Department of Health Care Finance (DHCF)

DC MMIS Core Solution

Companion Guide (CG)

DC Medicaid 837D Fee-for-Service (FFS) Claims

November 26, 2025

Version 1.7

This Companion Guide to the v5010 Accredited Standards Committee (ASC) X12N Implementation Guides and associated errata adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with Gainwell Technologies (Gainwell). Transmissions based on this Companion Guide, used in tandem with the v5010 ASC X12N 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 Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that exceeds the requirements or usages of data expressed in the Implementation Guides.

Change History

The following change history log contains a record of changes made to this document.

Version	Date	Author	Description
1.0	01/30/2025	Gainwell	Initial Document
1.1	02/05/2025	Leslie Lawson	Gainwell Tech Writer Review
1.2	06/11/2025	DC EDI SWS Team	Minor updates applied Unique ISA13 value required added Billing Provider PRV added LX Segment added
1.3	06/17/2025	Scott M. Bullington	Gainwell Tech Writer Review
1.4	08/18/2025	DC EDI SWS Team	Updated email contact
1.5	8/22/2025	Jessica DiBartolo	Gainwell Technical Writer Review
1.6	11/24/2025	DC EDI SWS Team	Updates applied: Moved SNIP 7 edits listing to section 5 from Appendix Service Facility edit was removed from A.4 table of SNIP 7 DC edits Provider edit hierarchy applied for Billing/Rendering Provider usage in A.4 table of SNIP 7 DC edits Updated transaction table Section 8 comments for Provider Data Usage to reflect the Provider Edit hierarchy Updated Billing/Rendering, NPI/Taxonomy, and Zip-Code usage Removed DC Medicaid Provider ID REF usages previously included in table Added Appendix sections as found in the Vendor Appendix reference document so they’re available in 837 CGs
1.7	11/26/2025	Jessica DiBartolo	Gainwell Technical Writer Review

Table of Contents

List of Tables

1. Introduction

1.1 Overview

This companion guide documents the transaction type listed below and further defines situational and required data elements that are used for processing claims for programs administered by DC Medicaid. This document is not the complete Electronic Data Interchange (EDI) transaction format specifications.

837 Healthcare Claim Dental (005010X224A2)

Refer to the ASC X12N Implementation Guides or 5010 Technical Report Type 3 (TR3) for information not supplied in this document, such as code lists, definitions, and edits. Data elements, segments, and loops not included in this guide are not used for processing transactions by DC Medicaid but must still be sent if the information is required for compliance with the ASC X12N version 5010A1 format.

1.2 Reference Information

X12N Implementation Guides or TR3s

The ASC X12N Implementation Guides or 5010 TR3s are standards developed by the X12 committee and published by the Washington Publishing Company (WPC): http://store.x12.org/store/healthcare-5010-consolidated-guides.

Overview of HIPAA Legislation

The HIPAA of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. 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. HIPAA serves to perform the following:

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

Compliance According to HIPAA

The HIPAA regulations at 45 Code of Federal Regulations (CFR) 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

Change the definition, data condition, or use of a data element or segment in a standard.
Add any data elements or segments to the maximum defined data set.
Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
Change the meaning or intent of the standard’s implementation specification(s).

Compliance According to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from the following:

Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
Modifying any requirement contained in the implementation guide.

2. Getting Started

2.1 Information for Existing DC Medicaid Trading Partners

What is Changing for DC Medicaid Trading Partners?

TP Registration: New and existing trading partners will need to complete an online trading partner registration and receive an updated trading partner ID (TPID) for use with Gainwell Technologies and DC Medicaid.

SFTP: Established trading partners using Secure File Transfer Protocol (SFTP) will need to request and complete an updated registration form and return to the DC Medicaid Electronic Data Interchange (EDI) Helpdesk.

TP Certification for Production EDI Submission: Trading partners must complete certification testing prior to submission of production transactions for DC Medicaid.

Receiver ID: ISA and GS Receiver ID value for DC Medicaid have been updated to use DCMEDICAID in place of the formerly used 100000 and 77033 ISA and GS values.

Unique ISA13 Required: For inbound DC Medicaid EDI submission, the ISA13 Interchange Control Number needs to be unique to each file and Trading Partner ID, or the file will reject as a duplicate submission.

SNIP: Strategic National Implementation Process (SNIP) Levels 1 through 7 will be applied to all file submissions to accelerate the identification and reporting of errors detected back to the submitting trading partner for correction and resubmission.

This includes Level 7 – Provider ID and Member ID business edits applied to validate the identifier values received against the new DC MMIS repository.

Replacement/Void Usage: For 837 Claim Void/Replacement adjustment submissions use 2300 REF with REF01 = F8 and REF02 = New DC MMIS ICN/TCN value as returned on the 277CA Claim Acknowledgement and 835 Remittance Advice outbound transactions from the New DC MMIS.

EDI Response Transactions: EDI response transactions have been updated for DC Medicaid and include the following transactions and report when applicable:

TA1 Acknowledgement
999 Acknowledgements
824 Application Reporting
Business Reject Report (BRR HTML Report)
277U Health Care Claim Pending Status Information
277CA Health Care Claim Acknowledgement

EDI Companion Guides: DC EDI trading partners should review the Companion Guide Transaction Tables for additional updates on DC Medicaid's support for the industry standard transaction types and code sets.

EDI Response Filenames: Response file naming conventions have also been updated for DC Medicaid and will reflect the following file naming convention. (See section A.2 for examples.)

See Section 6 - Table 1 for new DC MMIS EDI response transactions and usage.

2.2 Trading Partner Registration and Certification

To get started, visit the following link for DC Medicaid trading partner information and instructions on registration as a trading partner:

Link: [INSERT DC MEDICAID SPECIFIC URL HERE]

2.2.1 Trading Partner Questions

For any trading partner questions, or to receive assistance with registering for an assigned TPID, please use the link above or contact DC Medicaid EDI Help Desk.

Email: dcedi@gainwelltechnologies.com
Telephone: [DC Operations – EDI Helpdesk Phone #]

3. Testing with DC Medicaid

3.1 Certification Testing

All trading partners must first be registered and then tested for certification to submit production EDI transactions. Any trading partner may submit test EDI transactions once registration is completed. The Usage Indicator, populated in element 15 of the ISA of an X12 file, indicates if a file is a test or a production. The required production certification is required on a per transaction type basis. For example, a trading partner may be certified to submit 837P Professional claims but not certified to submit 837I Institutional claim files until after 837I certification testing is also completed by the trading partner.

3.2 SNIP Levels Applied

SNIP Levels 1 through 7 are applied to test and production EDI file submissions.

[DC CORE MMIS SNIP Levels – Policymaker Review & Approval Placeholder]

Trading partners must submit a set number of test files of a particular transaction type with a minimum number of transactions within each file. Each test file must pass validation without receiving any failures or rejections to become certified for production.

[INSERT DC MEDICAID SPECIFIC URL HERE]

3.2.1 837 Claim Transaction Test Files

A minimum of three test files must be submitted with a minimum of 15 transactions within each file. Trading partners can submit as many test files as are necessary to complete certification for the targeted transaction type. Each transaction type requires testing and certification to authorize the submission of production transaction files for DC Medicaid.

3.2.2 Review Testing and Certification Information

To begin testing, review the “EDI Certification Status” page of DC Core MMIS-Online under the “Account Maintenance” menu option to verify when testing for a particular transaction has been completed.

The EDI Certification Status page is found by logging into your trading partner account on the DC Core MMIS-Online website:

[INSERT DC MEDICAID SPECIFIC URL HERE]

Detailed instructions for retrieving and interpreting HIPAA validation acknowledgments may be found in the Business Scenarios and Transmission Examples Appendices found at the end of this Companion Guide.

4. EDI Connectivity Overview

The following secure EDI channels are available for use by registered trading partners contingent on completion of the required administrative tasks and approvals, where applicable.

4.1 Web Portal Upload and Retrieval (Batch Mode)

X12 batch files can be uploaded via the DC Core MMIS-Online web portal through use of the File Exchange X12 Upload option available to registered trading partners. The associated acknowledgments and responses to transactions submitted can be accessed by selecting the Download/Responses under the File Exchange menu.

For additional information, or to begin using the Web Portal upload/down EDI secure channel, please refer to the module DC CORE MMIS-Online user guides at:

[INSERT DC MEDICAID SPECIFIC URL HERE]

4.2 SFTP File Exchange (Batch Mode)

Trading partners who have submitted X12 transactions via SFTP in the past can be enabled to continue using SFTP for file submission and retrieval from their designated SFTP Pickup location. To complete the required SFTP registration required to enable use of this EDI secure channel, please contact the DC Medicaid EDI Helpdesk:

Email: [DC Operations – EDI Helpdesk Email Address]
Telephone: dcedi@gainwelltechnologies.com

4.3 Trading Partner File Retransmissions

This section provides Gainwell Technologies' specific procedures for re-transmissions.

ISA13 Interchange Control Number needs to be unique to each file and Trading Partner ID.

4.4 Passwords

Trading Partners create their own password at the time of registration and are required to update it every 60 days as per the DC CORE MMIS-Online requirements. Passwords must be at least seven characters long, contain at least one uppercase character, at least one numeral, and at least one special character.

5. Payer Business Rules and Limitations

5.1 DC Medicaid EDI 837 Claim File Submissions

Listed below are the transmission and transaction constraints associated with the submission of the 837 Healthcare claim transaction for DC Medicaid:

Only one Interchange per EDI transmission.
Only one transaction type per interchange is permitted for submission.
Maximum of 5,000 claims per EDI transmission.
Claims and encounters must always be submitted in separate files.
Use of a unique trading partner ISA13 value is required on each EDI file submission for a trading partner submitter (historical submitted values for DC Medicaid with the old DC MMIS are not applicable, just new DC MMIS submitted values going forward).
DC Medicaid does not allow dependents to be enrolled under a primary subscriber, rather all enrollees/members are primary subscribers within each DC Medicaid Program or Managed Care Organization (MCO).
Submissions by non-registered or non-approved trading partners will be rejected.
The subscriber is always the same as the patient (dependent). Data submitted in the Patient Hierarchical Level (2000C loop) will be ignored.
Inbound 837 transactions are validated through SNIP Levels 1 through 7.
Individual document level EDI validation is applied with errors reported via the 999, 824, and BRR EDI response files.

5.2 Level 7 Edits Applied for DC Medicaid 837 Claim Submissions

Table 1: SNIP Level 7 Edits as Applied to EDI 837 Transaction Files

SNIP 7 Edit	Edit Description
Transaction Set Purpose Code Edit	BHT02 must be equal to ‘00’ Original or 837 will reject.
EDI Input Class Edit	BHT06 must be equal to ‘CH’ Chargeable for DC Claim Submissions.
New Billing Provider Edit **Required Data:** NPI | Specialty | Zip (+4)	A valid NPI for DC Medicaid Billing Provider is required and is validated when submitted including a valid Tax ID in REF02 using the REF01 ‘EI’ qualifier. **Provider Validation Hierarchy DC Medicaid:** NPI -> Provider Specialty -> Zip (+4)

SNIP 7 Edit	Edit Description
New Rendering Provider Edit **Required Data:** NPI | Specialty | Zip (+4)	A valid NPI for DC Medicaid Rendering Provider is required and is validated when submitted on DC encounters and claims including a valid Tax ID in REF02 using the REF01 'EI' qualifier. **Provider Validation Hierarchy DC Medicaid:** NPI -> Provider Specialty -> Zip (+4)
Provider Pay to Affiliation Edit	Ensures a valid MMIS relationship between the Billing & Rendering Provider (when submitted) on 837s for DC Medicaid.
Subscriber/Recipient Edit	Valid DC Medicaid Recipient ID and DOB are required.
HCP (Repricing Info) Segment Edit	Use of HCP segment is not permitted.
Claim Filing Indicator Edit	Must have a value of 'MC' Medicaid or the 837 will reject.
COB Paid Date Edit	Future dates are not accepted and the 837 will reject.
Subscriber Entity Type Edit	Subscriber entity type must be equal to '1' person.
Relationship Code Edit	Subscriber is always the patient requiring '18' Self or the 837 will reject.
Payer Claim Control Number Edit	Required value with a maximum of 20 characters for use in REF02 where REF01 = F8 when this segment is used for CLM05-03 when equal to 7 or 8.
Release Information Code Edit	'Y' Yes is required in CLM09 or the 837 will reject.
Response Code Edits	'Y' Yes is required in CLM06 and CLM08 or the 837 will reject.

6. Acknowledgements and Reports

The acknowledgements/reports listed below are related to the submission of EDI transactions by a trading partner. These acknowledgements/reports are downloaded via the DC CORE MMIS-Online Web portal or through SFTP for those that submit via SFTP connection.

Table 2: Acknowledgements and Reports

Type	Acknowledgement/Report Description
TA1	TA1 Interchange Acknowledgement – This acknowledgement is sent if requested by setting ISA14 to “1”, or if ISA14 is set to ”0” and there is an error that needs to be reported.
999	999 Functional Acknowledgement – This acknowledgement file reports any errors found while checking compliance against TR3 specifications, or acceptance of an EDI transaction that meets the TR3 specifications for SNIP Levels 1 and 2.
277U (PEND)	277 Pended Acknowledgement – This acknowledgement is used to report claims with a pended status and are sent weekly (005010X228).
277CA	277 Claim Acknowledgement – This transaction is used to report claims accepted for adjudication in the submitted 837 transactions, sent daily (005010x214).
824	824 Application Reporting – This transaction is used to report the results of data content edits and errors detected. It is designed to report rejections based on business rules such as invalid diagnosis codes, invalid procedure codes, and invalid provider numbers. The 824 Application Reporting response will only be generated by the EDI Gateway if there are errors within the transaction for SNIP Level 3 through 7 (005010X186).
BRR	BRR – A business operations version error report generated to support the trading partner’s understanding and ability to quickly identify and resolve errors for resubmission of rejected transactions.

For additional detailed information concerning the TA1, 999, 824 and BRR, please reference the DC CORE MMIS-Online user guides available to trading partners:

Link: [INSERT DC MEDICAID SPECIFIC 5010 APPENDIX A VENDOR SPECS URL HERE]
Link: [INSERT DC MEDICAID SPECIFIC URLs LISTED HERE]

7. ISA and GS Segment Values for 837D Dental Claim

Table 3: 837D ISA and GS Segments Transaction Table

Loop ID	Reference	Name	Codes	Length	Notes/Comments
HEADER	ISA	Interchange Control Header			
	ISA06	Interchange Sender ID		15	DC Medicaid trading partner ID
	ISA08	Interchange Receiver ID		15	DCMEDICAID
	ISA13	Interchange Control Number		9	Unique Control Number per file defined by the sending Trading Partner
	GS	Functional Group Header			
	GS02	Application Sender's Code		2/15	DC Medicaid assigned trading partner ID
	GS03	Application Receiver's Code		15	DCMEDICAID
	GS08	Version/Release Code	005010X224A2	12	
	GE	Functional Group Trailer			
	GE01	Number of Transaction Sets Included		1/6	
	GE02	Group Control Number	Must be identical to the value in GS06	1/9	
	IEA	Interchange Control Number			
	IEA01	Number of Included Functional Groups		1/5	
	IEA02	Interchange Control Number	Must be identical to the value in ISA13	9	

8. 837D Companion Guide Transaction Table

Listed in the following table are the specific requirements for submitting and processing an ASC X12N 837 Healthcare Claim Dental transaction file to Gainwell for DC Medicaid.

Use these guidelines in conjunction with the official ASC X12N 837 TR3 document to submit 837 Healthcare Claim Institutional transaction files.

Table 4: 837D CG Transaction Table

Loop ID	Reference	Name	Codes	Length	Notes/Comments
Header	ST	Transaction Set Header			
	ST01	Transaction Set Identifier Code	837	3	837
	ST02	Transaction Set Control Number		4/9	Sequential number assigned by sender ST and SE must be equivalent
	ST03	Technical Report Type 3 Version Name	005010X224A2	1/35	
	BHT	Beginning Hierarchical Transaction Segment	BHT	3	
	BHT01	Hierarchical Structure Code	0019	4	0019
	BHT02	Transaction Set Purpose Code	00	2	00 – Original
	BHT03	Reference Identification		1/50	Submitter Transaction Identifier
	BHT05	Time	HHMM	4/8	Transaction Set Creation Time
	BHT06	Transaction Type Code	CH	2	CH = Chargeable
1000A	NM1	Submitter Name			
	NM101	Entity Identifier Code	41	2/3	
	NM102	Entity Type Qualifier	1 or 2	1	
	NM103	Name Last or Organization Name		1/60	
	NM104	Name First		1/35	
	NM105	Name Middle		1	
	NM106	Name Prefix		1/10	
	NM107	Name Suffix		1/10	
	NM108	Identification Code Qualifier	46	1/2	
	NM109	Identification Code		2/80	DC Medicaid assigned trading partner ID

Loop ID	Reference	Name	Codes	Length	Notes/Comments
1000B	NM1	Receiver Name			
	NM101	Entity Identifier Code	40	2/3	
	NM102	Entity Type Qualifier	2	1	2 – Non-Person
	NM103	Name Last or Organization Name		1/60	DCMEDICAID
	NM108	Identification Code Qualifier	46	1/35	46
	NM109	Identification Code		15	DCMEDICAID
2000A	HL	Billing/Pay-to Provider Hierarchical Level			
	HL01	Hierarchical ID Number	1	1/12	
	HL03	Hierarchical Level Code	20	1/2	
	HL04	Hierarchical Child Code	1	1	
2000A	PRV	Billing Provider Specialty Information			Provider Specialty is required on DC Medicaid Claim Submissions
	PRV01	Provider Code	BI	1/3	BI – Billing
	PRV02	Reference Identifier	PXC	2/3	Taxonomy Code
	PRV03	Reference Identification		1/50	Billing Provider Taxonomy
2010AA	NM1	Billing Provider Name			Required on DC Medicaid Claim Submissions
	NM101	Entity Identifier Code	85	2/3	
	NM102	Entity Type Qualifier	1 or 2	1/1	
	NM103	Name Last or Organization Name		1/60	
	NM104	Name First		1/35	
	NM105	Middle Name		1/25	
	NM107	Name Suffix		1/10	
	NM108	Identification Code Qualifier	XX	1/2	XX = National Provider ID (NPI)
	NM109	Identification Code		2/80	NPI – Billing Provider NPI

Loop ID	Reference	Name	Codes	Length	Notes/Comments
2010AA	N3	Billing Provider Address			
	N301	Address Information		1/55	
	N302	Address Information		1/55	
2010AA	N4	Billing Provider City/State/Zip Code			
	N401	City Name		2/30	
	N402	State or Province Code		2/2	
	N403	Postal Code		9	
2010AA	REF	Billing Provider Tax Identification			Required on DC Medicaid Claim Submissions
	REF01	Reference Identification Qualifier	EI	2/3	EI – Tax ID
	REF02	Reference Identification		1/50	Billing Provider Tax ID
2000B	HL	Subscriber Hierarchical Level			
	HL01	Hierarchical ID Number	2	1/12	
	HL02	Hierarchical Parent ID Number		1/12	
	HL03	Hierarchical Level Code	22	1/2	
	HL04	Hierarchical Child Code	0	1/1	
2000B	SBR	Subscriber Information			

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	SBR01	Payer Responsibility Sequence Number Code	A – Payer Responsibility Four B – Payer Responsibility Five C – Payer Responsibility Six D – Payer Responsibility Seven E – Payer Responsibility Eight F – Payer Responsibility Nine G – Payer Responsibility Ten H – Payer Responsibility Eleven P – Primary S – Secondary T – Tertiary U – Unknown	1/1	
	SBR02	Individual Relationship Code		2	
	SBR03	Reference Identification		1/50	
	SBR04	Name		1/60	
	SBR05	Insurance Type Code		1/3	
	SBR09	Claim Filing Indicator Code	MC	1/2	MC – Medicaid
2010BA	NM1	Subscriber Name			Required on DC Medicaid Claim Submissions
	NM101	Entity Identifier Code	IL	2/3	IL – Subscriber
	NM102	Entity Type Qualifier	1	1	1 – Person
	NM103	Name Last Organization		1/60	
	NM104	Name First		1/35	
	NM105	Name Middle		1/25	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	NM107	Name Suffix		1/10	
	NM108	Identification Code Qualifier	MI	1/2	MI – Member Identification
	NM109	Identification Code		7/10	DC Medicaid Recipient/Member ID
2010BA	N3	Subscriber Address			Required on DC Medicaid Claim Submissions
	N301	Address Information		1/55	
	N302	Address Information		1/55	
2010BA	N4	Subscriber City/State/Zip Code			Required on DC Medicaid Claim Submissions
	N401	City Name		2/30	
	N402	State or Province Code		2	
	N403	Postal Code		5/9	
2010BA	DMG	Subscriber Demographic Information			Required on DC Medicaid Claim Submissions
	DMG01	Date Time Period Format Qualifier	D8	2/3	
	DMG02	Date Time Period	CCYYMMDD Date of Birth	1/35	
	DMG03	Gender Code	M = Male		
2010BB	NM1	Payer Name			
	NM101	Entity Identifier Code	PR	2/3	PR – Payer
	NM102	Entity Type Qualifier	2	1	
	NM103	Name Last or Organization		1/60	DCMEDICAID
	NM108	Identification Code Qualifier	PI	1/2	PI – Payer Identification
	NM109	Identification Code		2/80	DCMEDICAID
	REF	Billing Provider Secondary Identification			Not used for DC Medicaid Claim Processing
2300	CLM	Claim Information		3	
	CLM01	Claim Submitter’s Identifier		1/38	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	CLM02	Monetary Amount		1/18	
	CLM05-1	Facility Code Value		1/2	
	CLM05-2	Facility Code Qualifier	A	1/2	
	CLM05-3	Claim Frequency Type Code	Valid Codes:	1	If codes 7 or 8 are used, then the original claim MUST be submitted in the 2300 – Payer Claim Control Number REF with REF01 = F8 using the DC Medicaid ICN
	CLM06	Yes/No Condition or Response Code	Y = Yes	1	
	CLM07	Provider Accept Assignment Code		1	
	CLM08	Yes/No Condition or Response Code	Y = Yes	1	
	CLM09	Release of Information Code		1	
	CLM11	Related Causes Information		1	
	CLM11-1	Related Causes Code	AA = Auto Accident OA = Other Accident EM = Employment	2/3	
	CLM11-2	Related Causes Code		2/3	
	CLM11-4	State or Province Code		2	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	CLM11-5	Country Code		2/3	Required if the auto accident was outside of the U.S. to identify the country in which the accident occurred
	CLM12	Special Program Code		2/3	
	CLM20	Delay Reason Code		1/2	
2300	DTP	Date – Accident			
	DTP01	Date Time Qualifier	439	3	
	DTP02	Date Time Period Format Qualifier	D8	2/3	
	DTP03	Date Time Period	CCYYMMDD	1/35	
2300	DTP	Date – Appliance Placement			
	DTP01	Date Time Qualifier	452	3	
	DTP02	Date Time Period Format Qualifier	D8	2/3	
	DTP03	Date Time Period	CCYYMMDD	1/35	
2300	DTP	Date – Service			
	DTP01	Date Time Qualifier	472	3	
	DTP02	Date Time Period Format Qualifier	D8	2/3	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	DTP03	Date Time Period	CCYYMMDD	/35	
2300	DN1	Orthodontic Total Months of Treatment			
	DN101	Quantity		1/15	
	DN102	Quantity		1/15	
2300	PWK	Claim Supplemental Information			Used to transmit Document Control Number when a claim attachment is submitted for a DC Medicaid Claim
	PWK01	Report Type	OZ	2/2	OZ – Support Data for Claim should be used when PWK segment is submitted on a DC 837 claim
	PWK02	Report Transmission Code	EL	1/2	EL – Electronically Only should be used when a 275 Electronic Claim Attachment is also submitted
	PWK05	Identification Code Qualifier	AC	1/2	AC – Attachment Control Number
	PWK06	Identification Code		2/80	Submitter Document Control Number for claim attachment
2300	AMT	Patient Amount Paid			
	AMT01	Amount Qualifier Code	F5	1/18	
	AMT02	Monetary Amount		1	
2300	REF	Original Reference Number	REF	3	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	REF01	Reference Identification Qualifier	F8	2/3	F8 = Original Reference Number
	REF02	Reference Identification		1/50	DC Medicaid Claim ICN/Claim ID This is the Claim number of the Original Claim Internal Control Number (ICN) and is required when submitting an adjustment claim to replace or cancel the Original Claim
2300	REF	Prior Authorization or Referral Number			
	REF01	Reference Identification Qualifier	9F	2	Referral Number
	REF02	Reference Identification		1/50	
2300	REF	Referral Identification			
	REF01	Reference Identification Qualifier	G1	2	Prior Authorization Number
	REF02	Reference Identification		1/50	
2300	REF	Referral Identification			
	REF01	Reference Identification Qualifier	G3	2/3	Predetermination Number
	REF02	Reference Identification		1/50	
2300	HI	Health Care Diagnosis Code			
	HI01-1	Code List Qualifier Code	ABK	1/3	ABK = Principal Diagnosis ICD-10

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	HI01-2	Industry Code		1/30	
	HI02-1	Code List Qualifier Code	ABF	1/3	ABF = Diagnosis ICD-10
	HI02-2	Industry Code		1/30	
	HI03-1	Code List Qualifier Code	ABF	1/3	ABF = Diagnosis ICD-10
	HI03-2	Industry Code		1/30	
	HI04-1	Code List Qualifier Code	ABF	1/3	ABF = Diagnosis ICD-10
	HI04-2	Industry Code		1/30	
2310A	NM1	Referring Provider Name			
	NM101	Entity Identifier Code	DN P3	2/3	DN P3
	NM102	Entity Type Qualifier	1	1	1
	NM103	Name Last or Organization Name		1/60	
	NM104	Name First		1/35	
	NM108	Identification Code Qualifier	XX	2	XX – National Provider ID (NPI)
	NM109	Identification Code	NPI	2/80	Referring Provider NPI
2310A	PRV	Referring Provider Specialty Information			

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	PRV01	Provider Code	RF	1/3	
	PRV02	Reference Identification Qualifier	PXC	2/3	
	PRV03	Reference Identification		1/50	
2310A	REF	Referring Provider Secondary Identification			Not used for DC Medicaid Claim Processing
2310B	NM1	Rendering Provider Name			NPI is required when 2310B Rendering Provider used on DC Medicaid Claim submissions
	NM101	Entity Identifier Code	82	2/3	
	NM102	Entity Type Qualifier		1	
	NM103	Name Last or Organization Name		1/60	
	NM104	Name First		1/35	
	NM105	Name Middle		1/25	
	NM108	Identification Code Qualifier	XX	2	XX – National Provider ID (NPI)
	NM109	Identification Code	NPI	2/80	Rendering Provider NPI
2310B	PRV	Rendering Provider Specialty Information			Required when 2310B Rendering Provider used on DC Medicaid claim submissions
	PRV01	Provider Code	PE	1/3	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	PRV02	Reference Identification Qualifier	PXC	2/3	
	PRV03	Reference Identification		1/50	Provider Taxonomy Code
2310B	REF	Rendering Provider Secondary Identification			Not used for DC Medicaid Claim Processing
2310C	NM1	Service Facility Location			
	NM101	Entity Identifier Code	77	2/3	
	NM102	Entity Type Qualifier	2	1	
	NM103	Name Last or Organization Name		1/60	Service location Name
	NM108	Identification Code Qualifier	XX	1/2	XX – National Provider ID (NPI)
	NM109	Identification Code		2/80	Service Facility NPI
2310C	N3	Service Facility Address			
	N301	Address Information		1/55	
	N302	Address Information		1/55	
2310C	N4	Service Location City/State/Zip			
	N401	City		2/30	
	N402	State		2	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	N403	Zip Code		3/15	
2310C	REF	Service Facility Location Secondary Identification			Not used for DC Medicaid Claim Processing
2320	SBR	Other Subscriber Information			
	SBR01	Payer Responsibility Sequence Number Code	P = Primary	1	
	SBR02	Individual Relationship Code	18	2	
	SBR03	Reference Identification	Insured Group or Policy Number	1/50	
	SBR04	Name		1/60	
	SBR09	Claim Filing Indicator Code		1/2	
2320	CAS	Claim Level Adjustments			
	CAS01	Claim Adjustment Group Code		1/2	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	CAS02	Claim Adjustment Reason Code		1/5	1 – Deductible Amount 2 – Co-Insurance Amount 3 – Co-Payment 96 – Carrier Non-Covered Charges 122 – Psychiatric Reduction Enter value "1" to indicate Deductible Amount Enter value "2" to indicate Co-Insurance Amount Enter value "3" to indicate Co-Payment Enter value "96" to indicate Carrier Non-Covered Charges Enter value "122" to indicate Psychiatric Reduction
	CAS03	Monetary Amount		1/18	
	CAS04	Quantity		1/15	Use CAS05-CAS019 to report additional adjustment reason codes under the same claim adjustment group code Repeat segment(s) for different group(s) used
2320	AMT	Coordination of Benefits (COB) Allowed Amount			
	AMT01	Amount Qualifier Code	D = Payer Paid Amount	1/3	
	AMT02	Monetary Amount	Paid Amount	1/18	
2320	AMT	Remaining Patient Amount			
	AMT01	Amount Qualifier Code	EAF	1/3	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	AMT02	Monetary Amount	Amount	1/18	
2320	AMT	Coordination of Benefits (COB) Total Non-Covered Amount			
	AMT01	Amount Qualifier Code	A8	1/3	
	AMT02	Monetary Amount	Amount	1/18	
2320	OI	Other Insurance Coverage Information			
	OI03	Yes/No Condition or Response Code	Y = Yes	1	
	OI06	Release of Information Code	A	1	
2330A	NM1	Other Subscriber Name			
	NM101	Entity Identifier Code	IL	2/3	
	NM102	Entity Type Qualifier	1 or 2	1	
	NM103	Name Last or Organization Name		1/60	Other Insurance Organization Name
	NM104	Name First		1/35	
	NM105	Name Middle		1/25	
	NM108	Identification Code Qualifier	MI	1/2	
	NM109	Identification Code	Member ID	2/80	Other Insurance Member ID

Loop ID	Reference	Name	Codes	Length	Notes/Comments
2330B	NM1	Other Payer Name			
	NM101	Entity Identifier Code	PR	2/3	
	NM102	Entity Type Qualifier	2	1	
	NM103	Name Last or Organization Name	Other Payer Last or Organization Name	1/60	
	NM108	Identification Code Qualifier	PI	1/2	
	NM109	Identification Code			
2330B	DTP	Claim Adjudication Date			
	DTP01	Date Time Qualifier	573	3	
	DTP02	Date Time Period Format Qualifier	D8	2/3	
	DTP03	Date Time Period	Other Insurance Paid Date CCYYMMDD	1/35	
2400	LX	Service Line			
	LX01	Assigned Number		1/6	
2400	SV3	Dental Service			
	SV301-1	Product/Service ID Qualifier	AD	2	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	SV301-2	Product/Service ID		1/48	
	SV301-3	Procedure Modifier		2	
	SV301-4	Procedure Modifier		2	
	SV301-5	Procedure Modifier		2	
	SV301-6	Procedure Modifier		2	
	SV302	Monetary Amount		1/18	
	SV303	Facility Code Value		1/2	
	SV304-1	Oral Cavity Designation Code		1/3	
	SV304-2	Oral Cavity Designation Code		1/3	
	SV304-3	Oral Cavity Designation Code		1/3	
	SV304-4	Oral Cavity Designation Code		1/3	
	SV304-5	Oral Cavity Designation Code		1/3	
	SV306	Quantity		1/15	
2400	TOO	Tooth Information			
	TOO01	Code List Qualifier Code	JP	1/3	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	TOO02	Industry Code		1/30	
	TOO03-1	Tooth Surface Code		1/2	
	TOO03-2	Tooth Surface Code		1/2	
	TOO03-3	Tooth Surface Code		1/2	
	TOO03-4	Tooth Surface Code		1/2	
	TOO03-5	Tooth Surface Code		1/2	
2400	DTP	Date – Service			
	DTP01	Date Time Qualifier	472	3	
	DTP02	Date Time Period Format Qualifier	D8	2/3	
	DTP03	Date Time Period	CCYYMMDD	1/35	
2400	DTP	Date – Prior Placement			
	DTP01	Date Time Qualifier	441	3	
	DTP02	Date Time Period Format Qualifier	D8	2/3	
	DTP03	Date Time Period	CCYYMMDD	1/35	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
2420A	NM1	Rendering Provider Name			NPI is required when 2420A Rendering Provider used on DC Medicaid Claim submissions
	NM101	Entity Identifier Code	82	2/3	
	NM102	Entity Type Qualifier		1	
	NM103	Name Last or Organization Name		1/60	
	NM104	Name First		1/35	
	NM105	Name Middle		1/25	
	NM107	Name Suffix		1/10	
	NM108	Identification Code Qualifier	XX	2	XX – National Provider ID
	NM109	Identification Code	NPI	2/80	Rendering Provider NPI
2420A	PRV	Rendering Provider Specialty Information			Required when 2420A Rendering Provider used on DC Medicaid claim submissions
	PRV01	Provider Code	PE	1/3	
	PRV02	Reference Identification Qualifier	PXC	2/3	
	PRV03	Reference Identification	Provider Taxonomy Code	1/50	
2420A	REF	Rendering Provider Secondary Identification			Not used for DC Medicaid Claim Processing

Loop ID	Reference	Name	Codes	Length	Notes/Comments
2430	SVD	Line Adjudication Information	SVD	3	
	SVD01	Identification Code	OT01	2/80	
	SVD02	Monetary Amount		1/18	
	SVD03-1	Product/Service ID Qualifier	AD – American Dental Association Codes	2	
	SVD03-2	Product/Service ID		2	
	SVD03-3	Procedure Modifier		2	
	SVD03-4	Procedure Modifier		2	
	SVD03-5	Procedure Modifier		2	
	SVD03-6	Procedure Modifier		2	
	SVD03-7	Description		1/80	
	SVD05	Quantity		1/15	
	SVD06	Assigned Number		1/6	
2430	CAS	Line Adjustment			

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	CAS01	Claim Adjustment Group Code	CR = Correction and Reversals CO = Contractual Obligations OA = Other Adjustments PI = Payor Initiated Reductions PR = Patient Responsibility	1/2	
	CAS02	Claim Adjustment Reason Code	1 = Deductible	1/5	
	CAS03	Monetary Amount	Amount	1/18	
	CAS04	Quantity		1/15	
	CAS05	Claim Adjustment Reason Code		1/5	
	CAS06	Monetary Amount	Amount	1/18	
	CAS07	Quantity		1/15	
2430	DTP	Line Adjudication Date			
	DTP01	Date Time Qualifier	573	3	
	DTP02	Date Format Qualifier	D8	2/3	
	DTP03	Payment Date	CCYYMMDD	1/35	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
TRAILER	SE	Transaction Set Trailer			
	SE01	Number of Included Segments		1/10	
	SE02	Transaction Set Control Number		4/9	

Appendix A. Companion Guide Appendices

A.1 Trading Partner Implementation Checklist

The DC CORE MMIS-Online web portal user guides contain all necessary steps for going live with Gainwell in submitting specified EDI transactions, and receiving EDI responses, including the 5010 837. It also covers the following categories:

Register for a Trading Partner ID
Test with DC Medicaid

The user guides can be found at the following links:

[INSERT DC MEDICAID SPECIFIC URL HERE]
[INSERT DC MEDICAID SPECIFIC URL HERE]
[INSERT DC MEDICAID SPECIFIC URL HERE]
[INSERT DC MEDICAID SPECIFIC URL HERE]

A.2 Retrieving Acknowledgements for X12 Transactions via SFTP Submission

Trading Partners who have submitted X12 transactions via SFTP may retrieve acknowledgements and responses from their designated SFTP pickup location. Any validation responses to the original submission (TA1, 999, 824, and BRR) will be based on the Gainwell internal file naming convention. This naming convention is as follows:

<Input Class>-<Sender ID>-<Receiver ID>-<Date: CCYYMMDD>-<Time: HHMMSS>-<File ID>-<Transaction Type>-<Usage: T for Test, P for Production>.edi

File Naming Convention Examples:

An inbound Dental Healthcare claim file from TPID DCTPIDXXXXXX, would be assigned an internal filename of:

VAN-DCTPIDXXXXXX-DCMEDICAID-20230616-112750-1367-005010X224A2-P.edi

The HIPAA validation acknowledgements would appear in this trading partner's SFTP pickup location with the files named as follows:

VAN-DCTPIDXXXXXX-DCMEDICAID-20230616-112750-1367-005010X224A2-P.edi-1367-TA1.edi
VAN-DCTPIDXXXXXX-DCMEDICAID-20230616-112750-1367-005010X224A2-P.edi-1367-999.edi
VAN-DCTPIDXXXXXX-DCMEDICAID-20230616-112750-1367-005010X224A2-P.edi-1367-824.edi
VAN-DCTPIDXXXXXX-DCMEDICAID-20230616-112750-1367-005010X224A2-P.edi-1367-BRR.edi

A.3 EDI File Transmission Examples

A.3.1 TA1 Interchange Acknowledgement

The TA1 interchange acknowledgement is used to verify the syntactical accuracy of the envelope of the X12 interchange. The TA1 interchange will indicate that the file was successfully received, as well as indicate what errors existed within the envelope segments of the received X12 file.

For detailed information concerning the TA1 Interchange Acknowledgement, please reference the DC CORE MMIS-Online user guides:

[INSERT DC MEDICAID SPECIFIC 5010 APPENDIX A VENDOR SPECS URL HERE]
[INSERT DC MEDICAID SPECIFIC URL HERE]

A.3.2 999 Implementation Acknowledgement for Health Care Insurance

The ASC X12 999 transaction set is designed to report only on conformance against a TR3.

A.3.3 824 Application Advice

This transaction is not mandated by HIPAA but will be used to report the results of data content edits of transaction sets. It is designed to report rejections based on business rules such as invalid diagnosis codes, invalid procedure codes and invalid provider numbers. The 824 Application Advice does not replace the 999 or TA1 transactions and will only be generated by DC CORE MMIS if there are errors within the transaction set.

For detailed information concerning the 824 Application Advice, please reference the DC CORE MMIS-Online user guides:

[INSERT DC MEDICAID SPECIFIC 5010 APPENDIX A VENDOR SPECS URL HERE]
[INSERT DC MEDICAID SPECIFIC URL HERE]

A.3.4 Business Rejection Report

DC CORE MMIS also produces a readable version of the 824 called the BRR. This report helps to facilitate the immediate correction and re-bill of claims rejected during HIPAA validation.

For detailed information concerning the BRR Rejection Report, please reference the DC CORE MMIS-Online user guides:

[INSERT DC MEDICAID SPECIFIC 5010 APPENDIX A VENDOR SPECS URL HERE]
[INSERT DC MEDICAID SPECIFIC URL HERE]

Appendix B. Acronyms

The following table contains the list of acronyms, and corresponding definitions, used in this document.

Table 5: Acronyms

Acronyms	Description
ASC	Accredited Standards Committee
BHT	Beginning of Hierarchical Transaction
BRR	Business Rejection Report
CFR	Code of Federal Regulations
CG	Companion Guide
CLM	Claim Information
DN	Referring Provider
EDI	Electronic Data Interchange
FFS	Fee For Service
Gainwell	Gainwell Technologies
GS	Functional Group Header
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
ICN	Internal Control Number
ID	Identification
ISA	Interchange Control Header
DC	District of Columbia
DC CORE MMIS	New DC Medicaid MMIS Solution
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
NPI	National Provider ID
OI	Other Insurance Coverage Information
PRV	Provider Specialty Information
PXC	Healthcare Provider Taxonomy Code
REF	Secondary Identification
RF	Referring Provider Specialty Information
SBR	Subscriber Information
SFTP	Secure File Transfer Protocol
SNIP	Strategic National Implementation Process
TPID	Trading Partner ID
TR3s	Technical Report Type 3

Acronyms	Description
VAN	Value Access Network/Data Aggregator
WPC	Washington Publishing Company