TEXAS MEDICAID

HIPAA TRANSACTION STANDARD COMPANION GUIDE

Refers to the Implementation Guide Long Term Care 837 Health Care Claim: Institutional

Based on ASC X12 version 005010
CORE v5010 Companion Guide

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TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

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Preface

This Companion Guide to the v5010 ASC X12N Implementation Guide and associated errata adopted under Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging electronically with Texas Medicaid. Transmissions based on this Companion Guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12N 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.

1 INTRODUCTION

Scope

Under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Secretary of the Department of Health and Human Services (HHS) is directed to adopt standards to support the electronic exchange of administrative and financial health care transactions. The purpose of the Administrative Simplification portion of HIPAA is to enable health information to be exchanged electronically and to adopt standards for those transactions.

Texas Medicaid defines a Trading Partner as any entity trading data with Texas Medicaid EDI. Trading partners include vendors, clearinghouses, Providers and billing agents.

The 5010 Technical Report Type 3 (TR3) dated May 2006 was used to create this Companion Guide for the 837 file format. All instructions in this document are written using information known at the time of publication and are subject to change.

Overview

This guide is intended as a resource to assist submitters in successfully conducting EDI 837 Health Care Claims: Institutional transactions with Texas Medicaid. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

The purpose of this document is to assist the provider with Texas Medicaid-particular data sets for information specified in the National Electronic Data Interchange Transaction Set Implementation Guide for the file type. The federal government has set standards to simplify Electronic Data Interchange (EDI). To comply with the standard, Texas Medicaid has updated the data sets for EDI files to be in accordance with HIPAA and is utilizing the ASC X12 nomenclature.

The instructions in this companion guide are not intended to be stand-alone requirements documents and must be used in conjunction with the associated ANSI ASC X12N National Implementation Guide. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

References

The ANSI ASC X12N Implementation Guides are available for purchase at the Washington Publishing Company web site at https://x12.org/products/technical-reports

The Texas Medicaid EDI Connectivity Guide which contains instructions regarding connectivity options including CORE compliant Safe Harbor information can be found on the EDI page of the Texas Medicaid website at https://www.tmhp.com/topics/edi

The Companion Guides, published by Texas Medicaid can be found at https://www.tmhp.com/topics/edi

Additional Information

Security and Privacy Statement

Covered entities were required to implement HIPAA Privacy Regulations no later than April 14, 2003. A covered entity is defined as a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction. Providers that conduct certain electronic transmissions are responsible for ensuring these privacy regulations are implemented in their business practices. Health and Human Services Commission (HHSC) is a HIPAA Covered Entity. Accordingly, Texas Medicaid is operating as a HIPAA Business Associate of HHSC as defined by the federally mandated rules of HIPAA. A Business Associate is defined as a person or organization that performs a function or activity on behalf of a covered entity but is not part of the covered entity's workforce.

The privacy regulation has three major purposes:

1. To protect and enhance the rights of consumers by providing them access to their health information and controlling the appropriate use of that information;
2. To improve the quality of health care in the United States by restoring trust in the health care system among consumers, health care professionals and the many organizations and individuals committed to the delivery of health care; and
3. To improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy and protection.

2 GETTING STARTED

Working with Texas Medicaid

This section describes how to interact with Texas Medicaid's Electronic Data Interchange (EDI) systems.

EDI Help Desk is available to assist trading partners in exchanging data with Texas Medicaid. Below are details on how to register and contact the department for assistance.

Trading Partner Registration

HHSC requires any entity exchanging electronic data with Texas Medicaid to be enrolled in the Texas Medicaid Program and approved for the submission of X12 transaction sets.

Texas Medicaid Enrollment Forms and instructions are available at:

https://www.tmhp.com/topics/provider-enrollment

Successful enrollment in Texas Medicaid is required before proceeding with EDI.

To get started with EDI transactions, the necessary forms and instructions are available at:

https://www.tmhp.com/resources/forms?field_topics_target_id=96

3 TESTING WITH TEXAS MEDICAID

Testing and Certification instructions, along with setup information can be found in Section 9.1 of the Texas Medicaid

EDI Connectivity Guide found at:

https://www.tmhp.com/sites/default/files/file-library/edi/TMHP_EDI_Connectivity_Guide.pdf

4 CONNECTIVITY WITH THE TEXAS MEDICAID COMMUNICATIONS

Transmission Administrative Procedures

The Texas Medicaid EDI Connectivity Guide that contains specific instructions regarding connectivity options, can be found on the EDI page of the Texas Medicaid website at:

https://www.tmhp.com/sites/default/files/file-library/edi/TMHP_EDI_Connectivity_Guide.pdf

Communication protocol specifications

The Texas Medicaid EDI Connectivity Guide that contains specific instructions regarding connectivity options, along with CORE compliant Safe Harbor information, can be found on the EDI page of the Texas Medicaid website at:

https://www.tmhp.com/sites/default/files/file-library/edi/TMHP_EDI_Connectivity_Guide.pdf

Passwords

Texas Medicaid provides instruction on resetting of passwords in section 5.1 of the Texas Medicaid EDI Connectivity Guide found at:

https://www.tmhp.com/sites/default/files/file-library/edi/TMHP_EDI_Connectivity_Guide.pdf

5 CONTACT INFORMATION

Customer Service

Texas Medicaid EDI Help Desk

The EDI Help Desk provides technical assistance only by troubleshooting Texas Medicaid EDI issues. Contact your system administrator for assistance with network, hardware, or telephone line issues.

To reach the Texas Medicaid EDI Help Desk, select one of the following methods:

- Fax 1-512-514-4230 or 1-512-514-4228
- Call 1-888-863-3638, option 3 (or call 1-512-514-4150, option 3)

The Texas Medicaid EDI Help Desk is available Monday through Friday, 7 a.m. to 7 p.m. CST.

Applicable websites/e-mail

This section contains detailed information about useful web sites and email addresses.

Texas Medicaid EDI Technical Information, such as code references, vendor file specifications, and additional Companion Guides can be found at:

https://www.tmhp.com/topics/edi

The Texas Medicaid Provider Procedures Manual is found at:

https://www.tmhp.com/resources/provider-manuals

EDI Helpful Links:

Washington Publishing Company – The Washington Publishing Company site includes reference documents pertaining to HIPAA, such as: implementation guides, data conditions, and the data dictionary for X12N standards.

Workgroup for Electronic Data Interchange (WEDI) – This site provides implementation materials and information.

National Uniform Billing Committee (NUBC) – This site is the official source of UB-04 billing information.

Texas Department of State Health Services (DSHS)

Texas Health and Human Services Commission

6 CONTROL SEGMENTS/ENVELOPES

ISA-IEA

- Texas Medicaid does not support repetition of a simple data element or a composite data structure.
- Texas Medicaid will accept one ISA/IEA in each file and one GS/GE per ISA.
- Texas Medicaid uses "*" (asterisk) as the element separator, and "~" (tilde) as the segment separator.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
Control Segments						
C.3		ISA	Interchange Control Header			
C.4		ISA01	Authorization Information Qualifier	00		
C.4		ISA03	Security Information Qualifier	00		
C.4		ISA05	Interchange ID Qualifier	ZZ		
C.5		ISA06	Interchange Sender ID			Provider Submitter ID
C.5		ISA07	Interchange ID Qualifier	ZZ		
C.5		ISA08	Interchange Receiver ID			Production = 617591011CMSP Testing = 617591011CMST
C.5		ISA11	Repetition Separator	| (pipe character)		
C.6		ISA14	Acknowledgement Requested	0 (zero)		
C.6		ISA15	Interchange Usage Indicator	P		ISA15="P" for both Production and Test
C.6		ISA16	Component Element Separator	: (colon character)		

GS-GE

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
Control Segments						
C.7		GS	Functional Group Header			
C.7		GS02	Application Sender's Code			Provider Submitter ID
C.7		GS03	Application Receiver's Code	617591011CMSP		This is Texas Medicaid's Electronic Transmitter Group Identifier.

7 TEXAS MEDICAID SPECIFIC BUSINESS RULES AND LIMITATIONS

Texas Medicaid will accept up to 5000 transactions per batch. If a file is submitted with more than 5000 transactions the entire file will be rejected and not processed by Texas Medicaid.

X12 files with more than one GS-GE Functional Group will fail to process in the Texas Medicaid system.

The Texas Medicaid Provider Procedures Manual is the providers' principal source of information about Texas Medicaid. The most recent version is found at:

https://www.tmhp.com/resources/provider-manuals

NTE02 Claim Note Description Definition

OI Attestation
Position 1 of NTE02, when NTE01 = 'ADD'.

Submit 'Y' in Position 1 of NTE02 if OI Attestation is YES. Submit 'N' in Position 1 of NTE02 if OI Attestation is (blank).

Medicare Attestation
Position 2 of NTE02, when NTE01 = 'ADD'. Submit 'Y' in Position 2 of NTE02 if Medicare Attestation is YES. Submit 'N' in Position 2 of NTE02 if Medicare Attestation is (blank).

Medicare Part A Amount
Positions 3-10 of NTE02, when NTE01 = 'ADD'. Include decimal places in amount. Fill spaces that remain for fields that share a single segment.

Medicare Part C Amount
Positions 11-18 of NTE02, when NTE01 = 'ADD'. Include decimal places in amount. Fill spaces that remain for fields that share a single segment.

Other Insurance Disposition
Positions 1-2 of NTE02, when NTE01 = 'UPI'. Fill spaces that remain for fields that share a single segment. Submit one of the following codes:

P -Paid

D - Denied

NI - No response (initial bill for services)

NS - No response (subsequent bill for services

Other Insurance Disposition Reason
Positions 3-5 of NTE02, when NTE01 = 'UPI'. Fill spaces that remain for fields that share a single segment. Submit one of the following codes:

P1 - Paid in Full

P2 - Partial Payment

P3- Benefit applied to client's deductible (other Insurance paid zero)

D1 - Not a covered service

D2 - Policy limit has been met

D3 - DOS outside of policy dates

D4 - Policy does not cover custodial care

D5 - Policy does not cover out of network provider/services

D6 - Duplicate claim

D7 - More information required

D8 - Claim submitted after insurance company filing deadline

D9 - Precertification required

D10 - Client not covered

D11 - No hospital stay submitted

D12 - Invalid policy

D13 - Policy not LTC-relevant

D14 - Policy information not accurate

D15 - Benefits paid and forwarded to the insured member

D16 - Medicare has paid all eligible benefits for these services

Other Insurance Paid Amount
Positions 6-15 of NTE02, when NTE01 = 'UPI'. Fill spaces that remain for fields that share a single segment.

Other Insurance Billed Date
Positions 16-23 of NTE02, when NTE01 = 'UPI'. Exactly 8 numeric characters in YYYYMMDD format. Submit when Positions 1-2 of NTE02 (Claim Note) = P, D, NI, or NS. Fill spaces that remain for fields that share a single segment.

8 ACKNOWLEDGEMENTS AND/OR REPORTS

Texas Medicaid provides HIPAA responses and acknowledgements that should be utilized by the Trading Partner for reconciliation purposes. Texas Medicaid does not provide proprietary reports as a standard part of the claims data process. Trading Partners should utilize the HIPAA responses provided for each transmission to reconcile claims.

The following responses will be received by the Trading Partner:

TA1 Transaction	Interchange Acknowledgement The TA1 will be sent if the submitter ID is not known or if the file received is structurally incorrect.
BID Document	Batch ID Report The BID file is sent as acknowledgement of file reception. This is not an indicator that the file was accepted; only received. This zero-byte file will provide the Texas Medicaid assigned batch ID within the file name. *This response will not be returned for files exchanged over the CORE Operating Rule "Safe Harbor" connection method.
999 Transaction	Implementation Acknowledgement This file provides high level transaction set response details for the 837 received. It does not contain transaction (claim) level responses.
277CA	Health Care Claim Acknowledgement The 277CA includes claim level acknowledgements including acceptance/rejection information. This file will not be sent if a negative 999 (rejection) or TA1 file has been returned.

9 TRADING PARTNER AGREEMENTS

This section contains general information concerning Trading Partner Agreements (TPA).

Trading Partners

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

Submitters have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

For example, a Trading Partner Agreement may specify, among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

Texas Medicaid Trading Partner Agreement will be found on this web page:

https://www.tmhp.com/resources/forms?field_topics_target_id=96

10 TRANSACTION SPECIFIC INFORMATION

This section uses a table to describe how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed. The tables contain a row for each segment where Texas Medicaid has something additional, over and above the information in the IGs. That information can:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the IGs internal code listings.
4. Clarify the use of loops, segments, composite and simple data elements.
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Texas Medicaid.

In addition to the row for each segment, one or more additional rows are used to describe Texas Medicaid's usage for composite and simple data elements and for any other information.

This section is used to describe the required data values that will be used by Texas Medicaid for those who submit a dental claim.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
76	1000B	NM1	Receiver Name			
77	1000B	NM103	Receiver Name	TMHP		
77	1000B	NM109	Receiver Primary Identifier	617591011CMSP		
80	2000A	PRV	Billing Provider Specialty Information			
80	2000A	PRV03	Provider Taxonomy Code			The Taxonomy code must be the Taxonomy code on file with Texas Medicaid. 837I submitters for Nursing Facilities must submit one of the following taxonomies in Loop 2000A PRV03 segment: 314000000X 313M00000X
84	2000AA	N1	Billing Provider Name			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
86	2010AA	NM109	Billing Provider Identification Code			NPI must be submitted unless the provider has an API (ATYPICAL PROVIDER IDENTIFIER) assigned which will be reported in Loop 2010BB.
91	2010AA	N3	Billing Provider Address			
91	2010AA	N301	Billing Provider Address Line			The Billing Provider address must be the address on file with Texas Medicaid.
92	2010AA	N4	Billing Provider City, State Zip Code			
92	2010AA	N401	Billing Provider City Name			The Billing Provider city name must be the city name on file with Texas Medicaid.
93	2010AA	N403	Billing Provider Postal Zone or ZIP Code			The Billing Provider ZIP Code (9 digits) name must be the ZIP Code on file with Texas Medicaid.
94	2010AA	REF	Billing Provider Tax Identification			
94	2010AA	REF02	Billing Provider Tax Identification Number			The submitted code must match what is on file with Texas Medicaid.
109	2000B	SBR	Subscriber Information			
111	2000B	SBR09	Claim Filing Indicator Code	VA		If trying to bill a billing code that begins with V0, then the submitter should use code VA in this segment.
112	2010BA	NM1	Subscriber Name			
114	2010BA	NM108	Identification Code Qualifier	MI		
122	2010BB	NM1	Payer Name			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
123	2010BB	NM103	Payer Name	TDHS/TDMHMR		
123	2010BB	NM108	Payer Name	PI		
123	2010BB	NM109	Payer Identifier	617591011CMSP		
129	2010BB	REF	Billing Provider Secondary Identification			
129	2010BB	REF01	Identification Code Qualifier	G2		If the provider has an API instead of an NPI, the API must be sent in the REF02.
143	2300	CLM	Claim Information			
145	2300	CLM05-03	Claim Frequency Code	1, 2, 3, 4		
153	2300	CL1	Institutional Claim Code			
153	2300	CL101	Admission Type Code	1		Texas Medicaid recommends the submitter use 1.
153	2300	CL103	Patient Status Code			When a member has been discharged, a value of “30 – Still A Patient” in Patient Discharge Status should be avoided unless there is a specific business case for its use.
154	2300	PWK	Claim Supplemental Information			
157	2300	PWK06	Attachment Control Number			PWK06, when PWK01 = 'EB', PWK02 = 'FT', PWK05 = 'AC'. This is a mandatory field if conveying Other Payer information in the 2320 loop. The amount of Other Insurance segments conveyed in the 2320 loop(s) must match the number of PWK segments submitted in the 2300 loop.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						If the Company Phone Number is not present, fill PWK06 with exactly 10 zeros.
163	2300	REF	Referral Number			
163	2300	REF02	Referral Number		8 Numeric	REF02 must contain a valid referral number and is recommended by Texas Medicaid. The referral number is needed to crosswalk to the provider's contract number for claim processing.
173	2300	REF	Medical Record Number			
173	2300	REF02	Medical Record Number		30 AN	Trace Sequence Number
176	2300	K3	File Information			
177	2300	K301	Fixed Format Information			Positions 1-8 of K301 if Subscriber DOB is present. If the Subscriber DOB is not present, fill K301 with spaces. This is a mandatory field if conveying Other Payer information in the 2320 loop. The amount of Other Insurance segments conveyed in the 2320 loop(s) must match the number of K3 segments submitted in the 2300 loop.
178	2300	NTE	Claim Note			
179	2300	NTE02	Claim Note		1-5 AN	To Submit Billing Provider Service Group NTE01 = 'ADD' NTE02 - Positions 24-28 Enter the appropriate

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Service Group for Billing Provider Code (left justified). Refer to Long Term Care Reference Codes under the LTC and Acute Care Reference Codes dropdown on the TMHP.com website: https://www.tmhp.com/topics/edi
179	2300	NTE02	Claim Note		1-5 AN	When Submitting the Residence Service Group NTE01 = 'ADD' NTE02 Positions 24-28 [5] spaces Positions 29-33 [5] enter the appropriate alpha/numeric Residence Service Group (left justified). Refer to Long Term Care Reference Codes under the LTC and Acute Care Reference Codes dropdown on the TMHP.com website: https://www.tmhp.com/topics/edi
179	2300	NTE02	Claim Note Text			See payer specific rules regarding NTE01 = UPI denoting Other Insurance.
180	2300	NTE	Billing Note			
180	2300	NTE02	Billing Note Text			See Appendix when NTE01 = ADD denoting Other Insurance.
220	2300	HI	Other Diagnosis Information			Texas Medicaid will only capture the first 4 diagnosis codes.
319	2310A	NM1	Attending Provider Name			
320	2310A	NM104	Attending Provider First Name			Mandatory for Texas Medicaid claims processing.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
321	2310A	NM109	Attending Provider Primary Identifier			NPI must be submitted unless the provider has an API assigned, which will be reported in Loop 2310A Attending Provider Secondary Identification. Either the NPI or API are required for claims processing and must not be the same as the billing provider information.
324	2310A	REF	Attending Provider Secondary Identification			
324	2310A	REF01	Reference Identification Qualifier	G2		If the provider has an API instead of an NPI, the API must be sent in the REF02.
336	2310D	NM1	Rendering Provider Name			If the Rendering Provider is the same as the Attending Provider, the Rendering Provider loop is not sent. The loop is required if the Rendering Provider is different from the Attending Provider and there is only one Rendering Provider for the claim.
337	2310D	NM104	Rendering Provider First Name			Mandatory for Texas Medicaid claims processing.
338	2310D	NM109	Rendering Provider Primary Identifier			NPI must be submitted unless the provider has an API assigned which will be reported in Loop 2310D Rendering Provider Secondary Identification. Either the NPI or API are required for claims processing.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
339	2310D	REF	Rendering Provider Secondary Identification			
339	2310D	REF01	Reference Identification Qualifier	G2		If the provider has an API instead of an NPI, the API must be sent in the REF02.
356	2320	SBR	Other Subscriber Information			
356	2320	SBR04	Other Insured Group Name			Required when SBR01 = U
356	2320	SBR09	Claim Filing Indicator			Required when SBR01 = U
383	2330A	REF	Other Subscriber Secondary Identification			Required if Loop 2320 is sent
384	2330B	NM1	Other Payer Name			
385	2330B	NM103	Other Payer Last or Organization Name			Positions 1-40, Other Payer Name-space fill to 40 characters. Positions 41-48, Policy Effective Date-in YYYYMMDD format. Positions 49-56, Policy Termination Date-in YYYYMMDD format, space fill to 56 characters if Termination Date is not available.
385	2330B	NM108	Identification Code Qualifier	PI		
385	2330B	NM109	Other Payer Primary Identifier			If the Insurance Company Number is not present or unknown, fill NM109 with 8

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						zeros.
389	2330B	DTP	Claim Check or Remittance Date			
389	2330B	DTP03	Adjudication or Payment Date			Submit when Positions 1-2 of NTE02 (Claim Note) = P, D
395	2330B	REF	Other Payer Claim Control Number			
395	2330B	REF02	Other Payer's Claim Control Number		20	Submit when Positions 1-2 of NTE02 (Claim Note) = P, D
423	2400	LX	Service Line Number			Texas Medicaid will accept up to 28 Service Lines per claim.
424	2400	SV2	Institutional Service Line			
424	2400	SV201	Service Line Revenue Code			0001 is not a valid value for Texas Medicaid. Any claims submitted with this value will be rejected and not processed.
428	2400	SV204	Unit or Basis for Measurement	UN		
428	2400	SV205	Service Unit Count			Texas Medicaid can accept a maximum of 99,999.99 for the units counted for claims processing.
428	2400	SV207	Line Item Denied Charge or Non-Covered Charge Amount			Other Insurance Paid amount at the detail-level.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
441	2400	NTE	Third Party Organization Notes			
441	2400	NTE02	Line Note Text			Texas Medicaid is requesting that the data sent in NTE02 be the Unit Rate for proper adjudication of the file.
466	2420C	NM1	Rendering Provider Name			Required if there are multiple Rendering Providers on the claim. If sent, the claim level 2310D Rendering Provider loop is not to be sent.
467	2420C	NM104	Rendering Provider First Name			Mandatory for Texas Medicaid claims processing.
468	2420C	NM109	Rendering Provider Primary Identifier			NPI must be submitted unless the provider has an API assigned which will be reported in Loop 2310D Rendering Provider Secondary Identification. Either the NPI or API are required for claims processing.
469	2420C	REF	Rendering Provider Secondary Identification			
469	2420C	REF01	Reference Identification Qualifier	G2		If the provider has an API instead of an NPI, the API must be sent in the REF02.

11 APPENDICES

Transmission Examples

The 837I transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, claim level, and claim service line level. Billing providers who sort claims using this hierarchy will use the 837I more efficiently because information that applies to all lower levels in the hierarchy will not have to be repeated within the transaction.

Texas Medicaid Note:
As an assumption for these file formats if the Subscriber is the same individual as the Patient, then the Patient Loop is not to be populated per HIPAA compliance. Information sent in the 2000C loop will be ignored by Texas Medicaid.

In the following example carriage return line feeds are inserted in place of ~ character for improved readability purposes.

Texas Medicaid Example Transaction:

ISA*00* *00* *ZZ*111111111 *ZZ*617591011CMSP
*151230*0123*|*00501*111111111*0*P*:
GS*HC*111111111*617591011CMSP*20151230*0123*9*X*005010X223A2
ST*837*0001*005010X223A2 BHT*0019*00*111111111*20151230*0123*CH
NM1*41*2*ORGANIZATION NAME*****46*1111111111
PER*IC*FIRST NAME*TE*1111111111
NM1*40*2*TEXASMEDICAID*****46*617591011CMSP
HL*1**20*1
NM1*85*2*ORGANIZATION NAME*****XX*1111111111 N3*100
MAIN STREET
N4*TOWN*TX*12345
REF*EI*111111111
HL*2*1*22*0 SBR*P*18*******MC
NM1*IL*1*LAST NAME*FIRST NAME*A***MI*1111111111 N3*100
MAIN STREET
N4*TOWN*TX*12345
DMG*D8*19420611*F
NM1*PR*2*TEXAS
MEDICAID*****PI*617591011CMSP
CLM*111111111111111*199.36***18:A:1**C*Y*Y
DTP*434*RD8*20151229-20151229
DTP*435*DT*201411101200
CL1*1*1*01
PWK*EB*FT***AC*5129144014
REF*9F*111111111 K3*19420611
NTE*UPI* P P1 4.0019420611
NTE*ADD*YY 4.00 4.00 10 22
HI*ABK:G43909
HI*ABJ:J45909
NM1*71*1*LAST NAME*FIRST NAME****XX*1111111111

PRV*AT*PXC*314000000X
NM1*82*1*LNAME*FNAME****XX*9999999999 LX*1
SV2*0100**92.52*UN*1**.00
DTP*472*RD8*20151229-20151229
NTE*TPO*92.52
SE*36*0001
GE*1*9 IEA*1*111111111

Change Summary

The following is a log of changes made since the original version of the document was published.

	Change	Date
1	Removed verbiage: 2300 CL102 7 TMHP recommends the submitter use 2 in CL102 (refer to SR 4339022).	11/11/2011
2	COR 53 LTC Cost Avoidance: New mapping in 2300 and 2320 loops for Other Insurance information.	11/26/2012
3	COR 135 Long Term Care Claims Forwarding modifications: Included Appendix that contains information that will be included on the outbound 837I that is forwarded to the MCO.	06/19/2014
4	Example transactions updated.	07/07/2014
5	COR 135 Long Term Care Claims Forwarding modifications: Updated 'Purpose' section to indicate that the TR3 dated October 2007 was a 5010 compliant guide. Insert CLM-05-03 Claim Frequency Type Code recommended mapping. Updated Description for CL103 Patient Discharge Status Updated example transaction to include updated Claim Frequency Type Code, Patient Discharge Status, Admission Date/Hour, Discharge Hour, and Admitting Diagnosis. Updated example transactions.	12/16/2014
6	Removed and replaced "TMHP" with "Texas Medicaid" except where TMHP is the data being sent outbound to an MCO. Added LX Service Line Number – Texas Medicaid will accept up to 28 Service Lines per claim.	02/17/2015
7	Updated to CAQH CORE Operating Rules Phase IV Template.	10/01/2016
8	Page 20 – Added entry for Billing Provider Service Group code submission in loop 2300 NTE01 and 02 Notes. Page 21 – Added entry for Residence Service Group code submission in loop 2300 NTE02. Page 24 – Added X12 Example in NTE02 beginning position 24.	02/01/2019
9	Removed yellow highlight from updates to Claim Note NTE on page 20 & 21. Removed yellow highlight to X12 transaction example on page 24.	02/01/2019
10	Added Attending Provider First Name as mandatory for claims processing. Additionally, added information on claim and detail level rendering provider submission.	08/28/2020
11	Updated http links to https links and updated formatting.	08/10/2023
12	Edifecs decommission of self-testing tool, removed reference	12/03/2025

	to Edifecs Section 3 Texas Medicaid provides a self-testing tool through Edifecs.	