 REF*D9	CMdS TCN for adjustment/Void	22030IGC0000044
2300 REF*F8	MCO assigned claims ID to adjust/void	MCO98765	2330B REF*F8	MCO assigned claim ID for adjusted claim	MCO23212
			2330B REF*BP	Value submitted in the REF*D9 of the previous adjustment	MCO98765
Scenario:	***Subsequent 837 Adjustment/Void initiated by MCO***				
N/A	***N/A***	***N/A***	2300 REF*D9	MCO assigned claim ID for adjusted claim	MC000445
N/A	***N/A***	***N/A***	2330B REF*F8	MCO assigned claim ID for adjusted claim	MC000445
			2330B REF*BP	CMdS TCN ID for claim being adjusted	22030IGC0000044
Scenario:	***Subsequent 837 Adjustment/Void initiated by MCO***				
N/A	***N/A***	***N/A***	2300 REF*D9	MCO assigned claim ID for adjusted claim	MC001237
N/A	***N/A***	***N/A***	2330B REF*F8	MCO assigned claim ID for adjusted claim	MC001237
			2330B REF*BP	Value submitted in the REF*D9 of the previous adjustment	MC000445

Figure 4: PACDR Adjustments/Voids Submitted After Go Live

11.4. PACDR Adjustments/Voids Submitted for Subcontractors

837 Location	837 Description	837 Value	PACDR Location	PACDR Description	PACDR Value
Scenario:	837 PACDR Encounter Submitted by MCO				
N/A	N/A	N/A	2300 REF*D9	MCO assigned claim ID for original claim	MCO22233
			2330B REF*F8	MCO assigned claim ID for original claim	MCO22233
Scenario:	Subsequent Adjustment initiated by MCO				
N/A	N/A	N/A	2300 REF*D9	MCO assigned claim ID for adjusted claim	MCO33344
N/A	N/A	N/A	2330B REF*F8	MCO assigned claim ID for adjusted claim	MCO33344
			2330B*REF*BP	Value submitted in the REF*D9 of the original enocunter	MCO22233

Figure 5: PACDR Adjustments/Voids Submitted for Subcontractors

11.5. Matching Logic for PACDR and Corresponding Inbound 837 Claim

The system will compare the following fields for the Non-Subcontractor PACDR transaction with the corresponding inbound MCO 837 claim that was submitted to CMdS.

- Billing Provider (Loop 2010AA NM109)
- Member Last Name (loop 2010BA NM103)
- Member Date of Birth (loop 2010BA DMG segment)
- CMdS TCN (loop 2300 REF*D9)
- Date of service - line level (loop 2400 DTP*472) for Professional (dental only if not a Subcontractor)
- Patient Account number (loop 2300 CLM01)
- Date of service (loop 2300 DTP*434) for institutional only
- Number of claim service lines
- Claim Frequency Code (loop 2300 CLM05-03).

If any of the above matching fails, PACDR claims will not be adjudicated and will be rejected in the 277DRA response.

This matching logic will be applicable for subcontractor PACDR claims and split claims.

11.6. Split Claim Scenario

The image below presents the split claim scenarios for 837 along with their corresponding PACDR's and provides guidance on the specific segments where the CMdS TCN and MCO TCN should be reported in the PACDR claims.

837 Location	837 Description	837 value	PACDR Location	PACDR Description	PACDR value
Scenario 1:	***837 Original claim submitted by Provider***				
2300 REF*D9	CMdS TCN	25290450000000100	N/A	N/A	N/A
	MCO split the original claim into two claims				
N/A	N/A		2300 REF*D9	CMdS TCN number	25290450000000100
N/A	N/A		2320 SBR03	Include the hardcode value for the split claim	SS
			2330B REF*F8	MCO assigned claim ID	MCO112245
			***CMdS will deny the claim 25290450000000100 and create a claim with new TCN generated.		
N/A	N/A		2300 REF*D9	CMdS TCN number	25290450000000100
N/A	N/A		2320 SBR03	Include the hardcode value for the split claim	SS
			2330B REF*F8	MCO assigned claim ID	MCO112255
			***CMdS will deny the claim 25290450000000100 and create a claim with new TCN generated.		
Scenario 2:	***MCO submitted internal adjustment to split claim 1***				
N/A	N/A		2300 REF*D9	MCO assigned claim ID for the adjusted claim	MCO456788
N/A	N/A		2330B REF*F8	MCO assigned claim ID for the adjusted claim	MCO456788
			2330B REF*BP	MCO TCN number for the split claim being adjusted	MCO112245
			2320 SBR03	Include the hardcode value for the split claim	SS
Scenario 3:	***Adjustment submitted by Provider for split claim 2***				
2300 REF*D9	CMdS TCN for split claim 2 adjustment	25290450000000200	2300 REF*D9	CMdS TCN for the adjustment	25290450000000200
2300 REF*F8	Claim ID assigned by MCO for the original claim	MCO112255	2330B REF*F8	MCO assigned claim ID for the adjusted claim	MCO776687
			2330B REF*BP	MCO TCN number for the split claim(split claim 2) being adjusted	MCO112255
			2320 SBR03	Include the hardcode value for the split claim	SS

Figure 6: Claim Split Scenario

The below image represents the 837 and its corresponding for BCBS split claim scenario for provider-initiated adjustment claims.

837 Location	837 Description	837 value	PACDR Location	PACDR Description	PACDR value
BCBS Scenario 4 Example					
	MCO split the original claim into two claims				
N/A	N/A		2300 REF*D9	CMdS TCN number	25290450000000100
N/A	N/A		2320 SBR03	Include the hardcode value for the split claim	SS
			2330B REF*F8	MCO assigned claim ID	020242XXXXA61960X-00
			***CMdS will deny the claim 25290450000000100 and create a claim with new TCN (25290450000000200) generated.		
N/A	N/A		2300 REF*D9	CMdS TCN number	25290450000000100
N/A	N/A		2320 SBR03	Include the hardcode value for the split claim	SS
			2330B REF*F8	MCO assigned claim ID	020242XXXXA61961X-00
			***CMdS will deny the claim 25290450000000100 and create a claim with new TCN (25290450000000300) generated.		
Scenario 4:	***Adjustment submitted by Provider for the original claim***				
2300 REF*D9	CMdS TCN for claim adjustment	25290450000000400	2300 REF*D9	CMdS TCN for the adjustment	25290450000000400
2300 REF*F8	Claim ID assigned by MCO for the original claim	020242XXXXA6196	2330B REF*F8	MCO assigned claim ID for the adjusted claim	020242XXXXA61960X-01
		Original DCN	2330B REF*BP	MCO TCN number of the identified split claim service line being adjusted(e.g., Split claim 2)	020242XXXXA61960X-00
			2320 SBR03	Include the hardcode value for the split claim	SS
			2300 REF*D9	CMdS TCN for the adjustment	25290450000000400
			2330B REF*F8	MCO assigned claim ID for the adjusted claim	020242XXXXA61961X-01
			2330B REF*BP	MCO TCN number of the identified split claim service line being adjusted(e.g., Split claim 2)	020242XXXXA61961X-00
			2320 SBR03	Include the hardcode value for the split claim	SS

Figure 7: BCBS split claim scenario for provider-initiated adjustment claims

The below image represents the claim line split scenario.

837 Location	837 Description	837 value	PACDR Location	PACDR Description	PACDR value
Scenario 1:	***837 Original claim submitted by Provider***				
2300 REF*D9	CMdS TCN	25290450000000100	N/A	N/A	N/A
	MCO split the original claim to have a different number of lines				
N/A	N/A		2300 REF*D9	CMdS TCN number	25290450000000100
N/A	N/A		2320 SBR03	Include the hardcode value for the split claim	SS
			2330B REF*F8	MCO assigned claim ID	MCO112245
			***CMdS will deny the claim 25290450000000100 and create a claim with new TCN generated.		
Scenario 2:	***MCO submitted internal adjustment to line split claim***				
N/A	N/A		2300 REF*D9	MCO assigned claim ID for the adjusted claim	MCO456788
N/A	N/A		2330B REF*F8	MCO assigned claim ID for the adjusted claim	MCO456788
			2330B REF*BP	MCO TCN number for the split claim being adjusted	MCO112245
			2320 SBR03	Include the hardcode value for the split claim	SS
Scenario 3:	***Adjustment submitted by Provider for line split claim***				
2300 REF*D9	CMdS TCN for split line claim adjustment	25290450000000200	2300 REF*D9	CMdS TCN for the adjustment	25290450000000200
2300 REF*F8	Claim ID assigned by MCO for the original claim	MCO112245	2330B REF*F8	MCO assigned claim ID for the adjusted claim	MCO776687
			2330B REF*BP	MCO TCN number for the split claim being adjusted	MCO112245
			2320 SBR03	Include the hardcode value for the split claim	SS

Figure 8: Claim line split scenario

11.7. Transmission Examples

Please contact the NM HIPAA Helpdesk for transmission examples beyond the samples already provided in this guide.

11.8. Frequently Asked Questions

NM HCA FAQs are available here https://www.hca.nm.gov/providers/hipaa-standard-companion-guides/. Also, your Conduent EDI Business Analyst(s) have EDI and X12 expertise to field all related inquiries. Please direct your questions to NM HIPAA Helpdesk.