Department of Health Care Finance (DHCF)

DC MMIS Core Solution

Companion Guide (CG)

DC Medicaid 837 FFS Claims

November 26, 2025

Version 1.7

This Companion Guide to the v5010 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	10/3/2024	Gainwell Technologies	Initial document creation
1.1	02/5/2025	Christian Moseby	Gainwell Tech Writer review
1.2	06/02/2025	DC EDI SWS Team	Added section for MCP Kick Payment claim submission information for 837P FFS
1.3	06/20/2025	Scott M. Bullington	Gainwell Tech Writer review
1.4	08/18/2025	DC EDI SWS Team	Updated email contact
1.4	08/25/2025	Gresham Wagner	Gainwell Tech Writer review
1.5	11/20/2025	DC EDI SWS Team	Updates applied: Moved SNIP 7 edits listing to section 5 from Appendix previously. 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. Billing/Rendering NPI/Taxonomy and Zip-Code usage. Also removed DC Medicaid Provider ID REF usages previously included in table. Added Appendix sections as found in the Vendor Appendix reference document so available in 837 CGs.
1.7	11/26/2025	Gresham Wagner	Gainwell Tech Writer review

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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 Professional (005010X222A1)

Refer to the Accredited Standards Committee (ASC) X12N Implementation Guides or 5010 Technical Report Type 3 (TR3s) 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.

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1.2 Reference Information

1.2.1 X12N Implementation Guides or TR3s

The ASC X12N Implementation Guides or 5010 TR3s (Type 3 Technical Report) are standards developed by the X12 committee and published by the Washington Publishing Company (WPC): http://store.x12.org/store/healthcare-5010-consolidated-guides.

1.2.2 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.

1.2.3 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).

1.2.4 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 What is Changing for Existing and New 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 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 1-7 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:

- [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 test 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 Interchange Control Header (ISA) of an X12 file, indicates if a file is test or 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 1-7 are applied to test and production EDI file submissions.

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]

3.3 837 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.

3.4 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 upon 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 use of 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: dcedi@gainwelltechnologies.com
- Telephone: [DC Operations – EDI Helpdesk Phone #]

4.3 EDI Filenames for New DC MMIS

When a Trading Partner's EDI file is received by the new DC MMIS, it will receive a new and unique filename using the DC EDI filename pattern found in this companion guide. The EDI response files will reflect that unique filename assigned, like in the DC Medicaid 837 Encounter submission and response files example below:

837 Claim file submission from DC Trading Partner

837 Claim Submission Original Filename:

Filename is determined by submitter. In the event SFTP is used as the Trading Partner EDI Secure Channel the filename must include 'VAN' for SFTP routing of 837 claim submissions to the new DC MMIS.

Each file received by the new DC MMIS is assigned a unique filename with the response files reflecting the Tracking ID from the 837 filename. The DC Medicaid EDI filename convention is as follows.

Filename: Sender ID-Receiver ID-Date-Time-Tracking ID-Transaction Type-Prod/Test Indicator

Example Claim submission response files generated by the new DC MMIS and returned to the DC Trading Partner.

New DC MMIS 837 Claim & Response Filenames:

DC Trading Partner ID--DCMEDICAID-20250701-470149-1959796-005010X222A1-P.edi-1659797-TA1.edi

DC Trading Partner ID-DCMEDICAID-20250701-470149-1959796-005010X222A1-P.edi-824.edi

DC Trading Partner ID--DCMEDICAID-20250701-470149-1959796-005010X222A1-P.edi-999.edi

DC Trading Partner ID--DCMEDICAID-20250701-470149-1959796-005010X222A1-P.edi-BRR *(HTML file)*

4.4 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 TPID.

4.5 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. Password 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 1-7.
- 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)
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)

SNIP 7 Edit	Edit Description
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 is sent weekly (005010X228).
277CA	277 Claim Acknowledgement – This transaction is used to report claims accepted for adjudication and those not accepted due to errors 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 Business Rejection Report – 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 Rejection Report, 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 837P Professional Claim

Table 3: 837P 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 required by DC Medicaid Trading Partner on each file submission.
	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	005010X222A1	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. 837P CG Transaction Table

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

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

Table 4: 837P CG Transaction Table

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	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	Implementation Convention Reference	005010X222A1	1/35	
	BHT	Beginning Hierarchical Transaction Segment			
	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	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	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.
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	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	NM103	Name Last or Organization Name		1/60	
	NM104	Name First		1/35	
	NM105	Middle Name		1/25	
	NM107	Name Suffix		1/10	
	NM101	Entity Identifier Code	85	2/3	
	NM108	Identification Code Qualifier	XX	1/2	XX = National Provider ID (NPI)
	NM109	Identification Code		2/80	NPI – Billing Provider NPI
2010AA	N3	Billing Provider Address			Required on DC Medicaid Claim Submissions
	N301	Address Information		1/55	
	N302	Address Information	Required if a second address line exists.	1/55	
2010AA	N4	Billing Provider City/State/Zip Code			Required on DC Medicaid Claim Submissions
	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	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	HL03	Hierarchical Level Code	22	1/2	
	HL04	Hierarchical Child Code	0	1/1	
2000B	SBR	Subscriber Information			
	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

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	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	
	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	Required if a second address line exists.	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	DC Recipient Date of Birth is required
	DMG03	Gender Code	M = Male		
2010BB	NM1	Payer Name			
	NM101	Entity Identifier Code	PR	2/3	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	NM102	Entity Type Qualifier	2	1	
	NM103	Name Last or Organization	DCMEDICAID	1/60	DCMEDICAID
	NM108	Identification Code Qualifier	PI	1/2	PI = Payer Identification
	NM109	Identification Code	DCMEDICAID	2/80	DCMEDICAID
2010BB	REF	Billing Provider Secondary Identification			Not used for DC Medicaid Claim Processing
2300	CLM	Claim Information			
	CLM01	Claim Submitter's Identifier	Patient Account Number	1/38	
	CLM02	Monetary Amount	Total Claim Charges	1/18	
	CLM05-1	Facility Code Value		1/2	
	CLM05-2	Facility Code Qualifier	B	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	
2300	CLM07	Provider Accept Assignment Code		1	
2300	CLM08	Benefits Assignment Certification Indicator	Y – Yes	1	
2300	CLM09	Release of Information Code		1	
	CLM10	Patient Signature Source Code	P	1	
	CLM11	Related Causes Information			

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	CLM11-1	Related Causes Code	AA = Auto Accident OA = Other Accident EM = Employment	2/3	
	CLM11-2	Related Causes Code		2/3	
	CLM11-3	Related Causes Code		2/3	
	CLM11-4	State or Province Code	Required if CLM11-1, CLM11-2, or CLM11-3 = AA to identify the state in which the automobile accident occurred. Use state code.	2	
	CLM11-5	Country Code	Required if the auto accident is outside the U.S. to identify the country in which the accident occurred.	2/3	
	CLM12	Special Program Code		2/3	
2300	DTP	Date – Onset of Current Illness/Symptom			
	DTP01	Date/Time Qualifier	431	3	
	DTP02	Date Time Period Format Qualifier	D8	2/3	
	DTP03	Date Time Period	CCYYMMDD	1/35	
2300	DTP	Date – Accident			DTP Required if CLM11-1 or -2 = AA or OA
	DTP01	Date/Time Qualifier	439	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
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	1/3	
	AMT02	Monetary Amount		1/18	
2300	REF	Prior Authorization or Referral Number			
	REF01	Reference Identification Qualifier	9F = Referral Number	2/3	
	REF02	Reference Identification	Assigned Referral Number	1/50	
2300	REF	REF – Payer Claim Control Number			
	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

Loop ID	Reference	Name	Codes	Length	Notes/Comments
					adjustment claim to replace or cancel the Original Claim.
2300	REF	REF – Payer Claim Control Number			DC Medicaid MCP usage for Kick Payment Claims.
	REF01	Reference Identification Qualifier	D9	2/3	D9 – Submitter Unique Identifier
	REF02	Reference Identification		1/50	Populated with submitter's unique Claim ID. Note: For MCP usage, the REF02 value should match the corresponding value submitted on the encounter.
2300	HI	Health Care Diagnosis Code			
	HI01-1	Code List Qualifier Code		1/3	
	HI01-2	Industry Code	Diagnosis Code	1/30	
	HI02-1	Code List Qualifier Code		1/3	
	HI02-2	Industry Code		1/30	
	HI03-1	Code List Qualifier Code		1/3	
	HI03-2	Industry Code		1/30	
	HI04-1	Code List Qualifier Code		1/3	
	HI04-2	Industry Code		1/30	
	HI05-1	Code List Qualifier Code		1/3	
	HI05-2	Industry Code		1/30	
	HI06-1	Code List Qualifier Code		1/3	
	HI06-2	Industry Code		1/30	
	HI07-1	Code List Qualifier Code		1/3	
	HI07-2	Industry Code		1/30	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	HI08-1	Code List Qualifier Code		1/3	
	HI08-2	Industry Code		1/30	
	HI09-1	Code List Qualifier Code		1/3	
	HI09-2	Industry Code		1/30	
	HI10-1	Code List Qualifier Code		1/3	
	HI10-2	Industry Code		1/30	
	HI11-1	Code List Qualifier Code		1/3	
	HI11-2	Industry Code		1/30	
	HI12-1	Code List Qualifier Code		1/3	
	HI12-2	Industry Code		1/30	
2310A	NM1	Referring Provider Name			
	NM101	Entity Identifier Code	DN P3	2/3	
	NM102	Entity Type Qualifier	1	1	
	NM103	Name Last or Organization Name		1/60	
	NM104	Name First		1/35	
	NM105	Middle Name		1/25	
	NM108	Identification Code Qualifier	XX	1/2	XX = NPI
	NM109	Identification Code		2/80	NPI
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 or 2	1	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	NM103	Name Last or Organization Name		1/60	
	NM104	Name First		1/35	
	NM105	Middle Name		1/25	
	NM108	Identification Code Qualifier	XX	1/2	XX = NPI
	NM109	Identification Code		2/80	NPI
2310B	PRV	Rendering Provider Specialty Information			Required when 2310B Rendering Provider used on DC Medicaid claim submissions
	PRV01	Provider Code	PE	1/3	PE – Performing
	PRV02	Reference Identifier	PXC	2/3	Taxonomy Code.
	PRV03	Reference Identification		1/50	Rendering Provider Taxonomy.
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	77 – Service Location
	NM102	Entity Type Qualifier	2	2	2 – Nonperson
	NM103	Name Last/Organization		1/35	Facility Name.
	NM108	Identification Code Qualifier	XX	1/2	XX = NPI
	NM109	Identification Code		2/80	NPI
2310C	N3	Service Facility Location Address			
	N301	Address Information		1/55	Facility Address.
2310C	N4	Service Facility Location City, State, Zip			
	N401	Service Facility City		2/30	Facility City.

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	N402	Service Facility State		2	Facility State.
	N403	Service Facility Zip		3/15	Facility Zip.
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		1	
	SBR02	Individual Relationship Code	18	2	
	SBR03	Reference Identification	Insured Group or Policy Number	1/50	
	SBR04	Name		1/60	
	SBR05	Insurance Type Code		1/3	
	SBR09	Claim Filing Indicator Code		1/2	
2320	CAS	Claim Level Adjustments			
	CAS01	Claim Adjustment Group Code	PR	1/2	
	CAS02	Claim Adjustment Reason Code	Use Valid Values	1/5	
	CAS03	Monetary Amount		1/18	
	CAS04	Quantity		1/15	
2320	AMT	Coordination of Benefits (COB) Allowed Amount			
	AMT01	Amount Qualifier Code	D	1/3	D – Paid
	AMT02	Monetary Amount		1/18	Paid Amount.
2320	OI	Other Insurance Coverage Information			

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	OI03	Yes/No Condition or Response Code	Y	1	
	OI04	Patient Signature Source Code	P	1	
	OI06	Release of Information Code	Y	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	
	NM104	Name First		1/35	
	NM105	Name Middle		1/25	
	NM108	Identification Code Qualifier	MI	1/2	
	NM109	Identification Code	Member ID	2/80	
2330B	NM1	Other Payer Name			
	NM101	Entity Identifier Code	PR	2/3	
	NM102	Entity Type Qualifier	2	1	
	NM103	Name Last or Organization Name		1/60	
	NM108	Identification Code Qualifier	PI	1/2	
	NM109	Identification Code		2/80	
2330B	DTP	Claim Check or Remittance Date			
	DTP01	Date/Time Qualifier	573	3	
	DTP02	Date Time Period Format Qualifier	D8	2/3	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	DTP03	Date Time Period	Paid Date CCYYMMDD	1/35	
2400	LX	Service Line Number			
	LX01	Assigned Number		1/6	
2400	SV1	Professional Service			
	SV101-1	Product/Service ID Qualifier	HC	2	
	SV101-2	Product/Service ID		1/48	
	SV101-3	Procedure Modifier		2	
	SV101-4	Procedure Modifier		2	
	SV101-5	Procedure Modifier		2	
	SV101-6	Procedure Modifier		2	
	SV101-7	Description		1/80	
	SV102	Monetary Amount		1/18	
	SV103	Unit or Base for Measurement Code		2	
	SV104	Quantity		1/15	
	SV105	Facility Code Value		1/2	
	SV107-1	Diagnosis Code Pointer		1/2	
	SV107-2	Diagnosis Code Pointer		1/2	
	SV107-3	Diagnosis Code Pointer		1/2	
	SV107-4	Diagnosis Code Pointer		1/2	
	SV109	Yes/No Condition Response Code		1	
	SV111	Yes/No Condition Response Code		1	
	SV112	Yes/No Condition Response Code		1	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	SV115	Copay Status Code		1	
2400	CRC	Condition Indicator/Durable Medical Equipment			
	CRC01	Code Category	09	2	09 = Durable Medical Equipment Certification
	CRC02	Certification Condition Code Applies Indicator	N or Y	1	
	CRC03	Condition Indicator	38	2	38 = Certification signed by the physician is on file at the supplier's office ZV = Replacement Item
	CRC04	Condition Indicator		2	
2400	DTP	Date – Service Date			
	DTP01	Date/Time Qualifier	472	3	
	DTP02	Date Time Period Format Qualifier	D8 or RD8	2/3	
	DTP03	Date Time Period	CCYYMMDD or CCYYMMDD-CCYYMMDD	1/35	
2400	DTP	Date – Last Certification Date			
	DTP01	Date/Time Qualifier	461	3	
	DTP02	Date Time Period Format Qualifier	D8	2/3	
	DTP03	Date Time Period	CCYYMMDD	1/35	
2400	REF	Clinical Laboratory Improvement Amendment (CLIA)			DC MEDICAID will only reimburse for laboratory services billed according to federal CLIA certification.
	REF01	Reference Identification Qualifier	X4	2/3	X4 – CLIA Number
	REF02	Reference Identification		1/50	CLIA Number.

Loop ID	Reference	Name	Codes	Length	Notes/Comments
					CLIA number is required when billing for laboratory services.
2410	LIN	Drug Identification			
	LIN02	Product/Service ID Qualifier	N4	2	
	LIN03	Product/Service ID		1/48	National Drug Code (NDC).
2410	CTP	Drug Pricing			
	CTP04	Quantity	Drug Unit Count	1/15	
	CTP05-1	Unit or Basis for Measurement Code	Unit of Measure Code	2	
2420A	NM1	Rendering Provider Name			NPI required when 2420A Rendering Provider is used on DC Medicaid Claim submissions
	NM101	Entity Identifier Code	82	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		1/25	
	NM108	Identification Code Qualifier	XX = NPI	1/2	
	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	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
2420A	REF	Rendering Provider Secondary Identification			Not used for DC Medicaid Claims processing.
2420C	NM1	Service Facility Location			
	NM101	Entity Identifier Code	77	2/3	77 – Service Location
	NM102	Entity Type Qualifier	2	2	2 -Nonperson
	NM103	Name Last/Organization		1/35	Facility Name
	NM108	Identification Code Qualifier	XX	1/2	XX = National Provider ID (NPI)
	NM109	Identification Code		2/80	Service Facility NPI
2420C	N3	Service Facility Location Address			
	N301	Address Information		1/55	Facility Address
2420C	N4	Service Facility Location City, State, Zip			
	N401	Service Facility City		2/30	Facility City
	N402	Service Facility State		2	Facility State
	N403	Service Facility Zip		3/15	Facility Zip
2420E	NM1	Ordering Provider			
	NM101	Entity Identifier Code	DK	2/3	DK – Ordering Provider
	NM108	Other	XX	1/2	XX – NPI
	NM109	Identification Code		2/80	Ordering Provider NPI
2420F	NM1	Referring Provider Name			
	NM101	Entity Identifier Code	DN P3	2/3	DN – Referring Provider Use the first iteration of this loop. Use if loop is used only once.

Loop ID	Reference	Name	Codes	Length	Notes/Comments
					P3 – Primary Care Provider Use only if loop is used twice. Use only on second.
	NM108	Identification Code Qualifier	XX	1/2	XX = National Provider ID (NPI)
	NM109	Identification Code		2/80	Referring Provider NPI
2430	SVD	Line Adjudication Information			
	SVD01	Identification Code	Valid Value	2/80	
	SVD02	Monetary Amount	Service Line Paid Amount	1/18	
	SVD03-1	Product/Service ID Qualifier	Valid Value	2	
	SVD03-2	Product/Service ID	Procedure Code	1/48	
	SVD03-3	Procedure Modifier	Modifier	2	
	SVD03-4	Procedure Modifier	Modifier	2	
	SVD03-5	Procedure Modifier	Modifier	2	
	SVD03-6	Procedure Modifier	Modifier	2	
	SVD03-7	Description		1/80	Use valid values.
	SVD05	Quantity	Quantity/Units	1/15	
2430	CAS	Line Adjustment			
	CAS01	Claim Adjustment Group Code	‘CR’ Correction and Reversals ‘CO’ ‘OA’ ‘PI’ ‘PR’	1/2	‘CR’ Correction and Reversals. ‘CO’ ‘OA’ ‘PI’ ‘PR’
	CAS02	Claim Adjustment Reason Code	Use valid values	1/5	
	CAS03	Monetary Amount	Deductible Amount	1/18	
	CAS04	Quantity		1/15	
	CAS05	Claim Adjustment Reason Code	Valid Value	1/5	

Loop ID	Reference	Name	Codes	Length	Notes/Comments
	CAS06	Monetary Amount	Amount	1/18	
	CAS07	Quantity		1/15	
	CAS08	Claim Adjustment Reason Code		1/5	
	CAS09	Monetary Amount		1/18	
2430	DTP	Line Adjudication Date			
	DTP01	Date/Time Qualifier	573	3/3	
	DTP02	Date Format Qualifier	D8	2/3	
	DTP03	Payment Date	Payment Date CCYYMMDD	8	
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 DC Medicaid for 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:

- [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 Technologies 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

Example Scenario – An inbound Professional Healthcare claim file from Trading Partner ID DCTPIDXXXXXX would be assigned an internal filename of:

VAN-DCTPIDXXXXXX-DCMEDICAID-20230616-112750-1367-005010X222A1-P.edi

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

VAN-DCTPIDXXXXXX-DCMEDICAID-20230616-112750-1367-005010X222A1-P.edi-1367-TA1.edi

VAN-DCTPIDXXXXXX-DCMEDICAID-20230616-112750-1367-005010X222A1-P.edi-1367-999.edi

VAN-DCTPIDXXXXXX-DCMEDICAID-20230616-112750-1367-005010X222A1-P.edi-1367-824.edi

VAN-DCTPIDXXXXXX-DCMEDICAID-20230616-112750-1367-005010X222A1-P.edi-1367-BRR.edi

A.3 EDI File Transmission Examples

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]

999 Implementation Acknowledgement for Healthcare Insurance

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

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]

BRR 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]

A.4 Response & Codes: 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.

The structure of a TA1 interchange acknowledgement depends on the structure of the envelope of the original Electronic Data Interchange (EDI) document. When the envelope of the EDI document does not contain an error, then the interchange acknowledgement will contain the Interchange Control Header (ISA), TA1, and IEA segments. The TA1 segment will have an Interchange Acknowledgement Code of "A" (Accepted) followed by a three-digit code of "000," which indicates that there were not any errors.

If the EDI document contains an error at the interchange level, such as in the ISA segment or the interchange control trailer (IEA), then the interchange acknowledgement will also only contain the ISA, TA1, and IEA segments. The TA1 segment will have an Interchange Acknowledgement Code of "R" (Rejected), which will be followed by a three-digit number that corresponds to one of the following codes:

Table 5: Interchange Acknowledgement Code

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
005	Invalid Interchange ID Qualifier for Sender
006	Invalid Interchange Sender ID
007	Invalid Interchange ID Qualifier for Receiver
009	Unknown Interchange Receiver ID
010	Invalid Authorization Information Qualifier Value (ISA01 is not "00" or "03")
012	Invalid Security Information Qualifier Value
013	Invalid Security Information Value
018	Invalid Interchange Control Number Value
019	Invalid Acknowledgment Requested Value
020	Invalid Test Indicator Value
021	Invalid Number of Included Groups Value
023	Improper (Premature) End-of-File (Transmission)
024	Invalid Interchange Content (e.g., Invalid GS Segment)
025	Duplicate Interchange Control Number

A.5 Standard Usage: 999 Functional Ack for Health Care Insurance

The ASC X12 999 transaction set is designed to report only on conformance against a Technical Report Type 3 guideline (TR3).

- The 999 is not limited to only IG errors. It can report standard syntax errors as well as IG errors.
- The 999 can NOT be used for any application-level validations.
- The ASC X12 999 transaction set is designed to respond to one and only one functional group (i.e., GS/GE) but will respond to all transaction sets (i.e., ST/SE) within that functional group.
- This ASC X12 999 Implementation Acknowledgment can NOT be used to respond to any management transaction sets intended for acknowledgment (i.e., TS 999, or interchange control segments related to acknowledgments, i.e., TA1 and TA3).
- Each segment in a 999 functional acknowledgment plays a specific role in the transaction. For example, the AK1 segment starts the acknowledgment of a functional group. Each AKx segment has a separate set of associated error codes.

The 999 functional acknowledgment includes, but is not limited to, the following required segments:

- ST – Transaction Set Header
- AK1 – Functional Group Response Header
- AK2 – Transaction Set Response Header
- IK3 – Error Identification
- CTX – Segment Context
- CTX – Business Unit Identifier
- IK4 – Implementation Data Element Note
- CXT – Element Context
- IK5 – Transaction set response trailer
- AK9 – Functional Group Response Trailer
- SE – Transaction Set Trailer

For additional information regarding the 999 transaction, please see the Technical Report Type 3 Acknowledgement Section of the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 Implementation Guideline for the transaction being submitted.

A.6 Response & Codes: 824 Application Advice

This transaction is not mandated by Health Insurance Portability and Accountability Act (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 Medicaid Claims Administration and Financial Solution (MCAFS) if there are errors within the transaction set.

The 824 acknowledgment is divided into two levels of segments: header and detail.

- The header level contains general information, such as the transaction set control reference number of the previously sent transaction, date, time, submitter, and receiver.
- The detail level reports the results of an application system's data content edits.

The 824 Application Advice includes, but is not limited to, the following segments and their roles:

Header Segments

- ST segment – Transaction Set Header
- BGN segment – Beginning Segment
- N1 segment – Submitter Name
- N1 segment – Receiver Name

Detail Segments

- OTI segment – Original Transaction Identification
- TED segment – Error or Informational Message Location
- RED segment – Error or Informational Message
- SE segment – Transaction Set Trailer

MCAFS Application errors in the RED segment of the 824 Application Advice would display one or more of the following codes:

Table 6: RED06 Element Code List: Insurance Business Process Application Error Codes

Error Code	Error Code Description
E001	Missing/Invalid submitter identifier
E002	Missing/Invalid receiver identifier
E003	Missing/Invalid member identifier
E004	Missing/Invalid subscriber identifier
E005	Missing/Invalid patient identifier
E006	Missing/Invalid plan sponsor identifier
E007	Missing/invalid payee identifier
E008	Missing/Invalid TPA/broker identifier

Error Code	Error Code Description
E009	Missing/Invalid premium receiver identifier
E010	Missing/Invalid premium payer identifier
E011	Missing/Invalid payer identifier
E012	Missing/Invalid billing provider identifier
E013	Missing/Invalid pay to provider identifier
E014	Missing/Invalid rendering provider identifier
E015	Missing/Invalid supervising provider identifier
E016	Missing/Invalid attending provider identifier
E017	Missing/Invalid other provider identifier
E018	Missing/Invalid operating provider identifier
E019	Missing/Invalid referring provider identifier
E020	Missing/Invalid purchased service provider identifier
E021	Missing/Invalid service facility identifier
E022	Missing/Invalid ordering provider identifier
E023	Missing/Invalid assistant surgeon identifier
E024	Amount/Quantity out of balance
E025	Duplicate
E026	Billing date predates service date
E027	Business application currently not available
E028	Sender not authorized for this transaction
E029	Number of errors exceeds permitted threshold
E030	Required loop missing
E031	Required segment missing
E032	Required element missing
E033	Situational required loop is missing
E034	Situational required segment is missing
E035	Situational required element is missing
E036	Data too long
E037	Data too short
E038	Invalid external code value
E039	Data value out of sequence
E040	"Not Used" data element present
E041	Too many sub-elements in composite
E042	Unexpected segment

Error Code	Error Code Description
E043	Missing data
E044	Out of range
E045	Invalid date
E046	Not matching
E047	Invalid combination
E048	Customer identification number does not exist
E049	Duplicate batch
E050	Incorrect data
E051	Incorrect date
E052	Duplicate transmission
E053	Invalid claim amount
E054	Invalid identification code
E055	Missing or invalid issuer identification
E056	Missing or invalid item quantity
E057	Missing or invalid item identification
E058	Missing or unauthorized transaction type code
E059	Unknown claim number
E060	Bin segment contents not in MIME format
E061	Missing/invalid MIME header
E062	Missing/Invalid MIME boundary
E063	Missing/Invalid MIME transfer encoding
E064	Missing/Invalid MIME content type
E065	Missing/Invalid MIME content disposition (filename)
E066	Missing/Invalid file name extension
E067	Invalid MIME base64 encoding
E068	Invalid MIME quoted-printable encoding
E069	Missing/Invalid MIME line terminator (should be CR+LF)
E070	Missing/Invalid "end of MIME" headers
E071	Missing/Invalid CDA in first MIME body parts
E072	Missing/Invalid XML tag
E073	Unrecoverable XML error
E074	Invalid Data format for HL7 data type
E075	Missing/Invalid required LOINC answer part(s) in the CDA
E076	Missing/Invalid Provider information in the CDA

Error Code	Error Code Description
E077	Missing/Invalid Patient information in the CDA
E078	Missing/Invalid Attachment Control information in the CDA
E079	Missing/Invalid LOINC
E080	Missing/Invalid LOINC Modifier
E081	Missing/Invalid LOINC code for this attachment type
E082	Missing/Invalid LOINC Modifier for this attachment type
E083	Situational prohibited element is present
E084	Duplicate qualifier value in repeated segment within a single loop
E085	Situational required composite element is missing
E086	Situational required repeating element is missing
E087	Situational prohibited loop is present
E088	Situational prohibited segment is present
E089	Situational prohibited composite element is present
E090	Situational prohibited repeating element is present
E091	Transaction successfully received but not processed as applicable business function not performed.
E092	Missing/Invalid required SNOMED CT answer part(s) in the CDA
W001	Missing/Invalid submitter identifier
W002	Missing/Invalid receiver identifier
W003	Missing/Invalid member identifier
W004	Missing/Invalid subscriber identifier
W005	Missing/Invalid patient identifier
W006	Missing/Invalid plan sponsor identifier
W007	Missing/invalid payee identifier
W008	Missing/Invalid TPA/broker identifier
W009	Missing/Invalid premium receiver identifier
W010	Missing/Invalid premium payer identifier
W011	Missing/Invalid payer identifier
W012	Missing/Invalid billing provider identifier
W013	Missing/Invalid pay to provider identifier
W014	Missing/Invalid rendering provider identifier
W015	Missing/Invalid supervising provider identifier
W016	Missing/Invalid attending provider identifier
W017	Missing/Invalid other provider identifier
W018	Missing/Invalid operating provider identifier

Error Code	Error Code Description
W019	Missing/Invalid referring provider identifier
W020	Missing/Invalid purchased service provider identifier
W021	Missing/Invalid service facility identifier
W022	Missing/Invalid ordering provider identifier
W023	Missing/Invalid assistant surgeon identifier
W024	Amount/Quantity out of balance
W025	Duplicate
W026	Billing date predates service date
W027	Business application currently not available
W028	Sender not authorized for this transaction
W029	Number of errors exceeds permitted threshold
W030	Required loop missing
W031	Required segment missing
W032	Required element missing
W033	Situational required loop is missing
W034	Situational required segment is missing
W035	Situational required element is missing
W036	Data too long
W037	Data too short
W038	Invalid external code value
W039	Data value out of sequence
W040	"Not Used" data element present
W041	Too many sub-elements in composite
W042	Unexpected segment
W043	Missing data
W044	Out of range
W045	Invalid date
W046	Not matching
W047	Invalid combination
W048	Customer identification number does not exist
W049	Duplicate batch
W050	Incorrect data
W051	Incorrect date
W052	Duplicate transmission

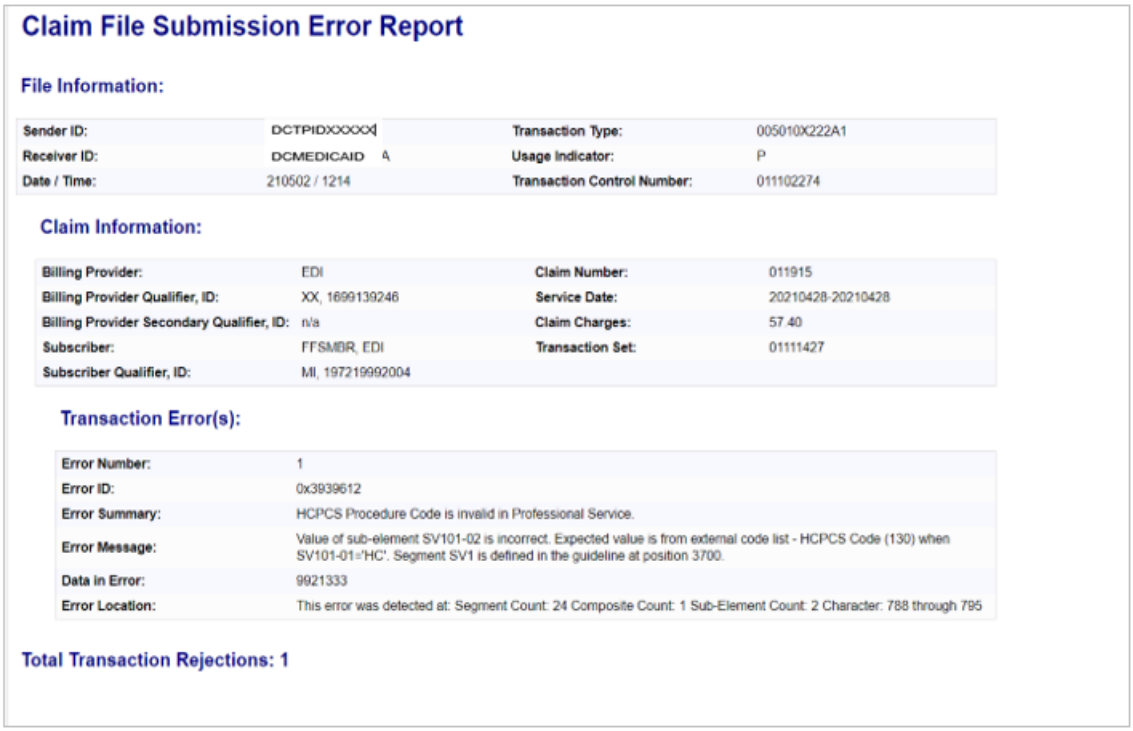
Error Code	Error Code Description
W053	Invalid claim amount
W054	Invalid identification code
W055	Missing or invalid issuer identification
W056	Missing or invalid item quantity
W057	Missing or invalid item identification
W058	Missing or unauthorized transaction type code
W059	Unknown claim number
W060	Bin segment contents not in MIME format
W061	Missing/Invalid MIME header
W062	Missing/Invalid MIME boundary
W063	Missing/Invalid MIME transfer encoding
W064	Missing/Invalid MIME content type
W065	Missing/Invalid MIME content disposition (filename)
W066	Missing/Invalid file name extension
W067	Invalid MIME base64 encoding
W068	Invalid MIME quoted-printable encoding
W069	Missing/Invalid MIME line terminator (should be CR+LF)
W070	Missing/Invalid "end of MIME" headers
W071	Missing/Invalid CDA in first MIME body parts
W072	Missing/Invalid XML tag
W073	Unrecoverable XML error
W074	Invalid Data format for HL7 data type
W075	Missing/Invalid required LOINC answer part(s) in the CDA
W076	Missing/Invalid Provider information in the CDA
W077	Missing/Invalid Patient information in the CDA
W078	Missing/Invalid Attachment Control information in the CDA
W079	Missing/Invalid LOINC
W080	Missing/Invalid LOINC Modifier
W081	Missing/Invalid LOINC code for this attachment type
W082	Missing/Invalid LOINC Modifier for this attachment type
W083	Situational prohibited element is present
W084	Duplicate qualifier value in repeated segment within a single loop
W085	Situational required composite element is missing
W086	Situational required repeating element is missing

Error Code	Error Code Description
W087	Situational prohibited loop is present
W088	Situational prohibited segment is present
W089	Situational prohibited composite element is present
W090	Situational prohibited repeating element is present
W091	Transaction successfully received but not processed as applicable business function not performed.
W092	Missing/Invalid required SNOMED CT answer part(s) in the CDA

A.7 Business Rejection Report (BRR)

District of Columbia (DC) Medicaid also produces a readable version of the 824 called the Business Rejection Report (BRR). This report helps to facilitate the immediate correction and re-bill of claims rejected during HIPAA validation. Refer to **Figure 1.**

Figure 1: Sample BRR



Claim File Submission Error Report

File Information:

Sender ID:	DCTPIDXXXXX	Transaction Type:	005010X222A1
Receiver ID:	DCMEDICAID A	Usage Indicator:	P
Date / Time:	210502 / 1214	Transaction Control Number:	011102274

Claim Information:

Billing Provider:	EDI	Claim Number:	011915
Billing Provider Qualifier, ID:	XX, 1699139246	Service Date:	20210428-20210428
Billing Provider Secondary Qualifier, ID:	n/a	Claim Charges:	57.40
Subscriber:	FFSMBR, EDI	Transaction Set:	01111427
Subscriber Qualifier, ID:	MI, 197219992004		

Transaction Error(s):

Error Number:	1
Error ID:	0x3939612
Error Summary:	HCPCS Procedure Code is invalid in Professional Service.
Error Message:	Value of sub-element SV101-02 is incorrect. Expected value is from external code list - HCPCS Code (130) when SV101-01='HC'. Segment SV1 is defined in the guideline at position 3700.
Data in Error:	9921333
Error Location:	This error was detected at: Segment Count: 24 Composite Count: 1 Sub-Element Count: 2 Character: 788 through 795

Total Transaction Rejections: 1

A.8 277CA Health Care Claim Acknowledgement

The 277CA is not generated in response to 837 Encounter submissions to the new DC MMIS.

In response to 837 Claims for DC Medicaid, a 277CA is generated and returned to communicate receipt by the DC Core MMIS Claim System when no Strategic National Implementation Process (SNIP) Level 1-5 and 7 errors have been detected and the claim submission is successfully received by the claim system. The 277CA also returns the DC Medicaid TCN/Claim ID for reconciliation and reference by the DC Medicaid trading partner in addition to the submitter assigned Trace Number returned in TRN.

Table 7: Information Receiver Application Trace Identifier

2220B	TRN	Information Receiver Application Trace Identifier	Codes	Length	Comments
	TRN01	Trace Type Code	2	2/3	Reference Transaction Trace Number
	TRN02	Reference Identification		1/50	Submitter's corresponding ST02 value from the associated 837 claim or encounter

Table 8: Claim Status Tracking Number

2220D	TRN	Information Receiver Application Trace Identifier	Codes	Length	Comments
	TRN01	Trace Type Code	2	2/3	Reference Transaction Trace Number
	TRN02	Reference Identification		1/50	Submitter's corresponding CLM01 value from the associated 837 claim or encounter

Table 9: DC Medicaid Claim Level Status Information

2200D	STC	Claim Level Status Information	Codes	Length	Comments
	STC01	Health Care Claim Status			DC Medicaid Claim Level Status Information
	STC01-01	Industry Code	A2	1/30	A2 – Acknowledgement/Acceptance into adjudication system
	STC01-02	Industry Code	19	1/30	19 – Entity Acknowledges receipt of claim/encounter
	STC01-03	Entity Identifier Code	PR	2/3	PR -Payer
	STC02	Date		8	Effective Date DC Medicaid Process Date
	STC03	Action Code	WQ	2/3	WQ – Accept
	STC04	Monetary Amount		1/18	

Table 10: DC Medicaid Assigned TCN/Claim ID

2220D	REF	Payer Claim Control Number	Codes	Length	Comments
	REF01	Reference Identification Qualifier	1K	2/3	Payer Claim Number
	REF02	Reference Identification		1/50	DC Medicaid Assigned Unique TCN/Claim ID Number

Appendix B. Glossary

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

Table 11: 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
COB	Coordination of Benefits
DC	DC Medicaid
DC CORE MMIS	New DC Medicaid MMIS Solution
DHCF	Department of Health Care Finance
DN	Referring Provider
EDI	Electronic Data Interchange
GAINWELL	Gainwell Technologies
GS	Functional Group Header
HCP	Claim Pricing/Repricing Information
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
ICN	Internal Control Number
ID	Identification
IEA	Interchange Control Trailer
ISA	Interchange Control Header
MCO	Managed Care Organization
NDC	National Drug Code
NPI	National Provider ID
REF	Secondary Identification
SBR	Subscriber Information
SFTP	Secure File Transfer Protocol
SNIP	Strategic National Implementation Process
SSL	Secure Session Layer
TPID	Trading Partner ID
TPL	Third-Party Liability

Acronyms	Description
TR3	Technical Report Type 3
VAN	Value Access Network/Data Aggregator
WPC	Washington Publishing Company

Appendix C. DDI Specific CG Value Updates

The following table contains the placeholders in this document for DDI specific production environment portal links and reference materials available to the trading partner community. The table also contains contact information for operations support including emails and phone numbers.

Once the DDI specific values are updated in the document this section and table should be removed.

Table 12: DDI Specific CG Value Updates

Placeholder	Description	DDI Specific Value: DC Medicaid
[EDI Helpdesk Email Address]	EDI Operations email address for inquiry and support	N/A
[EDI Helpdesk Phone #]	EDI Operations phone # for inquiries and support	N/A
[INSERT DC MEDICAID SPECIFIC URL HERE]	DC Prod Online Portal – Trading Partner 'getting started' link and DC finalized and published User Guides links	N/A
[INSERT DC MEDICAID SPECIFIC 5010 APPENDIX A VENDOR SPECS URL HERE]	Link to DC 5010 Appendix A Vendor Spec document on Prod	N/A
[INSERT DC MEDICAID SPECIFIC URLs LISTED HERE]	Link to all DC EDI Companion Guides and reference documents on Prod	N/A
DC_Operations@GAINWELLTECHNOLOGIES.COM	Email contact information placeholder as populated in PER segment for payer contact info	N/A
(XXX) XXX-XXXX	Phone contact information placeholder as populated in PER segment for payer contact info	N/A

