Georgia Department of Community Health (DCH)

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3)
Implementation Guide
Based on ASC X12N version: 005010X223A2

837 Health Care Claim/Encounter: Institutional Encounter (837I)

November, 2014 005010 Version: 2.3

Disclosure Statement

The following Georgia Department of Community Health (DCH) Companion Guide is intended to serve as a companion guide to the corresponding ASC X12N/005010X223 Health Care Claim Institutional (837I), its related Addenda (005010X223A2) and its related Errata (005010X223E1). The companion guide further specifies the requirements to be used when preparing, submitting, receiving and processing electronic health care administrative data. This companion guide supplements, but does not contradict, disagree, oppose, or otherwise modify the 005010X223 in a manner that will make its implementation by users to be out of compliance.

Note:

Type 1 TR3 Errata are substantive modifications, necessary to correct impediments to implementation, and identified with a letter 'A' in the errata document identifier. Type 1 TR3 Errata were formerly known as Implementation Guide Addenda.

Type 2 TR3 Errata are typographical modifications, and identified with a letter 'E' in the errata document identifier.

The information contained in this Companion Guide is subject to change. Electronic Data Interchange (EDI) submitters are advised to check the Georgia Web Portal site http://www.mmis.georgia.gov regularly for the latest updates.

About DCH

Through effective planning, purchasing and oversight, the Georgia Department of Community Health (DCH) provides access to affordable, quality health care to millions of Georgians, including some of the state's most vulnerable and underserved populations.

DCH is responsible for Medicaid and PeachCare for Kids®, the State Health Benefit Plan, Healthcare Facility Regulation and Health Information Technology in Georgia. http://dch.georgia.gov/

Mission Statement

We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

We are dedicated to ***A Healthy Georgia.***

Preface

This Companion Guide to the 5010 ASC X12N Technical Report Type 3 Implementation Guides and associated errata and addenda adopted under HIPAA clarifies and specifies the data content when exchanging electronically with DCH. Transmissions based on this companion guide, used in tandem with 005010 ASC X12 TR3 Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N TR3 Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that is any way exceeds the requirements or usages of data expressed in the TR3 Implementation Guides.

Table of Contents

1 Introduction

This section describes how TR3 Implementation Guides, also called 837I ASC X12N (version 005010X223), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that Georgia Medicaid has information additional to the TR3 Implementation Guides. 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 implementation guide's internal code listings.
4. Clarify the use of loops, segments, composite and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Georgia Medicaid.

In addition to the row for each segment, one or more additional rows are used to describe Georgia Medicaid's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column to provide additional information from Georgia Medicaid for specific segments provided by the TR3 Implementation Guide. The following is just an example of the type of information that would be spelled out or elaborated on in the Section 10: Transaction Specific Information.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10 percent and notes or comments about the segment itself go in this cell.
193	2100C	NM109	Subscriber Primary Identifier	00	15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Georgia Medicaid Management Information System (GAMMIS).

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
241	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 Scope

This companion guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 837I Implementation Guide for the purpose of submitting institutional encounter claims electronically. This companion guide is not intended to replace the TR3 Implementation Guide. The TR3s define the national data standards, electronic format, and values for each data element with an electronic transaction. The purpose of this companion guide is to provide trading partners with a companion guide to communicate Georgia Medicaid-specific information required to successfully exchange transactions electronically with Georgia Medicaid. The instructions in this companion guide are not intended to be stand-alone requirements. 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.

Georgia Medicaid will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain Georgia Medicaid-specific information, though processed, may be rejected. For example, a compliant 837 institutional encounter claim (837I) created with an invalid Georgia Medicaid member identification number will be rejected by Encounter processes for member id number not on file. For questions regarding appropriate billing procedures, as well as for policy and billing information, providers should refer to their policy-specific area of the Georgia Medicaid online billing manual.

Refer to this companion guide first if there is a question about how Georgia Medicaid processes a HIPAA transaction. For further information, contact the HP Enterprise Services EDI Services Team at

1-877-261-8785 or 1-770-325-9590. This companion guide is intended as a resource to assist providers, clearinghouses, service bureaus, and all other trading partners with Georgia Medicaid interChange in successfully conducting EDI of administrative health care transactions. This companion guide provides instructions for enrolling as a Georgia Medicaid trading partner, obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information. This companion guide does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.2 Overview

Per HIPAA requirements, Georgia Medicaid and all other covered entities must comply with the EDI standards for health care as established by the Secretary of the federal Department of Health and Human Services (HHS). The Secretary of the HHS is required under HIPAA to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. Additionally, HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

The HIPAA requirements serve to:

- Create better access to health insurance.
- Limit fraud and abuse.
- Reduce administrative costs.

This companion guide is designed to help those responsible for testing and setting up electronic encounter claim transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting and identifies codes and data elements that do not apply to Georgia Medicaid. This companion guide supplements (but does not contradict) requirements in the ASC X12N 837 (version 005010X223) 837I implementation guide. This information should be given to the provider's business area to ensure that the 837I health care encounter claim transaction is interpreted correctly.

This companion guide provides communications-related information a trading partner needs to enroll as a trading partner, obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with Georgia Medicaid.

This companion guide must be used in conjunction with the TR3 Implementation Guide instructions. The companion guide is intended to assist trading partners in implementing the electronic 837I health care encounter claim transaction that meets Georgia Medicaid processing standards by identifying pertinent structural and data-related requirements and recommendations. Updates to this companion guide will occur periodically and new companion guides will be posted on the Georgia Medicaid Management Information System (GAMMIS) Web Portal EDI >> Companion Guides page.

1.3 References

The TR3 Implementation Guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The TR3 Implementation Guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that your IT staff, or software vendor, review this companion guide in its entirety and follow the stated requirements to exchange HIPAA-compliant files with Georgia Medicaid.

The TR3 Implementation Guides for X12N and all other HIPAA standard transactions are available electronically at http://www.wpc-edi.com/.

1.4 Additional Information

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979, ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X 12 standard is recognized by the United States as the standard for North America. EDI adoption has been proved to reduce the administrative burden on providers.

The intended audience for this companion guide is the technical and operational staff responsible for generating, receiving, and reviewing electronic health care transactions.

National Provider Identifier

As a result of HIPAA, the federal HHS adopted a standard identifier for health care providers. The Final Rule published by the HHS adopted the National Provider Identifier (NPI) as the standard identifier.

The NPI replaces all payer-specific identification numbers (e.g., Medicaid provider numbers) on nationally recognized electronic transactions (also known as standard transactions); therefore, all health care providers are required to obtain an NPI to identify themselves on these transactions. The NPI is the only identification number that should be submitted on these transactions from a health care provider.

For all non-healthcare providers where an NPI is not assigned, the Medicaid provider number should be submitted.

Acceptable Characters

For real-time, the HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. For batch, HIPAA transactions can contain carriage returns and line feeds, however it is recommended that the data is received in one, continuous stream without carriage return and line feeds. Georgia Medicaid accepts the extended character set. Uppercase characters are recommended.

Acknowledgements

An accepted 824 Application Reporting for Insurance transaction, rejected 824 Application Reporting for Insurance transaction, or rejected TA1 InterChange Acknowledgement will be generated in response to all batch submitted files.

Trading partners are responsible for retrieving acknowledgments from the GAMMIS Web Portal to determine the status of their files.

2 Getting Started

2.1 Working with Georgia Medicaid

This section describes how to interact with HP Enterprise Services' EDI Department.

Georgia Medicaid trading partners should exchange electronic health care transactions with HP Enterprise Services via the GAMMIS Web Portal, Remote Access Server (RAS), Secure File Transfer Protocol (SFTP), Network Routing Module Service (NRM), and Healthcare Transaction Services (HTS) or through a Georgia Medicaid approved Value Added Network (VAN).

After establishing a transmission method, each trading partner must successfully complete testing. Additional information is provided in the next section of this companion guide. After successful completion of testing, production transactions may be exchanged.

2.2 Trading Partner Registration

This section describes how to register as a trading partner with HP Enterprise Services.

All trading partners are required to complete the Georgia Medicaid trading partner agreement (TPA) form to enroll into EDI Services. Those trading partners that are using an already enrolled billing agent, clearinghouse, or software vendor do not need to enroll separately since they are already enrolled to transmit electronically. Only one trading partner ID is assigned per submitter location. If multiple trading partner IDs are needed for the same address location, please attach a letter to the TPA explaining the need for the additional trading partner ID. Providers must use the secure GAMMIS Web Portal to delegate access to their clearinghouse, billing agent, or software vendor to allow EDI files to be downloaded on their behalf. Information on how to delegate access is found in the Web Portal User Account Management Guide on the GAMMIS Web Portal Provider Information >> Provider Manuals page.

If you are already enrolled to transmit or receive electronically and would like to make a change to your EDI trading partner ID profile or provider ID (ERA Only) profile, please complete the HP EDI Submitter Update Form found on the GAMMIS Web Portal page EDI >> Registration Forms indicating the changes you wish to make. The following changes can be made: Trading Partner Name, Contact Information, Address, Status (Active or Inactive), Transmission Method, and Transaction Types. Trading partners cannot change their trading partner ID. This ID can simply be deactivated using the EDI Submitter Update Form and a new EDI TPA for enrollment must be submitted once the original trading partner ID has been deactivated.

Trading Partners that will be exchanging electronic health care transactions SFTP are required to complete the SFTP Setup Request Form found on the GAMMIS Web Portal page EDI >> Registration Forms. This form must be signed by an authorized agent and is necessary to transmit to and from the GAMMIS server. Failure to submit this form will cause your enrollment to be delayed, and/or returned to you as incomplete. For more information on SFTP access, please review the SFTP Setup and Data Transfer Requirements manual on the EDI >> Software and Manuals page.

If you have already completed these forms, you will not be required to complete them again. Please contact the HP Enterprise Services EDI Services Team at 1-877-261-8785 or 1-770-325-9590 if you have any questions about these forms.

2.3 Certification and Testing Overview

All trading partners will be certified through the completion of trading partner testing.

All trading partners that exchange electronic transactions with Georgia Medicaid must complete trading partner testing. This includes billing agents, clearinghouses or software vendors. Failure to do so will prevent successful transmissions of electronic files to the GAMMIS. Testing is not required if using the Provider Electronic Solutions (PES) software.

Providers who use a billing agent, clearinghouse or software vendor will not need to test for those electronic transactions that their entity submits on their behalf.

3 Testing with Georgia Medicaid

Before exchanging production transactions with GAMMIS, each trading partner must complete testing. All trading partners who plan to exchange transactions must contact HP Enterprise Services EDI Services Team at 1-877-261-8785 or 1-770-325-9590 in advance to discuss the testing process, criteria, and schedule. Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

For batch inbound transactions that do not have an associated response (e.g., 837, 834) testing is done through Ramp Manager which is a free interactive X12 testing website, configured to test GAMMIS X12N inbound transactions against the TR3 Implementation Guides and Georgia specific processing rules. To access Ramp Manager, visit the Georgia Health Partnership Ramp Management System Web site at: https://sites.edifecs.com/index.jsp?gamedicaid. A set of instructions for using the Ramp Manager site and its tools are available in the Ramp Manager User Guide, located on the EDI >> Software and Manuals page.

You will be required to have a test file that has passed compliance for each type of transaction you will be sending. The status of each transaction should show “Passed” in Ramp Manager to show that you have successfully passed compliance before HP Enterprise Services can make you an active trading partner.

For batch and real-time transactions that do have an associated response (e.g., 270/271, 276/277)

HP Enterprise Services will process these transactions in a test environment to verify that the file structure and content meet HIPAA standards and Georgia Medicaid-specific data requirements and provide the associated response transaction. Once this validation is complete, the trading partner may submit production transactions to HP Enterprise Services for processing.

HP Enterprise Services does not require a specific number of test files to be sent however your test file(s) should contain as many as possible to cover each of your business scenarios.

4 Connectivity with Georgia Medicaid / Communications

This section describes the process to submit HIPAA 837I transactions, along with submission method, security requirements, and exception handling procedures.

Georgia Medicaid supports multiple methods for exchanging electronic healthcare transactions:

- GAMMIS Web Portal
- Remote Access Server (RAS) (PES Users Only)
- Secure File Transfer Protocol (SFTP) (Batch Only)
- Network Routing Module Service (NRM) (Real-Time Only)
- Georgia Medicaid approved Value Added Network (VAN)
- Healthcare Transaction Services (HTS) (Batch or Real-Time)

4.1 Process Flows

This section contains the process flow and appropriate text.

Health Care Claim and Response
The response to a batch transaction will consist of the following:

1. First level response: TA1 will be generated when errors occur within the outer envelope (no 824 will be generated).
2. Second level response: 824 will be generated. “Rejected” 824 when errors occur during 837I compliance validation or “Accepted” 824 if no errors are detected during the compliance validation.
3. Third level response: Once the transaction is “Accepted” the transaction is translated and sent to the backend for processing. The proprietary encounter 837 response report will be generated daily once the translated file has processed. This report will contain accepted and rejected encounter claims.

Each transaction is validated to ensure that the 837I complies with the 005010X223A2 TR3 Implementation Guide.

Transactions that fail this compliance check will generate a “Rejected” 824 file back to the sender with BGN08=U to indicate that the file failed compliance. Transactions that pass this compliance check will generate an “Accepted” 824 file back to the sender with BGN08=WQ to indicate that the file passed compliance. For encounter submissions files that contain multiple transactions (ST/SE) and one or more of those transactions fail this compliance check the entire file will be “Rejected” back to the sender with BGN08=U.

4.2 Transmission Administrative Procedures

This section provides Georgia Medicaid's specific transmission administrative procedures. Determine if the transmission you are sending is Test or Production and is using the appropriate indicator. For details about available Georgia Medicaid Access Methods, refer to the Communication Protocol Specifications section below.

Georgia Medicaid is available only to authorized users. Submitters must be Georgia Medicaid trading partners. A submitter is authenticated using a Username and Password assigned by the trading partner.

System Availability

The system is typically available 24x7 with the exception of scheduled maintenance windows which are posted on the GAMMIS Web Portal at https://www.georgia.gov. Non-Routine and emergency downtime will also be posted on the GAMMIS Web Portal. The system is available on all holidays.

Transmission File Size

The HIPAA TR3 Implementation Guide states on the CLM (Claim Information) segment that the developers recommend that trading partners limit the size of the size of the transaction (ST/SE) envelope to be a maximum of 5,000 CLM segments.

The Georgia Department of Community Health does not have a maximum for the number of claims per transaction (ST/SE); however the file size must not exceed 50mb.

Transmission Errors

When processing 837 transactions that have Interchange Header errors a TA1 will be generated. If the Interchange Header is valid, but the 837 transaction fails compliance an 824 will be generated.

Production File-naming Convention

Georgia Medicaid will only accept Windows/PC/DOS formatted files. Any file transmitted to GAMMIS must be named in accordance to standard file naming conventions, including a valid three character file extension.

- Preferred extension is: .dat, however other extensions such as .txt, .edi, .txn are allowed.

Georgia Medicaid allows for the upload and download of zipped or compressed files. Any data file contained within the zipped file must contain a valid three character file extension. Zipped files must not contain directory folders or structures and must contain only one (1) file.

SFTP submitters

During the SFTP transmission all files should be named with a temporary extension "tmp" or "temp" until they are fully uploaded, and then renamed to the final filename.

Example:

- **During upload:** 837x_20110328_001.txt.pgp.tmp
- **After upload rename to:** 837x_20110328_001.txt.pgp

These "tmp" filename extensions tell the SFTP server the transmission is in process. Once the "tmp" is removed from the name, the SFTP server will assume the transmission is complete, and processing of the file can be performed.

4.3 Retransmission Procedure

Georgia Medicaid does not require any identification of a previous transmission of a file. All files sent should be marked as original transmissions.

4.4 Communication Protocol Specifications

This section describes Georgia Medicaid's communication protocol(s).

Georgia Medicaid Web Portal

Georgia Medicaid's Web Portal solution provides communication, data exchange, and self-service tools to the provider and member community. The Portal consists of both public and secure areas (web pages requiring a username and password). The public area contains general information, such as program awareness, notices, and forms, and allows users to respond to surveys. Providers can also apply to be a Georgia Medicaid provider online using the provider enrollment wizard, which includes the ability to track their application through the enrollment process. Once enrolled in Medicaid, providers can access their personal information using their provider number and Personal Identification Number (PIN).

The Georgia Medicaid Web Portal is designed, but not limited to support the following Internet browsers for submissions:

- Internet Explorer, version 6 or 7
- Firefox, version 3.x

Secure File Transfer Protocol (SFTP)

Georgia Medicaid allows submitters with a file size of 2K or larger the ability to data exchange SFTP. For more information on SFTP access, please review the SFTP Setup and Data Transfer Requirements manual on the EDI >> Software and Manuals page.

Network Routing Module Service (NRM)

HP Enterprise Services provides a Network Routing Model (NRM) which is an interactive server that is a multi-threaded windows service responsible for listening for input from a configured Value Added Network (VAN) data present port using socket connections. For more information on NRM, please contact the HP Enterprise Services EDI Services Team at 1-877-261-8785 or 1-770-325-9590.

Remote Access Server (RAS)

Remote Access Server (RAS) enables providers to access all options of the secure Web Portal without the use of an Internet Service Provider. This option is only available to Provider Electronic Solution (PES) users who do not have an existing Internet connection. For more information on RAS, please contact the HP Enterprise Services EDI Services Team at 1-877-261-8785 or 1-770-325-9590.

Healthcare Transaction Services (HTS)

HP Enterprise Services provides a Healthcare Transaction Service (HTS) submission method which allows trading partners to submit the 270/271 (Eligibility Inquiry and Response) and 276/277 (Claims Status Inquiry and Response) transactions from their system directly to the MMIS via a fully automated process. This system-to-system EDI web service is supported by a specific Georgia Medicaid schema and Web Services Description Language (WSDL) that are outlined in the Georgia Medicaid HTS Guide. Once trading partners develop the web service to the guide's specification they can test the web client application on the GAMMIS test servers prior to being approved for production. Interested trading partners must contact HP Enterprise Services EDI Services Team at 1-877-261-8785 or 1-770-325-9590 to obtain a copy of the HTS guide.

4.5 Passwords

Providers must adhere to the GAMMIS use of passwords. Providers are responsible for managing their own data. Each provider is responsible for managing access to their organization's data through the MMIS security function. Each provider must take all necessary precautions to ensure that they are safeguarding their information and sharing their data (e.g., Granting access) only with users and entities who meet the required privacy standards. It is equally important that providers know who on their staff is linked to other providers or entities, in order to notify those entities whenever they remove access for that person in your organizations.

For more information regarding passwords and use of passwords, contact the HP Enterprise Services EDI Services Team at 1-877-261-8785 or 1-770-325-9590.

5 Contact Information

Refer to this companion guide with questions, and then use the contact information below for questions not answered by this companion guide.

5.1 EDI Customer Service

This section contains detailed information concerning EDI Technical Assistance, especially contact numbers.

Most questions can be answered by referencing the materials posted on the GAMMIS Web Portal at https://www.mmis.georgia.gov. If you have questions related to Georgia Medicaid's Institutional Encounter (837I) Health Care Claim, contact the HP Enterprise Services EDI Team at 1-877-261-8785 or 1-770-325-9590.

5.2 EDI Technical Assistance

This section contains detailed information concerning EDI Technical Assistance, especially contact numbers.

HP Enterprise Services EDI Services Team can help with connectivity issues or transaction formatting issues at 1-877-261-8785 or 1-770-325-9590 Monday through Friday 8:00 a.m. to 5:00 p.m. EST. with the exception of holidays or via e-mail using the Contact Us link on the GAMMIS Web Portal.

Trading Partner ID: The Trading Partner ID is the GAMMIS key to accessing trading partner information. Trading partners should have this number available each time they contact the HP Enterprise Services EDI Services Team.

5.3 Provider Contact Center

This section contains detailed information concerning Provider Contact Center, especially contact numbers.

The Provider Contact Center should be contacted instead of the HP Enterprise Services EDI Services Team for questions regarding the details of a member's benefits, claim status information, credentialing and many other services. Provider Contact Center is available at 1-800-766-4456 or 1-770-325-9600 Monday through Friday 7:00 a.m. to 7:00 p.m. EST. with the exception of holidays or via e-mail using the Contact Us link on the GAMMIS Web Portal.

Note: Have the applicable provider identifier, the NPI for health care providers or the Medicaid provider ID for atypical providers available for tracking and faster issue resolution.

The Provider Relations representative, also known as field representatives, conduct training sessions on various Georgia Medicaid topics for both large and small groups or providers and billers. In addition to provider education, field representatives are available to assist providers with complex billing and claims processing questions. To find or contact the appropriate Provider Relations Representative, use the Contact Us link on the GAMMIS Web Portal.

5.4 Applicable Websites

This section contains detailed information about useful Web sites.

From GAMMIS secure Portal at https://www.mmis.georgia.gov non-enrolled providers can begin the enrollment process and enrolled providers can do all of the following:

- Create Dental, Institutional, and Professional claims for submission to GAMMIS.
- Check claim status and member enrollment.
- Submit authorizations, notifications, and referrals.
- View, download, and print explanation of benefits (EOBs), and Remittance Advices.

Trading Partners can do the following:

- Create Trading Partner Profile and complete authorization testing.

- Submit batch transactions (270, 276, 837D, 837I and 837P).
- Download batch transactions/acknowledgements (271, 277, 277U, TA1, 824, 834, 999, 820 and 835).
- View, download and print companion guides.

A suite of other EDI and provider tools are also available on the GAMMIS Web Portal.

Additional information is available on the following Web sites:

Accredited Standards Committee (ASC X12)

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

Accredited Standards Committee (ASC X12N)

- ASC X12N develops and maintains X12 EDI and XML standards, standards interpretations and guidelines as they relate to all aspects of insurance and insurance-related business processes. www.x12.org

American Dental Association (ADA)

- Develops and maintains a standardized data set for use by dental organizations to transmit claims and encounter information. www.ada.org

American Hospital Association Central Office on ICD-9-CM (AHA)

- This site is a resource for the International Classifications of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes, used in medical transcription and billing, and for Level 1 HCPCS. www.ahacentraloffice.org

American Hospital Association Central Office on ICD-10-CM/ICD-10-PCS (AHA)

- This site is a resource for the International Classifications of Diseases, 10th edition, Clinical Modification (ICD-10-CM) codes, used for reporting patient diagnoses and (ICD-10-PCS) for reporting hospital inpatient procedures. www.ahacentraloffice.org

American Medical Association (AMA)

- This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org

Centers for Medicare & Medicaid Services (CMS)

- CMS is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health-Care Transactions and Code Sets Model Compliance Plan at www.cms.hhs.gov/HIPAAGenInfo/
- This site is the resource for information related to the Health-Care Common Procedure Coding System (HCPCS). www.cms.hhs.gov/HCPCSReleaseCodeSets/
- This site is the resource for Medicaid HIPAA informational related to the Administrative Simplification provision. www.cms.gov/medicaid/hipaa/adminsim

- This site is the resource for information related to Place of Service Codes. http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

Committee on Operating Rules for Information Exchange (CORE)

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

Council for Affordable Quality Healthcare (CAQH)

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

Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard-setting organizations and transaction change request system. www.hipaa-dsmo.org www.caqh.org

Georgia Department of Community Health (DCH)

- This DCH Web site assists providers with HIPAA billing and policy questions, as well as enrollment support. www.mmis.georgia.gov

Health Level Seven (HL7)

- HL7 is one of several ANSI-accredited Standards Development Organizations (SDOs), and is responsible for clinical and administrative data standards. www.hl7.org

Healthcare Information and Management Systems (HIMSS)

- An organization exclusively focused on providing global leadership for the optimal use of information technology (IT) and management systems for the betterment of health care. www.himss.org

Medicaid HIPAA Compliant Concept Model (MHCCM)

- This site presents the Medicaid HIPAA Compliance Concept Model, information, and a toolkit. www.mhccm.org

National Committee on Vital and Health Statistics (NCVHS)

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

National Council of Prescription Drug Programs (NCPDP)

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

National Uniform Billing Committee (NUBC)

- NUBC is affiliated with the American Hospital Association (AHA). It develops and maintains a national uniform billing instrument for use by the institutional health-care community to transmit claims and encounter information. www.nubc.org

National Uniform Claim Committee (NUCC)

- NUCC is affiliated with the American Medical Association (AMA). It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org

Office for Civil Rights (OCR)

- OCR is the office within the Department of Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

United States Department of Health and Human Services (HHS)

- The DHHS Web site is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction technical report type 3 implementation guides and code sets. www.wpc-edi.com
  - Claim adjustment Reason Codes (CARC): http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
  - Health Care Provider Taxonomy Code Set: http://www.wpc-edi.com/reference/

Workgroup for Electronic Data Interchange (WEDI)

- WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org

6 Control Segments/Envelopes

6.1 ISA-IEA

This section describes Georgia Medicaid's use of the interchange control segments. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

To promote efficient, accurate electronic transaction processing, please note the following GAMMIS specifications:

- Each trading partner is assigned a unique trading partner ID.
- All dates are in the CCYYMMDD format with the exception of the ISA09 which is YYMMDD.
- All date/times are in the CCYYMMDDHHMM format.
- GAMMIS Trading Partner ID is 77034. This value must be sent within the ISA08 for inbound transactions and will be sent within the ISA06 for outbound transactions.

- Batch responses are not returned until all inquiries are processed. Limiting the number of total inquiries per ISA-IEA will produce faster results.
- Only one (1) ISA/IEA is allowed per logical file.
- Utilize BHT Segment for Transaction Set Inquiry Response association.

Transactions transmitted during a session or as a batch are identified by an ISA header segment and IEA trailer segment, which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The tables below represent the interchange envelope information.

837I Encounter (Inbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.3		ISA	Interchange Control Header			
C.4		ISA01	Authorization Information Qualifier	00, 03		
			No Authorization Information Present	00	2	
C.4		ISA02	Authorization Information		10	Space fill
C.4		ISA03	Security Information Qualifier	00, 01		
			No Security Information Present	00	2	
C.4		ISA04	Security Information		10	Space fill
C.4		ISA05	InterChange ID Qualifier	01, 14, 20, 27-30, 33, ZZ		
			Mutually Defined	ZZ	2	
C.4		ISA06	InterChange Sender ID		15	'Trading Partner ID supplied by Georgia Medicaid', left justified and space filled.
C.5		ISA07	InterChange ID Qualifier	01, 14, 20, 27-30, 33, ZZ		
			Mutually Defined	ZZ	2	
C.5		ISA08	InterChange Receiver ID		15	Value = '77034' - GAMMIS Trading Partner ID, left justified and space filled.
C.5		ISA09	InterChange Date		6	Format is YYMMDD
C.5		ISA10	InterChange Time		4	Format is HHMM
C.5		ISA11	Repetition Separator	^, }, |		The repetition separator is a

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						delimiter and not a data element. It is used to separate repeated occurrences of a simple data element or a composite data structure. This value must be different from the data element separator, component element separator, and the segment terminator.
			Repetition Separator	^	1	
			Repetition Separator	}	1	
			Repetition Separator	|	1	
C.5		ISA12	InterChange Control Version Number	00501	5	
C.5		ISA13	InterChange Control Number		9	Must be identical to the associated interchange control trailer IEA01.
C.6		ISA14	Acknowledgment Requested	0, 1		
			No interchange acknowledgment requested	0	1	
			Interchange acknowledgement requested	1	1	
C.6		ISA15	Usage Indicator	T, P		
			Test data	T	1	
			Production data	P	1	
C.6		ISA16	Component Element Separator	:	1	The component element separator is a delimiter and not a data element. It is used to separate component data elements within a composite data structure. This value must be different from the data element separator and the segment terminator.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.10		IEA	Interchange Control Trailer			
C.10		IEA01	Number of Included Functional Groups		1/5	Number of included Functional Groups. Must equal '1' for the real-time transaction to qualify for immediate response.
C.10		IEA02	Interchange Control Number		9	The control number assigned by the interchange sender. Must be identical to the value in ISA13.

6.2 GS-GE

This section describes Georgia Medicaid's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how GAMMIS expects functional groups to be sent and how GAMMIS will send functional groups. These discussions will describe how similar transaction sets will be packaged and Georgia Medicaid's use of functional group control numbers. The tables below represent the functional group information.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.7		GS	Functional Group Header			
C.7		GS01	Functional ID Code	HC	2	
C.7		GS02	Application Sender's Code		2/15	'Trading Partner ID supplied by Georgia Medicaid'. This will equal the value in ISA06.
C.7		GS03	Application Receiver's Code		5	Value = '77034' - GAMMIS Trading Partner ID. This will equal the value in ISA08.
C.7		GS04	Date		8	Format is CCYYMMDD
C.8		GS05	Time		4/8	Format is HHMM
C.8		GS06	Group Control Number		1/9	Group control number. Must be identical to the value in GE02.
C.8		GS07	Responsible Agency Code	X	1	
C.8		GS08	Version/Release/ Industry ID Code		12	005010X223A2

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.9		GE	Functional Group Trailer			
C.9		GE01	Number of Transaction Sets Included		1/6	Number of included Transaction Sets. Must equal '1' for the real-time transaction to qualify for immediate response.
C.9		GE02	Group Control Number		1/9	The functional group control number. Same value as GS06.

6.3 ST-SE

This section describes Georgia Medicaid's use of transaction set control numbers.

Georgia Medicaid recommends that trading partners follow the guidelines set forth in the TR3 Implementation Guide – start the first ST02 in the first file with 000000001 and increment from there. The TR3 Implementation Guide should be reviewed for how to create compliant transactions set control segments.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
67		ST	Transaction Set Header			
67		ST01	Transaction Set Identifier Code	837	3	
67		ST02	Transaction Set Control Number		4/9	Transaction control number. Identical to the value in SE02.
67		ST03	Implementation Convention Reference		12	005010X223A2

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
488		SE	Transaction Set Trailer			
488		SE01	Number of Included Segments		1/10	Total number of segments included in a transaction set including ST and SE segments.
488		SE02	Transaction Set Control Number		4/9	Transaction set control number. Identical to the value in ST02.

6.4 Control Segment Notes

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.

6.5 File Delimiters

Georgia Medicaid requests that submitters use the following delimiters on your 837 file. If used as delimiters, these characters (* : ~ ^) must not be submitted within the data content of the transaction sets. Contact the HP Enterprise Services EDI Services Team at 1-877-261-8785 or 1-770-325-9590 if there is a need to use a delimiter other than the following:

Data Element: Byte 4 in the ISA segment defines the data element separator to be used throughout the entire transaction. The recommend data element delimiter is an asterisk (*).

Repetition Separator: ISA11 defines the repetition separator to be used throughout the entire transaction. The recommend repetition separator is a caret (^).

Component-Element: ISA16 defines the component element delimiter to be used throughout the entire transaction. The recommended component-element delimiter is a colon (:).

Data Segment: Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The recommended data segment delimiter is a tilde (~).

7 Georgia Medicaid Specific Business Rules and Limitations

This section describes Georgia Medicaid's business rules, for example:

- Communicating payer specific edits
- Billing for specific services

Before submitting electronic encounter claims to GAMMIS, please review the appropriate HIPAA Technical Report Type 3 (TR3) Implementation Guide and Georgia Medicaid companion guide. In addition, Georgia Medicaid recommends that you review the Georgia Medicaid billing guides. These guides provide additional billing instructions for specific provider types. They are available on the GAMMIS Web Portal Provider Information >> Provider Manuals page.

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

7.1 Logical File Structure

There can only be one interchange (ISA/IEA) per logical file. The interchange can contain multiple functional groups (GS/GS) however; the functional groups must be the same type.

7.2 Compliance Checking

Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. In additional to Level 4, Level 7 for the patient (dependent) level will occur. If 2000C patient loop is received, it will fail compliance. All other levels will be validated within the GAMMIS.

7.3 International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)

On January 16, 2009, HHS published a final rule adopting ICD-10-CM and ICD-10-PCS to replace ICD-9-CM and ICD-9-PCS in HIPAA transactions, effective implementation date of October 1, 2013. The implementation of ICD-10 was delayed a second time from October 1, 2014 to October 1, 2015 by final rule CMS-0043-F issued on August 4, 2014.

Until that time, October 1, 2015, the codes in ICD-10-CM are not valid for any purpose or use. If Georgia Medicaid receives any transaction that contains the ICD-10-CM or ICD-10-PCS qualifiers the transaction will fail compliance. The submitter will need to correct the compliance failure and resubmit the transaction for processing.

7.4 Submitter

Submissions by non-approved trading partners will be rejected.

7.5 Document Level

The Georgia Department of Community Health process files at the batch level for encounters. This means if one compliance error is received in the file, the entire file will be rejected and reported on the 824 transaction.

7.6 Processing for the 2300-HI Segment for the "Principal Procedure Information"

The Georgia Department of Community Health will only use the value sent in the HI01-2, where HI01-1 equals BR in the Principal Procedure Information HI segment until ICD-10 is implemented. At that time the value of BBR will be used. If the new value of CAH is sent within the HI01-1, the value received in the HI01-2 will not be used for processing the claim.

Note: HIPAA allows the BP, BBR or CAH qualifier values at the claim level within the HIxx-1 composite element, the HCPCS procedure code value would then be placed in the HIxx-2 composite element. For institutional claims, the Georgia Department of Community Health only allows the HCPCS procedure code at the detail level within the 2400-SV202-2, where 2400-SV202-1 = "HC". If the HCPCS procedure code is received within the HI segment, the claim will not fail compliance. However, the claim will not process correctly within the adjudication system.

7.7 Processing for the 2300-HI Segment for the "Other Procedure Information"

The Georgia Department of Community Health will only use the value sent in the HI01-2, where HI01-1 equals BQ in the Principal Procedure Information HI segment until ICD-10 is implemented. At that time the value of BBQ will be used.

Note: HIPAA allows the BQ and/or BBQ qualifier values at the claim level within the HIxx-1 composite

element, the HCPCS procedure code value would then be placed in the HIxx-2 composite element. For institutional claims, the Georgia Department of Community Health only allows the HCPCS procedure code at the detail level within the 2400-SV202-2, where 2400-SV202-1 = "HC." If the HCPCS procedure code is received within the HI segment, the claim will not fail compliance. However, the claim will not process correctly within the adjudication system.

7.8 Processing for the 2300-HI Segment for the "Patient's Reason for Visit"

Per the TR3 Implementation Guide, the patient reason for visit is required for outpatient visits. To determine outpatient visit, the TR3 Implementation Guide along with the National Uniform Billing Committee (NUBC) manual was used. The patient reason for visit (HI*PR) is required where 2300-CLM01 (Type of Bill) first two (2) positions equal 13 or 85 AND 2300-CL101 (Admission Type Code) equal 1, 2 or 5 AND 2400-SV201 (Revenue Code) equal 045x, 0516, 0526 or 0762.

7.9 Name Normalization (CORE Standard)

In an effort to further simplify the eligibility inquiry and response transaction, and reduce the number of non-matches, Georgia Medicaid, in collaboration with the Healthcare Administrative Simplification Collaborative, which consists of a number of health plans across the state of Georgia, has adopted the Name Normalization standard developed by the Council for Affordable Quality Healthcare (CAQH).

More specifically, Georgia Medicaid has adopted the CORE 258: Phase II Normalizing Patient Last Name Rule, where CORE stands for Committee on Operating Rules for Exchange. This applies to the HIPAA adopted X12N 270/271 eligibility inquiry and response and 276/277 claim status inquiry and response transactions and specifies the requirements for a CORE-certified health plan (or information source), to normalize a person's last name during any name validation or matching process by the health plan (or information source). This CORE rule applies only to certain characters in a person's last name including:

- Punctuation values;
- Uppercase letters;
- Special characters; and
- Name suffixes and prefixes.

Georgia Medicaid applies these normalization rules to both the patient's first name and last name. For additional information on CORE 258, refer to http://www.caqh.org/pdf/CLEAN5010/258-v5010.pdf.

Please Note: The delimiters that may be used in the Patient Last Name according to the CORE standard are limited to space, comma, and forward slash. Any other non-alphabetic delimiter will be viewed as a special character. Valid examples include:

- SMITH SR;
- SMITH, SR; and
- SMITH/SR

7.10 Hospice Claims Requiring Long Term Care (LTC) Provider Number (2310E Service Facility Location Name Loop)

For Hospice Claims that require the LTC provider number, the LTC provider information must be sent within the 2310E Service Facility Location Name Loop, where the 2310E NM101=77 and NM109 must equal the LTC provider NPI.

7.11 Hospice Claims Requiring Long Term Care (LTC) Provider Number (2310E Service Facility Location Name Loop)

For Hospice Claims that require the LTC provider number, the LTC provider Medicaid ID must be sent in 2310E REF02, where REF01=G2.

7.12 Additional Compliance Check based on Upgrade

With the recent upgrade to the compliance engine there are a few compliance checks that were added. If the following is received on the inbound claim, it will fail compliance:

- If, Billing Provider and Service Facility Provider Loops are both present, where the information is equal.
- If, PO Box or P.O. Box is received anywhere within the data within the 2010AA N301 and N302.
- If, 2300 CL103=20, Date of death is required within the 2300 HI (Occurrence Information) where the Occurrence Code equals '55'.

8 Acknowledgements and/or Reports

8.1 The TA1 Interchange Acknowledgement

The TA1 allows the receiver of a file to notify the sender that an invalid interchange structure was received or that problems were encountered. The TA1 verifies only the interchange header (ISA/GS) and trailer (IEA/GE) segments of the file envelope.

For batch and real-time if ISA or GS errors were encountered then the generated TA1 report with the Interchange Header errors will be returned for pickup.

What to look for in the TA1

The TA1 segment indicates whether or not the submitted interchange control structure passed the HIPAA compliance check.

If TA104 is "R" then the transmitted interchange control structure header and trailer were rejected because of errors. The submitter will need to correct the errors and resubmit the corrected file to GAMMIS.

Example:

- TA1*900000001*090721*1700*R*006~

The data elements in the TA1 segment are defined as follows:

TA101 contains the Interchange Control Number (ISA13) from the file to which this TA1 is responding ("900000001" in the example above).

TA102 contains the Interchange Date ("090721" in the example above).

TA103 contains the Interchange Time ("1700" in the example above).

TA104 code indicates the status of the interchange control structure ("R" in the example above). The definition of the code is as follows;

"R" – The transmitted interchange control structure header and trailer are rejected because of errors.

TA105 code indicates the error found while processing the interchange control structure ("006" in the example above). The definitions of the codes are as follows:

Code	Description
000	No Error
001	The InterChange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.
002	This Standard as Noted in the Control Standards Identifier is Not Supported
003	This Version of the Controls is Not Supported
004	The Segment Terminator is Invalid
005	Invalid InterChange ID Qualifier for Sender
006	Invalid InterChange Sender ID
007	Invalid InterChange ID Qualifier for Receiver
008	Invalid InterChange Receiver ID
009	Unknown InterChange Receiver ID
010	Invalid Authorization Information Qualifier Value
011	Invalid Authorization Information Value
012	Invalid Security Information Qualifier Value
013	Invalid Security Information Value
014	Invalid InterChange Date Value
015	Invalid InterChange Time Value
016	Invalid InterChange Standards Identifier Value
017	Invalid InterChange Version ID Value
018	Invalid InterChange Control Number Value
019	Invalid Acknowledgment Requested Value
020	Invalid Test Indicator Value
021	Invalid Number of Included Groups Value
022	Invalid Control Structure
023	Improper (Premature) End-of-File (Transmission)
024	Invalid InterChange Content (e.g., Invalid GS Segment)
025	Duplicate InterChange Control Number
026	Invalid Data Element Separator

Code	Description
027	Invalid Component Element Separator
028	Invalid Delivery Date in Deferred Delivery Request
029	Invalid Delivery Time in Deferred Delivery Request
030	Invalid Delivery Time Code in Deferred Delivery Request
031	Invalid Grade of Service Code

The TA1 segment will be sent within its own interchange (i.e., ISA-TA1-IEA)

Example of a TA1 within its own interchange

ISA*00* *00* *ZZ*77034 *ZZ*RECEIVER
*110721*1701*^*00501*000000001*0*P*:~TA1*900000001*110720*1245*R*006~IEA*0*000000001~

For additional information, consult the Interchange Control Structures, X12.5 Guide. TR3 Implementation Guides may be obtained by logging on to www.wpc-edi.com and following the links to 'EDI Publications' and '5010 Technical Reports.'

8.2 The 824 Application Reporting for Insurance

Each time a 5010 837 X12 file is submitted to GAMMIS, an 824 Application Reporting for Insurance is sent to the submitter within one business day. An 824 does not guarantee processing of the transaction. It only signifies that GAMMIS received the Functional Group. The following sections explain how to read the 824 to find out whether a file is accepted or rejected. If a Functional Group is accepted, no action is required by the submitter. If the Functional Group is rejected, the submitter must correct the errors and submit the corrected file to GAMMIS.

What to look for in the 824

Locate every BGN08 data element. This data element indicates whether or not the submitted Functional Group passed the HIPAA compliance check. If each BGN08 data element appears as "WQ", this means the entire Functional Group was accepted for processing. The transaction will process.

If BGN08 data element equals "U" (Rejected) at least one transaction set was rejected, you should review the transaction (ST/SE) for the claims that have been rejected.

Example of the 824 Application Reporting for Insurance where at least one transaction on the incoming 837 failed compliance

ISA*00* *00* *ZZ*77034 *ZZ*TP ID *130327*1336*^*00501*023520122
*0*T*:~
GS*AG*77034*TPID*20130327*1336*1*X*005010X186~
ST*824*0001*005010X186~

BGN*11*F03574DBFB5B4C06B79B6EED316AAF27*20130327*133644**030811128**U~
N1*41*GEORGIA FAMILIES*46*77034~
N1*40*SUBMITTER*46*12345~
OTI*TA*TN*NA***20130322*1128*103081112*0001*837*005010X223A2~
SE*6*0001~
ST*824*0002*005010X186~
BGN*11*5D48DC995A834C00A64922DB5C94277D*20130327*133644**030811128**U~
N1*41*GEORGIA FAMILIES*46*77034~
N1*40* SUBMITTER *46*12345~
OTI*IR*IX*NA***20130322*1128*103081112*0002*837*005010X223A2~
REF*X1*EPPATACCTNUMB000~
DTM*232*20120106~
TED*024**CLM*21*2~
RED*NA**94**IBP*E053~
TED*024**CLM*21*2~
CTX*Segment SV1 Element 782*SV1*47**2*782~
RED*NA**94**IBP*E053~
SE*13*0002~
ST*824*0003*005010X186~
BGN*11*BA42141A3B3342BF9B290420C9296CC4*20130327*133644**030811128**U~
N1*41*GEORGIA FAMILIES*46*77034~
N1*40* SUBMITTER *46*12345~
OTI*TA*TN*NA***20130322*1128*103081112*0003*837*005010X223A2~
SE*6*0003~
GE*3*1~
IEA*1*023520122~

Example of the 824 Application Reporting for Insurance where all transactions on the incoming 837 passed compliance

ISA*00* *00* *ZZ*77034 *ZZ*TPID *130327*1415*^*00501*023520124*
0*T*:~
GS*AG*77034*TPID*20130327*1415*1*X*005010X186~
ST*824*0001*005010X186~
BGN*11*831A614214B142A3BB58725421E8789B*20130327*141557**030811128**WQ~
N1*41*GEORGIA FAMILIES*46*77034~
N1*40* SUBMITTER *46*12345~
OTI*TA*TN*NA***20130322*1128*103081112*0001*837*005010X223A2~
SE*6*0001~
ST*824*0002*005010X186~
BGN*11*CBA1964FFDAD4353B71840825A2514DE*20130327*141557**030811128**WQ~
N1*41*GEORGIA FAMILIES*46*77034~
N1*40* SUBMITTER *46*12345~
OTI*TA*TN*NA***20130322*1128*103081112*0002*837*005010X223A2~
SE*6*0002~
GE*2*1~

IEA*1*023520124~

BGN: This segment indicates the beginning of a transaction set.

Example:

BGN*11*F03574DBFB5B4C06B79B6EED316AAF27*20130327*133644**030811128**U~
BGN*11*5D48DC995A834C00A64922DB5C94277D*20130327*133644**030811128**U~
BGN*11*BA42141A3B3342BF9B290420C9296CC4*20130327*133644**030811128**U~
BGN*11*831A614214B142A3BB58725421E8789B*20130327*141557**030811128**WQ~
BGN*11*CBA1964FFDAD4353B71840825A2514DE*20130327*141557**030811128**WQ~

- BGN01 is the Transaction Set Purpose Code and will always equal '11'(Response).
- BGN02 is a unique value assigned by the submitter.
- BGN03 is the date the 824 was created.
- BGN04 is the time the 824 was created.
- BGN06 is equal to BHT03 from the original file (Originator Application Transaction Identifier).
- BGN08 indicates if the transaction (ST/SE) is 'Accepted' or 'Rejected'.

N1: First occurrence of the N1 segment contains information from the 1000B (Receiver Loop) on the original 837 input file.

Example:

N1*41*GEORGIA FAMILIES*46*77034~

- N101 is equal to '41' indicating Receiver.
- N102 is equal to 1000B-NM103 'GEORGIA FAMILIES' from the original file (Receiver Name).
- N103 is equal to '46' indicating Electronic Transmitter Identification Number (ETIN).
- N104 is equal to 1000B-NM109 '77034' from the original file (Receiver Primary Identifier).

N1: Second occurrence of the N1 segment contains information from the 1000A (Submitter Loop) on the original 837 input file.

Example:

N1*40*SUBMITTER*46*12345~

- N101 is equal to '40'indicating Submitter.
- N102 is equal to 1000A-NM103 'SUBMITTER' from the original file (Submitter Name).
- N103 is equal to '46' indicating Electronic Transmitter Identification Number (ETIN).
- N104 is equal to 1000A-NM109 '12345' (Trading Partner ID) from the original file (Submitter Identifier).

OTI: This segment contains information about the Original Transaction Identification.

Example:

OTI*TA*TN*NA***20130322*1128*103081112*0001*837*005010X223A2~
OTI*IR*IX*NA***20130322*1128*103081112*0002*837*005010X223A2~
OTI*TA*TN*NA***20130322*1128*103081112*0003*837*005010X223A2~

- OTI01 contains the application acknowledgment code. The first character indicates the edit level, and the second character indicates the results of the edit. In the example above, the first occurrence of OTI01 reflects 'TA' (Transaction Set Accept), the second occurrence of OTI01 reflects 'BR' (Batch Reject), and the third occurrence of OTI01 reflects 'IR' (Item Reject). The definitions of the codes are as follows:

Code	Description
BA	Batch Accept
BE	Batch Accept with Error
BP	Batch Partial Accept/Reject
BR	Batch Reject
IA	Item Accept
IE	Item Accept with Error
IP	Item Partial Accept/Reject
IR	Item Reject
TA	Transaction Set Accept
TE	Transaction Set Accept with Error
TP	Transaction Set Partial Accept/Reject
TR	Transaction Set Reject

- OTI02 contains the reference Identification Qualifier regarding the value within OTI01. In the example above, the first occurrence of OTI02 reflects 'TN' (Transaction Reference Number), the second occurrence of OTI02 reflects 'BT' (Batch Number), and the third occurrence of OTI03 reflects 'IX' (Item Number). The definitions of the codes are as follows:

Code	Description
BT	Batch Number (When OTI01=BA, BC, BE, BP or BR)
BE	Batch Accept with Error (When OTI01=IA, IC, IE, IP or IR)
BP	Batch Partial Accept/Reject (When OTI01=TA, TC, TE, TP or TR)

- OTI03 will always contain the value of 'NA'.
- OTI06 is equal to GS04 from the original file (Date).
- OTI07 is equal to GS05 from the original file (Time).
- OTI08 is equal to GS06 from the original file (Group Control Number).
- OTI09 is equal to ST02 from the original file (Transaction Set Control Number).
- OTI10 is equal to ST01 (837) from the original file (Transaction Set Identifier).
- OTI11 is equal to GS08 from the original file (Transaction Version)

REF: This segment contains additional information about the Original Transaction Identification if available.

Example:

REF*X1*EPPATACCTNUMB000~

- REF01 is equal to 'X1' (Provider Claim Number).
- REF02 is equal to the 2300-CLM01 or 2300-REF02, where REF01=D9 from the original file when available.
  Note: If a claim fails compliance at the claim level and the 837 received contains the 2300-REF02, where REF01=D9, that is the value returned within this REF segment. If the REF01=D9 is not present on the 837, the value received within the CLM01 will be returned within this REF segment. If a claim fails compliance prior to the claim level, the value returned within this REF segment is a random assigned number.

DTM: This segment contains additional information about the Original Transaction Identification if available.

Example:

DTM*232*20120106~

- DTM01 is equal to '232' (Claim Statement Period Start) or '233' (Claim Statement Period End).
- DTM02 is equal to the date of service on the original submitted claim. If DTM01='232' DTM02=Service Start Date. If DTM01='233' DTM02=Service End Date.

AMT: This segment contains additional information about the Original Transaction Identification if available.

Example:

AMT*T3*260~

- AMT01 is equal to 'T3' (Total Submitted Charges).
- AMT02 is equal to 2300-CLM02 (Total Submitted Charges) on the original submitted claim.

NM1: This segment contains additional information about the Original Transaction Identification if available.

Example:

NM1*HK*1*MEMLNAME*MEMFNAME*M***MI*123456789012~

- NM101 is equal to 'HK' (Subscriber).
- NM102 is equal to '1' (Person).
- NM103 is equal to 2010BA-NM103 (Member Last Name) on the original submitted claim.
- NM104 is equal to 2010BA-NM104 (Member First Name) on the original submitted claim.
- NM105 is equal to 2010BA-NM105 (Member Middle Initial) on the original submitted claim.
- NM108 is equal to 2010BA-NM108 (Identification Code Qualifier) on the original submitted claim.
- NM109 is equal to 2010BA-NM109 (Member ID) on the original submitted claim.

TED: This segment reports errors or warnings about the data referenced within the OTI Loop.

Example:

TED*024**CLM*21*2~

- TED01 is equal to '24' (Other Unlisted Reason).
- TED03 is equal to the segment ID and segment position within the original transaction set of the data referenced within this TED segment.
- TED04 is equal to the segment position within the transaction set that contains the error. If segment is missing, it is the numerical count position of the next identifiable segment in the transaction set.

- TED05-1 is equal to the element position in the segment. It indicates the relative position of a simple data element or the relative position of a composite data structure with relative position of the component within the composite data structure in error in the data segment.
- TED05-2 is equal to the component data element position in a composite. This will always be present if RED06 applies to a repeating data element.
- TED07 is a copy of the bad data element on the original submitted claim unless invalid characters are present or data is missing on the original submitted claim.

CTX: This segment is used to identify the segment ID and segment position within the original transaction set of the data that triggered the situational requirement.

Example:

CTX*Segment SV1 Element 782*SV2*47**2*782~

- CTX01-1 contains the name or 'TAG' of a context, such as the industry name (e.g., Segment SBR element 1069).
- CTX02 contains the segment ID of the data segment in error. (e.g., SBR).
- CTX03 contains the segment position in the transaction set.
- CTX04 contains the loop identifier code if the situational requirement relates to a loop.
- CTX05-1 contains the element position in a segment. This indicates the relative position of a simple data element, or the relative position of a composite data structure with the relative position of the component within the composite data structure, in error, in the data segment the count starts with 1 for the simple data element or composite data structure immediately following the Segment ID.
- CTX05-2 contains the component data element position in a composite. This identifies the component data element position within the composite that is in error.
- CTX06-1 contains the data element number or composite element at the segment level.
- STC06-2 contains the data element within a composite.

RED: This segment is used to provided error or informational message location.

Example:

RED*NA**94**IBP*E053~

- RED01 will always contain the value of 'NA'.
- RED03 will always contain the value of '94'.
- RED05 will always contain the value of 'IBP'.
- RED06 contains the application error code for insurance business process from external code source '895'. The first position is always an alpha character and used to report an Error 'E' or Warning 'W'. The definitions of the codes are as follows:

Code	Description
E001 / W001	Missing/Invalid submitter identifier
E002 / W002	Missing/Invalid receiver identifier

Code	Description
E003 / W003	Missing/Invalid member identifier
E004 / W004	Missing/Invalid subscriber identifier
E005 / W005	Missing/Invalid patient identifier
E006 / W006	Missing/Invalid plan sponsor identifier
E007 / W007	Missing/invalid payee identifier
E008 / W008	Missing/Invalid TPA/broker identifier
E009 / W009	Missing/Invalid premium receiver identifier
E010 / W010	Missing/Invalid premium payer identifier
E011 / W011	Missing/Invalid payer identifier
E012 / W012	Missing/Invalid billing provider identifier
E013 / W013	Missing/Invalid pay to provider identifier
E014 / W014	Missing/Invalid rendering provider identifier
E015 / W015	Missing/Invalid supervising provider identifier
E016 / W016	Missing/Invalid attending provider identifier
E017 / W017	Missing/Invalid other provider identifier
E018 / W018	Missing/Invalid operating provider identifier
E019 / W019	Missing/Invalid referring provider identifier
E020 / W020	Missing/Invalid purchased service provider identifier
E021 / W021	Missing/Invalid service facility identifier
E022 / W022	Missing/Invalid ordering provider identifier
E023 / W023	Missing/Invalid assistant surgeon identifier
E024 / W024	Amount/Quantity out of balance
E025 / W025	Duplicate
E026 / W026	Billing date predates service date
E027 / W027	Business application currently not available
E028 / W028	Sender not authorized for this transaction
E029 / W029	Number of errors exceeds permitted threshold
E030 / W030	Required loop missing
E031 / W031	Required segment missing
E032 / W032	Required element missing
E033 / W033	Situational required loop is missing
E034 / W034	Situational required segment is missing
E035 / W035	Situational required element is missing
E036 / W036	Data too long
E037 / W037	Data too short
E038 / W038	Invalid external code value
E039 / W039	Data value out of sequence

Code	Description
E040 / W040	"Not Used" data element present
E041 / W041	Too many sub-elements in composite
E042 / W042	Unexpected segment
E043 / W043	Missing data
E044 / W044	Out of range
E045 / W045	Invalid date
E046 / W046	Not matching
E047 / W047	Invalid combination
E048 / W048	Customer identification number does not exist
E049 / W049	Duplicate batch
E050 / W050	Incorrect data
E051 / W051	Incorrect date
E052 / W052	Duplicate transmission
E053 / W053	Invalid claim amount
E054 / W054	Invalid identification code
E055 / W055	Missing or invalid issuer identification
E056 / W056	Missing or invalid item quantity
E057 / W057	Missing or invalid item identification
E058 / W058	Missing or unauthorized transaction type code
E059 / W059	Unknown claim number
E060 / W060	Bin segment contents not in MIME format
E061 / W061	Missing/invalid MIME header
E062 / W062	Missing/Invalid MIME boundary
E063 / W063	Missing/Invalid MIME transfer encoding
E064 / W064	Missing/Invalid MIME content type
E065 / W065	Missing/Invalid MIME content disposition (filename)
E066 / W066	Missing/Invalid file name extension
E067 / W067	Invalid MIME base64 encoding
E068 / W068	Invalid MIME quoted-printable encoding
E069 / W069	Missing/Invalid MIME line terminator (should be CR+LF)
E070 / W070	Missing/Invalid "end of MIME" headers
E071 / W071	Missing/Invalid CDA in first MIME body parts
E072 / W072	Missing/Invalid XML tag
E073 / W073	Unrecoverable XML error
E074 / W074	Invalid Data format for HL7 data type
E075 / W075	Missing/Invalid required LOINC answer part(s) in the CDA
E076 / W076	Missing/Invalid Provider information in the CDA

Code	Description
E077 / W077	Missing/Invalid Patient information in the CDA
E078 / W078	Missing/Invalid Attachment Control information in the CDA
E079 / W079	Missing/Invalid LOINC
E080 / W080	Missing/Invalid LOINC Modifier
E081 / W081	Missing/Invalid LOINC code for this attachment type
E082 / W082	Missing/Invalid LOINC Modifier for this attachment type
E083 / W083	Situational prohibited element is present
E084 / W084	Duplicate qualifier value in repeated segment within a single loop
E085 / W085	Situational required composite element is missing
E086 / W086	Situational required repeating element is missing
E087 / W087	Situational prohibited loop is present
E088 / W088	Situational prohibited segment is present
E089 / W089	Situational prohibited composite element is present
E090 / W090	Situational prohibited repeating element is present
E091 / W091	Transaction successfully received but not processed as applicable business function not performed.

For additional information, consult the Application Reporting (824) Guide. It can be obtained by logging onto www.wpc-edi.com.

8.3 Report Inventory

There are no acknowledgement reports at this time.

9 Trading Partner Agreements

Providers who intend to conduct electronic transactions with Georgia Medicaid must sign the Georgia Medicaid Trading Partner Agreements. A copy of the agreement is available on the GAMMIS Web Portal page EDI >> Registration Forms.

Trading Partners

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

Payers 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.

10 Transaction Specific Information

This section describes how ASC X12N Technical Report Type 3 (TR3) Implementation Guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Georgia Medicaid has something additional, over and above, the information in the TR3s. That information can:

- Limit the repeat of loops, or segments
- Limit the length of a simple data element
- Specify a sub-set of the TR3s internal code listings
- Clarify the use of loops, segments, composite and simple data elements
- Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Georgia Medicaid

In addition to the row for each segment, one or more additional rows are used to describe Georgia Medicaid's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

10.1 837I Encounter (Inbound)

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
68		BHT	Beginning of Hierarchical Transaction			
68		BHT02	Transaction Set Purpose Code	00, 18		
			Original	00	2	
69		BHT06	Transaction Type Code	31, CH, RP		
			Reporting	RP	2	
71	1000A	NM1	Submitter Name			
72	1000A	NM109	Identification Code		2 / 10	CMO Regional Medicaid Provider ID.
73	1000A	PER	Submitter EDI Contact Information			
74	1000A	PER02	Name		1/60	Required if different than the name contained in the Submitter Name (Loop

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						1000A-NM1 segment).
74	1000A	PER03	Communication Number	EM, FX, TE		
			Telephone	TE	2	
74	1000A	PER04	Communication Number		10	Submitter Contact Telephone Number
76	1000B	NM1	Receiver Name			
77	1000B	NM103	Name Last or Organization Name		1/60	'GEORGIA FAMILIES'
77	1000B	NM109	Identification Code		5	'77034' – GAMMIS Payer ID.
80	2000A	PRV	Billing Provider Specialty Information			
80	2000A	PRV01	Provider Code	BI	2	
80	2000A	PRV02	Reference Identification Qualifier	PXC	3	
80	2000A	PRV03	Provider Specialty Code		10	Billing Provider Taxonomy Code
84	2010AA	NM1	Billing Provider Name			
86	2010AA	NM108	Identification Code Qualifier	XX	2	
86	2010AA	NM109	Identification Code		10	Billing Provider NPI
88	2010AA	N4	Billing Provider City, State, Zip Code			
89	2010AA	N403	Zip Code		9	Billing Provider Zip Code + 4 digit postal code (excluding punctuation and blanks).
90	2010AA	REF	Billing Provider Tax Identification			Healthcare providers must send NPI in the associated NM109. EIN required within this loop. Non-Healthcare providers must send the Georgia Medicaid Provider ID within the 2010BB-REF02, where REF01=G2.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
90	2010AA	REF01	Reference Identification Qualifier	EI	2	
90	2010AA	REF02	Reference Identification		9	
107	2000B	HL	Subscriber Hierarchical Level			For Georgia Medicaid, the insured and the patient are always the same person. Use this HL segment to identify the member and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop will fail compliance (SNIP Level 7).
108	2000B	HL04	Hierarchical Child Code	0, 1		
			No Subordinate HL Segment in This Hierarchical Structure	0	1	For Georgia Medicaid the Member is the Subscriber so there should never be a Dependent Level.
109	2000B	SBR	Subscriber Information			
109	2000B	SBR01	Payer Responsibility Sequence Number Code	A-H, P, S, T, U		
			Secondary (Primary COB)	S	1	
			Tertiary (Secondary COB)	T	1	
110	2000B	SBR09	Claim Filing Indicator Code	11-17, AM, BL, CH, CI, DS, FI, HM, LM, MA, MB, MC, OF, TV, VA, WC, ZZ		
			Medicaid	MC	2	The value sent at this level should always be 'MC'.
112	2010BA	NM1	Subscriber Name			

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
113	2010BA	NM102	Entity Type Qualifier	1, 2		
			Person	1	1	
113-114	2010BA	NM108	Identification Code Qualifier	II, MI		
			Member Identification Number	MI	2	
114	2010BA	NM109	Identification Code		12	12-digit Georgia Member Medicaid ID.
122	2010BB	NM1	Payer Name			
123	2010BB	NM103	Name Last or Organization Name		26	'GEORGIA FAMILIES'
124	2010BB	NM108	Identification Code Qualifier	PI, XV		
			Payor Identification	PI	2	
124	2010BB	NM109	Identification Code		5	'77034' – GAMMIS Payer ID.
125	2010BB	N4	Payer City, State, Zip Code			
125	2010BB	N401	City Name		6	'TUCKER'
125	2010BB	N402	State or Province Code		2	'GA'
126	2010BB	N403	Postal Code		9	'300855201'
129	2010BB	REF	Billing Provider Secondary Identification			Required segment for non-healthcare providers who are unable to obtain an NPI ID.
129	2010BB	REF01	Reference Identification Qualifier	G2, LU		
			Provider Commercial Number	G2	2	
130	2010BB	REF02	Reference Identification		10	Georgia Medicaid Provider ID
143	2300	CLM	Claim Information			
144	2300	CLM01	Claim Submitter's Identifier		1/38	Patient Account Number GF is requiring a concatenated field for the CLM01 element. This will

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						allow maximum usage of this element to carry multiple information segments inside the single element. These sub-elements will not be separated by the ":", but merely concatenated together. Although this format is not required by the TR3 Implementation Guide, it will be required by GF for correct processing and evaluation of the encounter. See next fields for CLM01 specifications. **Note**: If, a claim fails compliance at the claim level and the 837 received contains the 2300-REF02, where REF01=D9, that value is returned within the REF02 on the 824, where REF01=X1. However, if the REF01=D9 is not present on the 837 and the claim fails compliance at the claim level, the value received in the CLM01 will be returned.
			Media Type (Position 1)		1	The Media Type will be the first byte of the CLM01 element in the X12 837 transaction. **P** – Paper **E** – Electronic **W** – Web **I** – IVR **R** – Portal
			Claim Status (Position 2)		1	The Claim Status will be the second byte of the CLM01 element in the X12 837 transaction. **P** – Paid

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						D – Denied
			CMO Claim Number/Patient Control Number (Positions 3-38)		1/36	The CMO Claim number combined with the Providers Patient Control Number will be in positions 3-38.
145	2300	CLM05-1	Facility Type Code		2	Enter the 2-digit Place of Service (POS) code at the claim header. **Note**: If the POS is not received at the detail, the header POS will be copied to the detail for processing.
145	2300	CLM05-2	Facility Code Qualifier	A		
145	2300	CLM05-3	Claim Frequency Type Code	1, 7, 8	1	Value indicates whether the current claim is an original claim, a void, or an adjustment. '1' = Original Claim '7' = Adjustment (Replacement of Paid Claim) '8' = Void (Credit only) The ICN to Credit should be placed in the REF02, where REF01=F8. Providers must use the most recently paid ICN when voiding or adjusting a claim.
149	2300	DTP	Discharge Hour			
149	2300	DTP01	Date/Time Qualifier	096	3	
149	2300	DTP02	Date Time Period Format Qualifier	TM	2	
149	2300	DTP03	Date Time Period		8	Discharge Hour (HHMM)
150	2300	DTP	Statement Dates			
150	2300	DTP01	Date/Time Qualifier	434	3	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
150	2300	DTP02	Date Time Period Format Qualifier	RD8	3	
150	2300	DTP03	Date Time Period		17	Statement From / Through Date. (CCYYMMDD-CCYYMMDD) When the statement is for a single date of service, the from/through date are the same.
153	2300	CL1	Institutional Claim Code			
153	2300	CL101	Admission Type Code		1	Required when patient is being admitted for inpatient services.
153	2300	CL102	Admission Source Code		1	Required for all inpatient and outpatient services when TOB (CLM05-1) = 11, 13, 14, 21, 22, 32 or 33.
158	2300	CN1	Contract Information			Use this segment if the rendering provider is Capitated by the CMO. CLM02 should be a value of zero. The paid amounts by line item should be zero.
158	2300	CN101	Contract Type Code	01-06, 09	1	
			Capitated	05	2	
166	2300	REF	Payer Claim Control Number			
166	2300	REF01	Reference Identification Qualifier	F8	2	
166	2300	REF02	Reference Identification		13	Enter the 13-digit assigned to the original claim submission. (ICN to be credit/ voided). Required if resubmitting a previously accepted encounter. Used in case for replacement.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
170	2300	REF	Claim Identifier for Transmission Intermediaries			
170	2300	REF01	Reference Identification Qualifier	D9	2	
170	2300	REF02	Reference Identification		1/20	Value Added Network Trace Number (Maximum Length Allowed = 20). This value will be returned on the 824 if the claim fails compliance at the claim level.
184	2300	HI	Principal Diagnosis			
184-185	2300	HI01-1	Code List Qualifier Code	ABK, BK	2/3	'ABK' – ICD-10 'BK' – ICD-9
185	2300	HI01-2	Industry Code		3/7	For ICD-10, length allowed is 3-7. For ICD-9, length allowed is 3-5.
187	2300	HI	Admitting Diagnosis			
188	2300	HI01-1	Code List Qualifier Code	ABJ, BJ	2/3	'ABJ' – ICD-10 'BJ' – ICD-9
188	2300	HI01-2	Industry Code		3/7	For ICD-10, length allowed is 3-7. For ICD-9, length allowed is 3-5.
189	2300	HI	Patient's Reason for Visit			Required when Type of Bill (CLM05-1) equals 13 or 85 AND Admission Type (CL101) equals 1, 2 or 5 AND Revenue Code (SV201) equals 045x, 0516, 0526 or 0762.
190	2300	HI01-1	Code List Qualifier Code	APR, PR	2/3	'APR' – ICD-10 'PR' – ICD-9
190	2300	HI01-2	Industry Code		3/7	For ICD-10, length allowed is 3-7. For ICD-9, length allowed is 3-5.
193	2300	HI	External Cause of Injury			
194	2300	HI01-1	Code List Qualifier Code	ABN, BN	2/3	'ABN' – ICD-10

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						'BN' – ICD-9
194	2300	HI01-2	Industry Code		3/7	For ICD-10, length allowed is 3-7. For ICD-9, length allowed is 3-5.
196	2300	HI02-1	Code List Qualifier Code	ABN, BN	2/3	Required if HI01-1=ABN. 'ABN' – ICD-10 'BN' – ICD-9
			ICD-10-CM	ABN	3	Required if HI01-1=ABN.
196	2300	HI02-2	Industry Code		3/7	For ICD-10, length allowed is 3-7.
198	2300	HI03-1	Code List Qualifier Code	ABN, BN	2/3	Required if HI01-1=ABN. 'ABN' – ICD-10 'BN' – ICD-9
			ICD-10-CM	ABN	3	Required if HI01-1=ABN.
198	2300	HI03-2	Industry Code		3/7	For ICD-10, length allowed is 3-7.
218	2300	HI	Diagnosis Related Group (DRG) Information			
218	2300	HI01-1	Code List Qualifier Code	DR	2	
219	2300	HI01-2	Industry Code		3/5	
220	2300	HI	Other Diagnosis Information			Other Diagnosis Codes that co-exist with the principal diagnosis co-exist at the time of admission or develops subsequently during member's treatment. The 837I allows for 2 Other Diagnosis Information segments for a total of 24 other diagnosis codes per claim.
221	2300	HI01-1	Code List Qualifier Code	ABF, BF	2/3	'ABF' – ICD-10 'BF' – ICD-9
221	2300	HI01-2	Industry Code		3/7	For ICD-10, length allowed is 3-7.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						For ICD-9, length allowed is 3-5.
239	2300	HI	Principal Procedure Information			
240	2300	HI01-1	Code List Qualifier Code	BBR, BR, CAH		
			ICD-10-PCS	BBR	3	
			ICD-9-CM	BR	2	
240	2300	HI01-2	Industry Code		3/7	For ICD-10, length allowed is 3-7. For ICD-9, length allowed is 3-4.
240	2300	HI01-3	Date Time Period Format Qualifier	D8	2	
240	2300	HI01-4	Date Time Period		8	Principal Procedure Date. (CCYYMMDD)
242	2300	HI	Other Procedure Information			
243	2300	HI01-1	Code List Qualifier Code	BBQ, BQ	2/3	
243	2300	HI01-2	Industry Code		3/7	For ICD-10, length allowed is 3-7. For ICD-9, length allowed is 3-4.
243	2300	HI01-3	Date Time Period Format Qualifier	D8	2	
243	2300	HI01-4	Date Time Period		8	Other Procedure Date. (CCYYMMDD)
Note: For those HI Segments Page 220 thru Page 312 within the 837I TR3 Implementation Guide that can repeat multiple times and allow up to 12 occurrences of information within each segment all will be captured and stored within the MMIS.						
319	2310A	NM1	Attending Provider Name			Required for Inpatient Services. The 2310A Attending Provider Loop will also be used to capture 'Ordering Provider' for those claims that are the results of

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						order/referral.
321	2310A	NM108	Identification Code Qualifier	XX	2	
321	2310A	NM109	Identification Code		10	Attending Provider NPI ID.
322	2310A	PRV	Attending Provider Specialty Information			
322	2310A	PRV02	Reference Identification Qualifier	PXC	3	
322	2310A	PRV03	Provider Specialty Code		10	Attending Provider Taxonomy Code. Used for claims submitted with NPI ID.
324	2310A	REF	Attending Provider Secondary Identification			Used for non-healthcare providers who are unable to obtain an NPI ID.
324	2310A	REF01	Reference Identification Qualifier	0B, 1G, G2, LU		
			Provider Commercial Number	G2	2	
325	2310A	REF02	Reference Identification		10	If, REF01=G2 value equals Georgia Medicaid Provider ID.
326	2310B	NM1	Operating Physician Name			
327	2310B	NM101	Entity Identifier Code	72	2	
328	2310B	NM108	Identification Code Qualifier	XX	2	
328	2310B	NM109	Identification Code		10	Operating Physician NPI ID.
331	2310C	NM1	Other Operating Physician Name			
332	2310C	NM101	Entity Identifier Code	ZZ	2	
333	2310C	NM108	Identification Code Qualifier	XX	2	
333	2310C	NM109	Identification Code		10	Other Operating Physician NPI ID.
334	2310C	REF	Other Operating Physician Secondary Identification			Used for non-healthcare providers who are unable to obtain an NPI ID.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
334	2310C	REF01	Reference Identification Qualifier	0B, 1G, G2, LU		
			Provider Commercial Number	G2	2	
335	2310C	REF02	Reference Identification		10	If, REF01=G2 value equals Georgia Medicaid Provider ID.
341	2310E	NM1	Service Facility Provider Name			
342	2310E	NM101	Entity Identifier Code	77	2	
342	2310E	NM108	Identification Code Qualifier	XX	2	
342	2310E	NM109	Identification Code		10	Service Facility Provider NPI ID.
345	2310E	N4	Service Facility Location City, State, Zip Code			
346	2310E	N403	Zip Code		9	Service Facility Provider Zip Code + 4 postal code (excluding punctuation and blanks)
347	2310E	REF	Other Operating Physician Secondary Identification			Used for non-healthcare providers who are unable to obtain an NPI ID.
347	2310E	REF01	Reference Identification Qualifier	0B, G2, LU		
			Provider Commercial Number	G2	2	
348	2310E	REF02	Reference Identification		10	If, REF01=G2 value equals Georgia Medicaid Provider ID.
349	2310F	NM1	Referring Provider Name			
350	2310F	NM101	Entity Identifier Code	DN	2	
351	2310F	NM108	Identification Code Qualifier	XX	2	
351	2310F	NM109	Identification Code		10	Referring Provider NPI ID.
352	2310F	REF	Referring Provider Secondary Identification			Used for non-healthcare providers who are unable to

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						obtain an NPI ID.
352-353	2310F	REF01	Reference Identification Qualifier	0B, 1G, G2		
			Provider Commercial Number	G2	2	
353	2310F	REF02	Reference Identification		10	Georgia Medicaid Provider ID
354	2320	SBR	Other Subscriber Information			
355	2320	SBR01	Payer Responsibility Sequence Number Code	A-H, P, S, T, U		CMO COB information will always be Primary and required in order for pricing to work effectively. This is also true for the corresponding segment occurrences associated with the Primary COB/CMO iteration.
			Primary (Always CMO)	P	1	
			Secondary (Primary COB)	S	1	
			Tertiary (Secondary COB)	T	1	
355	2320	SBR02	Relationship Code	01, 18-21, 39-40, 53, G8	2	'18' for CMO. For all other relationships use one of the other listed values.
356	2320	SBR09	Claim Filing Indicator Code	11-17, AM, BL, CH, CI, DS, FI, HM, LM, MA, MB, MC, OF, TV, VA, WC, ZZ	2	'MC' for CMO. For all other relationships use one of the other listed values.
358	2320	CAS	Claim Level Adjustments			
359-363	2320	CAS02, CAS05, CAS08, CAS11, CAS14,	Adjustment Reason Code		1/3	All external code source values from code source 139 are allowed. Use "225" for interest. Any

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		CAS17				interest paid for the claim should be reported in a CAS segment. Note: Do not report interest paid as a separate line item on the encounter record.
364	2320	AMT	Coordination of Benefits (COB) Payer Paid Amount			
364	2320	AMT01	Amount Qualifier Code	D	1	
364	2320	AMT02	Payer Paid Amount		10	CMO Amount Paid when Primary, otherwise Amount paid per COB. It is acceptable to show "0" amount paid.
377	2330A	NM1	Other Subscriber Name			
379	2330A	NM108	Identification Code Qualifier	II, MI		
			Member Identification Number	MI	2	
379	2330A	NM109	Identification Code		12	12-digit Georgia Member Medicaid ID.
384	2330B	NM1	Other Payer Name			
385	2330B	NM109	Identification Code		2/80	This number must be identical to at least once occurrence of the 2430-SVD01 to identify the other payer if the 2430 loop is present. Georgia Medicaid captures third party payment amount(s) from the service line(s) in 2430-SVD02. **Note:** The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						to 15 times for a single detail.
389	2330B	DTP	Claim Check or Remittance Date			
389	2330B	DTP01	Date Claim Paid	573	3	
389	2330B	DTP02	Date Time Period Format Qualifier	D8	2	
389	2330B	DTP03	Date Time Period		8	Adjudication Date (CCYYMMDD) Date claim was received by CMO.
395	2330B	REF	Other Payer Claim Control Number			
395	2330B	REF01	Reference Identification Qualifier	F8	2	
395	2330B	REF02	Reference Identification		1/50	CMO Internal Control Number.
423	2400	LX	Service Line Number			
423	2400	LX01	Line Counter		2	Georgia Medicaid will accept up to the HIPAA allowed 999 detail lines per claim.
424	2400	SV2	Institutional Service Line			
424	2400	SV201	Service Line Revenue Code		4	
425	2400	SV202-1	Product/Service ID	ER, HC, HP, IV, WK		
			HCPCS Code	HC	2	
428	2400	SV205	Service Unit Count		5	Enter the number of days spent in hospital or at home. Georgia Medicaid will process only the whole number when units are entered with decimals. Example: Units entered on the transaction 3.75 will be

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						processed as 3 units.
471	2420D	NM1	Referring Provider			Required if referring provider is different than reported in 2310F.
473	2420D	NM108	Identification Code Qualifier	XX	2	
473	2420D	NM109	Identification Code		10	Referring Provider NPI ID.
474	2420D	REF	Referring Provider Secondary Identification			Used for non-healthcare providers who are unable to obtain an NPI ID.
474-475	2420D	REF01	Reference Identification Qualifier	0B, 1G, G2		
			Provider Commercial Number	G2	2	
475	2420D	REF02	Reference Identification		10	Georgia Medicaid Provider ID.
476	2430	SVD	Line Adjudication Information			
476	2430	SVD01	Identification Code		2/80	This number should match one occurrence of the 2330B-NM109 identifying Other Payer.
477	2430	SVD02	Service Line Paid Amount		1/10	Service Line Paid Amount.
480	2430	CAS	Claim Level Adjustments			
482-484	2430	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17	Adjustment Reason Code		1/3	All external code source values from code source 139 are allowed.
486	2430	DTP	Claim Check or Remittance Date			
486	2430	DTP01	Date/Time Qualifier	573	3	
486	2430	DTP02	Date Time Period Format Qualifier	D8	2	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
486	2430	DTP03	Date Time Period		8	Adjudication Date or CMO Paid Date. (CCYYMMDD)

11 Appendices

11.1 Implementation Checklist

This appendix contains all necessary steps for going live with Georgia Medicaid.

1. Call the HP Enterprise Services EDI Services Team with any questions at the Toll Free Number.
2. Check the Georgia Web Portal http://www.mmis.georgia.gov regularly for the latest updates.
3. Confirm you have completed your TPA Agreement and been assigned a Trading Partner ID.
4. Make the appropriate changes to your systems/business processes to support the updated companion guides:
    - If you use third party software, work with your software vendor to have the appropriate software installed.
    - If testing system-to-system (Real-Time) interface the Trading Partner or provider must work with your software vendor to have the appropriate software installed at their sites(s) prior to performing testing with Georgia Medicaid.
5. Identify the transactions you will be testing:
    - Health Care Eligibility/Benefit Inquiry and Information Response (270/271)
    - Health Care Claim Status Request and Response (276/277)
    - Health Care Premium Payment (820)
    - Health Care Benefit Enrollment and Maintenance (834)
    - Health Care Payment/Advice (835)
    - Health Care Claim: Dental (837D)
    - Health Care Claim: Institutional (837D)
    - Health Care Claim: Professional (837P)
6. Confirm you have reported all the NPIs you will be using for testing by validating them with Georgia Medicaid. Make sure your claim(s) successfully pay to your correct Provider ID, if you have associated multiple Georgia Medicaid provider IDs to one NPI and/or taxonomy code.
    - If the entity testing is a billing intermediary or software vendor, they should use the provider's identifiers on the test transaction.
7. When submitting test files, make sure the members/claims you submit are representative of the type of service(s) you provide to Georgia Medicaid members.
8. Schedule a tentative week for the initial test.
9. Confirm the email/phone number of the testing contact and confirm that the person you are speaking with is the primary contact for testing purposes.

11.2 Transmission Example

This is an example of a batch file containing one claim. For Georgia Medicaid batch files have the ability to loop at the functional group, transaction and hierarchical levels. Each functional group within an interchange has to be the same transaction type.

ISA*00* *00* *ZZ*TPID *ZZ*77034 *130326*0800*^*00501*505043666*0 *T*:~
GS*HC*TPID*77034*20130326*0800*135260*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*130871338*20130328*0138*RP~
NM1*41*2*SUBMITTER INC*****46*12345~
PER*IC*CONTACT NAME*TE*4041231234~
NM1*40*2*GEORGIA FAMILIES*****46*77034~
HL*1**20*1~
NM1*85*2*BILLING PROVIDER*****XX*BILLPNPIID5~
N3*BILL PROV STREET~
N4*ATLANTA*GA*303686229~
REF*EI*BILLTAXID~
HL*2*1*22*0~
SBR*S*18*******MC~
NM1*IL*1*MEMLNAME*MEMFNAME****MI*MEMID1234567~
N3*123 MEMBER STREET~
N4*BUFORD*GA*30518~
DMG*D8*19531207*M~
NM1*PR*2* GEORGIA FAMILIES *****PI*77034~
N4*TUCKER*GA*300855202~
REF*G2*MEDICAIDPROVIDERID~
CLM*EPPATACT1*2138.61***11:A:1**A*Y*Y~
DTP*096*TM*0012~
DTP*434*RD8*20120703-20120705~
DTP*435*DT*201207030014~
CL1*4*5*01~
REF*D9*TRACENUM~
HI*BK:V3000~
HI*BJ:V3000~
HI*DR:0391~
HI*BF:V053~
HI*BR:9547:D8:20120703~
NM1*71*1*PROVLNAME*PROVFNAME****XX*NPIID~
PRV*AT*PXC*208000000X~
SBR*P*18*105010610******MC~

CAS*CO*172*148.19~
AMT*D*1393.52~
OI***Y***Y~
NM1*IL*1*MEMLNAME*MEMFNAME****MI*MEMID1234567~
N3*123 MEMBER STREET~
N4*BUFORD*GA*30518~
NM1*PR*2*CMO*****PI*TPID~
DTP*573*D8*20120724~
REF*F8*CMOICN~
LX*1~
SV2*0171**1190.5*DA*2~
SVD*TPID*1393.52**0171*2~
CAS*CO*45*-203.02~
DTP*573*D8*20120730~
LX*2~
SV2*0250**60.1*UN*2~
SVD*TPID*0**0250*2~
CAS*CO*45*60.1~
DTP*573*D8*20120730~
LX*3~
SV2*0270**91.38*UN*3~
SVD*TPID*0**0270*3~
CAS*CO*45*91.38~
DTP*573*D8*20120730~
LX*4~
SV2*0270**108.17*UN*1~
SVD*TPID*0**0270*1~
CAS*CO*45*108.17~
DTP*573*D8*20120730~
LX*5~
SV2*0300**35.96*UN*2~
SVD*TPID*0**0300*2~
CAS*CO*45*35.96~
DTP*573*D8*20120730~
LX*6~
SV2*0301**451.84*UN*6~
SVD*TPID*0**0301*6~
CAS*CO*45*451.84~
DTP*573*D8*20120730~
LX*7~

SV2*0471**82.6*UN*1~
SVD*TPID*0**0471*1~
CAS*CO*45*82.6~
DTP*573*D8*20120730~
LX*8~
SV2*0636**118.06*UN*2~
SVD*TPID*0**0636*2~
CAS*CO*45*118.06~
DTP*573*D8*20120730~
SE*83*0001~
GE*1*135260~
IEA*1*505043666~

11.3 Frequently Asked Questions

This appendix contains a compilation of questions and answers relative to Georgia Medicaid and its providers.

Q: As a trading partner or clearinghouse, who should I contact if I have questions about testing, specifications, trading partner enrollment or if I need technical assistance with electronic submission?

A: EDI testing and trading partner enrollment support is available Monday through Friday 8a.m.-5p.m. by calling toll-free at (877) 261-8785 or locally at (770) 325-9590.

Q: Who should I contact if I have questions pertaining to billing or to check on the status of a submitted claim?

A: Providers should contact the Provider Contact Center for any non-EDI related questions or GAMMIS Web Portal assistance by calling the Interactive Voice Response System (IVRS) toll-free at (800) 766-4456 or locally at (770) 325-9600.

Q: After I submit my EDI Trading Partner Agreement Form, when should I expect to receive my Trading Partner ID?

A: Once we receive your EDI enrollment in the mail and process it, which takes 1-5 days, you should receive your trading partner Web Portal logon credentials by e-mail immediately. You will also receive your EDI Welcome Letter by mail within 5-7 business days of your application being approved. If your trading partner logon credentials were not received, contact EDI Services Monday-Friday 8a.m.-5p.m. EST at (877) 261-8785 or locally at (770) 325-9590, or submit a Contact Us Inquiry on the GAMMIS Web Portal. For authentication purposes, please be prepared with your Trading Partner Name, Trading Partner ID assigned, and Mailing Address.

Q: What are the steps that Providers need to take to begin sending EDI Transactions and testing with HP Enterprise Services?

A: All providers must already be enrolled with Georgia Medicaid to apply for EDI Enrollment, unless using a clearinghouse, software vendor, or billing agent. However, providers may also enroll as direct electronic submitters using the EDI Trading Partner Agreement. A copy of the EDI Agreement can be downloaded from the GAMMIS Web Portal on the EDI >> Registration Forms page. Once approved to send EDI transactions, all providers/submitters (except those using an enrolled clearinghouse, software vendor, or billing agent) will be required to go through testing using their chosen EDI software, clearinghouse, or vendor. Testing is not required for use of the PES software. Providers can contact EDI Services toll-free at (877) 261-8785 or locally at (770) 325-9590 for additional details regarding EDI transactions, testing, and PES training. Providers can begin testing files in Ramp Manager immediately. Once testing is passed, providers should submit the necessary EDI trading partner agreement (if enrolling for the first time) or the EDI Update form (if making a change to their transaction) to be made active in Production.

Q: How do I access Ramp Manager to test my transactions?

A: You can access Ramp Manager online by visiting the Georgia Health Partnership Ramp Management System at https://sites.edifecs.com/index.jsp?gamedicaid.

Q: Is there a certain number of test files that need to be sent through Ramp Manager?

A: No; however, HP Enterprise Services requires a test file to pass compliance for each transaction type and trading partner that will be sending files. The status of each transaction should show “PASS” in Ramp Manager to show that you have successfully passed compliance before HP Enterprise Services can make you active.

Q: I am a provider. How do I enroll to receive my Remittance Advice electronically (835-ERA)?

A: Providers must complete and submit an HP Submitter Update Form indicating that they would like to receive an ERA835 for the payee ID. If you wish to delegate access to these 835 ERAs (Electronic Remittance Advice) so that your clearinghouse, software vendor, or billing agent can access these on your behalf, you must provide them access to your file downloads. Contact your clearinghouse, software vendor, or billing agent to get the e-mail address and username that you should grant access to, then follow the instructions in the GAMMIS Web Portal User Account Management Guide on the Provider Information >> Provider Manuals page. Refer to section 3.2, titled "Providers or Trading Partners Delegating Access to a Billing Agent or Trading Partner Account" for detailed instructions. You will need to grant the "Trade Files Download" role for a user to have access to your 835 ERA file.

Q: After I submit my provider enrollment application, when should I expect to receive my PIN letter in the mail?

A: You should receive your PIN letter within 5-7 business days of your Provider Enrollment application being approved. If you do not receive your PIN letter within this timeframe, please contact EDI Services Monday-Friday 8am-5pm EST at (877) 261-8785 or locally at (770) 325-9590, or submit a Contact Us Inquiry on the GAMMIS Web Portal. For authentication purposes, please be prepared with the provider's account information: provider's Name, provider ID, Tax ID/SSN, and the Mailing Address.

Q: Where is my PIN letter being sent?

A: PIN letters are sent to the provider's mailing address on file. If the mailing address shown on file is incorrect, providers must submit the Medicaid Change of Information form (as shown on the GAMMIS Web Portal under the Provider Information >> Provider Manuals page) to ensure the address is up–to-date before the PIN letter reissue request can be processed.

Q: How do I request and submit EDI files through the Web Portal?

A: Establish an internet connection to the provider secure Web Portal using your trading partner account logon credentials. Select the Trade Files menu in order to download and/or upload EDI files.

- **File Upload**
  The File Upload page allows the user to select a file from a local hard drive and upload it to the Georgia MMIS. The file extension should end in .txt. Users of the feature include clearinghouses, software vendors, third party agents, and providers that wish to upload batch EDI transactions directly, including claim and encounter submissions. To use the batch upload option, providers must use HIPAA-compliant software or vendors that can create required data in HIPAA-compliant ANSI X12 Addenda format.

- **File Download**
  The File Download page allows the user to select a file from the secure GAMMIS Web Portal and download it to their system. The download process begins when the download option is checked and the user selects the download button.

Q: How long are ERA835, 277U, 824 and/or 999's available for download on the GAMMIS Web Portal?

A: All outbound EDI transactions will be made available for download on the provider portal for six weeks from the date of creation. Providers and trading partners are encouraged to download the documents as soon as they are available.

Q: What types of acknowledgment reports will HP return following EDI submission?

A: A TA1 will be generated when errors occur within the interchange envelope ISA/IEA. If no TA1 is generated, by default an 824 Acknowledgment is returned to the trading partner for all 837P, 837I, and 837D claim transaction types. A 999 acknowledgement will be returned on batch 270

(Eligibility) and 276 (Claim Status) and failed 270 Real-Time (Eligibility Requests) and 276 Real-Time (Claim Status) transaction types. For those real-time 270 and 276 transactions that pass compliance, the respective 271 and 277 transactions will be generated. The 835 (ERA) will be returned to the payee provider or trading partner delegated by the provider if the claims were accepted electronically and forwarded for claims adjudication. The 277U (Unsolicited Claim Status Report) is returned if there was a problem with the claims that prevented the claims adjudication system from processing the claims (for example, Invalid NPI or Provider Not on File).

Q: Will electronic remittances (835) be returned in one file for all providers or a separate file for each provider?

A: There will be separate files for each provider.

Q: Will our trading partner number or submitter ID, as shown in the ISA06, be returned in the remittance advice 835 file?

A: No, the ISA08 and GS03 within the remittance advice 835 will contain the Payee Provider ID.

Q: What filename will be used for the 835 files?

A: As documented in the 835 companion guides, the filename will be in this format: BatchID_TransactionType_FileName_ProviderNumber_Sequence Number_ProcessDate.out.dat.

Q: Will HP Enterprise Services continue to send paper EOBs for providers that are receiving the Electronic Remittance Advice (ERA)?

A: No, unless specifically requested by the provider to receive both. Providers can notify EDI Services or the Provider Enrollment Unit if they wish to receive both the paper EOB and the ERA.

Q: Where can we find the Georgia Medicaid/PeachCare for Kids® HIPAA Companion Guides?

A: The companion guides are available on the Web Portal on the EDI >> Companion Guides page.

Q: Where can I find a copy of the HIPAA ANSI TR3 Implementation Guides?

A: The TR3 Implementation Guides must be purchased from the Washington Publishing Company at www.wpc-edi.com.

12 Change Summary

This section describes the differences between the current Companion Guide and previous guides(s).

Version	Date	Section/Pages	Descriptions
1.6	03/28/2013	Entire document	Complete revision to comply with CAQH® (Council for Affordable Quality Healthcare) CORE™ (Committee on Operating Rules for Information Exchange) v5010 Master Companion Guide Template. Transaction specific data elements, and their values, were not changed. All previous versions are obsolete.
2.0	4/29/2013	Logo on Cover Page Entire Document	Changed Logo on Cover Page to be the new branding logo. Changed any reference to TR3 to be TR3 Implementation Guide or Implementation Guides. Changed references to companion guide that were listed as 'document' to 'companion guide'.
2.1	12/12/2013	Section 7, page 22 Section 10.1, pages 42, 44 & 48	Added 7.10, Service Facility Location Name Information for Hospice. Removed 2310A-Referring Provider Information (NM1-REF) – Incorrect information for this companion guide. Added 2310A-NM1 Attending - Added note. Added 2310F Referring NM1, REF. Added 2420D Referring NM1, REF.
2.2	9/15/2014	Section 7	Modified section 7.3. Added sections 7.11 and 7.12.
2.3	11/20/2014	Section 7	Modified section 7.12.