Attachment K Information Systems

ADMINISTRACIÓN DE SEGUROS DE SALUD

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NÚMERO DE CONTRATO

1. **Medicare Platino Reference Manual**
2. **ADDENDUMS**

ADMINISTRACIÓN DE SEGUROS DE SALUD

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NÚMERO DE CONTRATO

Medicare Platino Reference Manual

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TABLE OF CONTENTS

TABLE OF CONTENTS 4
I. INTRODUCTION 5
II. DEFINITIONS 6
III. MEDICAID ELIGIBILITY PROCESSES 13
A. ELIGIBILITY DETERMINATION 13
B. NOTICE OF DECISION 13
C. ELIGIBILITY DATE 13
D. ENROLLEE RECERTIFICATION 15
E. ELIGIBILITY END DATE 15
F. ELIGIBILITY EXTENSIONS 16
IV. ENROLLMENT IN GHP CARRIERS 16
A. GENERAL ENROLLMENT REQUIREMENTS 16
B. EFFECTIVE DATE OF ENROLLMENT 16
C. TERM OF ENROLLMENT 17
D. CARRIER NOTIFICATION PROCEDURES RELATED TO REDETERMINATION 17
E. ENROLLMENT PROCEDURES 18
F. ENROLLEE SELECTION OF CARRIER 18
V. DATA EXCHANGE BETWEEN PRMP AND CARRIERS 20
A. DATA EXCHANGE BETWEEN MEDICAID, ASES AND THE CARRIERS 20
B. GHP ENROLLMENT 21
VIII. GHP DISENROLLMENT (CANCELLATION/TERMINATION OF ELIGIBILITY) 22
A. DISENROLLMENT FROM THE GHP 22
B. GHP DISENROLLMENT EFFECTIVE DATE 22
IX. CARRIER DISENROLLMENT 23
A. DISENROLLMENT INITIATED BY THE ENROLLEE 23
B. EFFECTIVE DATE OF TEMPORARY PAYMENT SUSPENSION 23
X. PREMIUM PAYMENTS 24
A. TYPES OF PAYMENTS 24
B. ASES REASONS FOR NOT EXECUTING A PREMIUM PAYMENT 25
C. EDI 820 PAYMENT FILE 25
ADDENDUM 26
XV. APPROVALS 26
REVISION SHEET 26

I. INTRODUCTION

The Puerto Rico Health Insurance Administration, hereinafter known as PRHIA or ASES, is a government corporation created inaccordance with Act No. 72 of September 7, 1993, amended,also known as the "Puerto Rico Health Insurance Administration Act". PRHIA was created for the purpose of administering, negotiating and contracting health insurance plans that allow eligible beneficiaries, particularly those who are medically needy, to obtain quality hospital services and other medical services.

Moving in this direction, PRHIA is the entity responsible for negotiating on behalf of the Puerto Rico Department of Health, the federal coverage authorized by CMS (that is, Medicare Platino and Federal PRGHP, which is made up of the Medicaid and CHIP programs), with health insurance companies. PRHIA handles contracting matters with the coverage provided by the Health Program of the Government of the State of Puerto Rico "PRGHP" that serves the Population of the State or Commonwealth where it is determined that they are not eligible to receive benefits, under a coverage classification federal contracted health insurance company.

PRHIA oversees the administration of the services provided to eligible beneficiaries, under various health programs including Medicare Platino; The PRHIA Information Systems Office is responsible for verifying and validating the eligibility, enrollment and payment processes issued by PRMP-PRMMIS for the contracted medical insurance.

This document constitutes a reference manual, designed with the purpose of assisting Medicare Advantage Organizations (MAO) contracted by PHIA, in the eligibility, enrollment and payment processes of beneficiaries. The processes of eligibility, enrollment and payments received daily and monthly are defined as established in agreement with the Department of Health - Medicaid Office in Puerto Rico in the PRMMIS system and in contract.

II. DEFINITIONS

Adjusted Payment: Reversal of a payment that has been adjudicated during the payment process of a previous premium payment cycle.

ASES: Administración de Seguros de Salud de Puerto Rico (the Puerto Rico Health Insurance Administration (PRHIA)), the entity within the Government of Puerto Rico responsible for oversight and administration of the Government Health Plan (GHP) or its Agent.

Auto-Assignment: The assignment of an Enrollee to a PMG and a PCP by ASES, Carriers or Puerto Rico Puerto Rico Medicaid Office (PRMP).

Business Day: Traditional workdays, including Monday, Tuesday, Wednesday, Thursday, and Friday. Puerto Rico's holidays, as defined in the Law for Compliance with the Fiscal Plan, Act No. 26 of April 29, 2017, or any other law enacted during the duration of this Contract regarding this subject, are excluded.

Calendar Days: All seven days of the week.

Eligibility End Date: Is the date in which a member loses his or her eligibility for the GHP. The Puerto Rico Puerto Rico Medicaid Office is the only entity with the authority to cancel an enrollee's eligibility.

Carrier to ASES Data Submissions: Document provides health insurance carriers information to submit their health care claims, network, provider, IPA, and capitation data to ASES. **Reference Addendum 6 or 7**

Carrier Change: process where the file of the beneficiaries who changed their MCO is sent to the Actuary, to collect the history of the use of claims and meeting of the beneficiary for the Vital Plan and Medicare Platino.

Centers for Medicare and Medicaid Services ("CMS"): The agency within the U.S. Department of Health and Human Services which is responsible for the Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Eligibility date: It is the start date of an eligibility period. It is assigned by the Puerto Rico Medicaid (PRPM) according to the evaluation performed and eligibility program determined (CHIP, Medicaid, Commonwealth). As provided in **Section 3 of the Contract**, a decision of the Puerto Rico Puerto Rico Medicaid Office where a person is eligible to receive services under the GHP, in a Medicaid, CHIP or Commonwealth coverage classification. Some public employees and retirees can enroll in GHP without first receiving a Certification.

Coverage Code: Code assigned by the Puerto Rico Puerto Rico Medicaid Office to eligible beneficiaries, according to Federal, CHIP and Commonwealth indigence criteria. Under GHP, the coverage code will coincide with the Plan Version.

Covered Services: Those Medically Necessary health care services (listed in Article 7 of this Contract) provided to Enrollees by Providers, the payment or indemnification of which is covered under this Contract.

Daily Basis: Each Business Day.

Deemed Newborns: Children born to a mother with Medicaid or CHIP eligibility on the date or delivery and are eligible from the date of birth. They will be granted an eligibility period of thirteen (13) months.

Disenrollment: The process by which an Enrollee's membership in the Contractor's Medicare Platino terminates.

Domestic Violence Population: Certain survivors of domestic violence referred by the Office of the Women's Advocate

Dual Eligible Enrollee: An Enrollee or potential enrollee eligible for both Medicaid and Medicare (Part A or Part A and B).
EDI: Electronic Data Interchange (EDI) Process **Reference Addendum 9**

Effective date of the change of Carrier: It is the start date of the enrollment of an affiliate in a selected Carrier. For changes made in the first twenty days of the month, registration with the Carrier will become effective on the first day of the following month according to the selection of the Carrier. For Carriers, changes made after the first twenty days of the month, Carriers' registration will take effect on the first day of the following month (20-day rule).

Effective Date of Disenrollment: The date on which an Enrollee ceases to be covered under the Contractor's Plan.

Eligibility: Eligibility is determined by the Puerto Rico Puerto Rico Medicaid Office of Department of Health.

Eligibility Determination: For each applicant for the Government Health Insurance Plan, hereinafter GHP, an eligibility determination precedes the enrollment confirmation and premium payment processes carried out at the ASES Finance Office by MMIS platform. The Medicaid Program of the Commonwealth of Puerto Rico, which administers the Puerto Rico Medical Assistance Program, is the entity with authority to determine if a person is eligible to receive medical services under the Federal GHP (Medicaid and CHIP) and the GHP State (Commonwealth Population) and Medicare Platino.

The evaluation of eligibility for each of the programs is based on the requirements established in state and federal regulations. Generally, the eligibility assessment for an individual is determined by income level and its correlation with indigence levels. In Platinum Medicare, the applicant's age (65 years or

older) or disability status referred to in Title XVIII of the Social Security Act is considered.

In any of the categories of health plans, beneficiaries are certified annually. This means that your eligibility is normally extended for a period of one (1) year on each successful certification.

Eligible Person - A person eligible to enroll in the GHP, as provided in Section 3 of this Contract, by virtue of being eligible for Medicaid, CHIP, or Commonwealth coverage.

Enrollment Effective Date (Carrier Effective Date): The date the eligible member is enrolled with the contracted Carrier. This date considers the effective date of eligibility or the effective date of the change in Carrier.

Enrollment End Date (Carrier End Date): The effective end date of the member's coverage period at the assigned insurance carrier.

Enrollment Start Date: This is the member's start date for the current period of continuous enrollment with the current insurance carrier.

Enrollee: A person who is enrolled in a Carrier's GHP, as provided in this Contract, and who, by virtue of relevant Federal and Puerto Rico laws and regulations, is an Eligible Person listed in Section 3 of the Contract.

Enrollment: The process by which an Eligible Person becomes an Enrollee of the Carrier's Plan.

Federal Category: Classification established by the Puerto Rico Puerto Rico Medicaid Office for an Enrollee, according to established criteria of indigence levels. This category includes the population that benefits from the Medicaid and CHIP programs.

FMAP change (change in the FPL- Federal Poverty Level) - is computed from a formula that considers the average per capita income for each State relative to the national average. Are used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.

Government Health Insurance Plan (GHP): The government health services program (formerly called "Vital") offered by the government and administered by ASES, serving a mixed population of eligible for Medicaid, CHIP and Commonwealth, and emphasizes the integrated delivery of physical and behavioral health services.

GHP Welcome Package: The first welcome package that a Carrier sends to Enrollees upon enrollment.

Health Insurer Code: This is the code assigned to the Insurance Company

Health Insurance Claim Number (HICN): Previously it was a Medicare enrollee's identification number and appeared in the enrollee's insurance card. A new Medicare Enrollee Identifier (MBI) replaced the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

HIPAA Transaction 270-271 - Eligibility and Benefit Response to a request inquiry about the health care eligibility and benefits associated with a subscriber or dependent. **Reference Addendum 10**

HIPAA Transaction 820 - Health Insurance Exchange Related Payments **Reference Addendum 2**

HIPAA Transaction 834 - The ANSI 834 EDI Enrollment Implementation Format is a standard file format for the electronic interchange of health plan enrollment data. The Health Insurance Portability and Accountability Act (HIPAA) requires that all health plans or health insurance companies accept a standard enrollment format: ANSI 834A Version 5010. An 834 file contains an order of data, such as a subscriber's name, hire date, etc. in a data segment. The 834 is used to transfer enrollment information from the insurance coverage sponsor, benefits, or policy to a payer. The intent of this implementation guide is to meet the specific need of the health care industry for the initial enrollment and subsequent maintenance of individuals who are enrolled in insurance products. This implementation guide specifically addresses the enrollment and maintenance of healthcare products only. One or more separate flexible spending and retirement guidelines may be developed. **Reference Addendum 3**

HIPAA Transaction 835 - is the electronic claim payment information and documents the electronic funds transfer (EFT). The 835 data shows how the claim is paid or denied electronically. Addendum 4

HIPAA Transaction 837 - data is how a claim is sent electronically Addendum 5

Identification Card (ID): A card bearing an Enrollee's name, contract number, and co-payment amounts, and a customer service telephone number, which is used to identify the Enrollee in connection with the provision of services.

Carriers: The Managed Care Organization that is a Party of this Contract, licensed as a Carrier by the Puerto Rico Commissioner of Insurance ("PRICO"), which contracts hereunder with ASES under the GHP for the provision of Covered Services and Benefits to Enrollees based on PMPM Payments

Managed Care Organization (MCO): An entity that is organized for the purpose of providing health care and is licensed as a Carrier by the Puerto Rico Commissioner of Insurance ("PRICO"), which contracts with ASES for the provision of Covered Services and Benefits Island-wide based on PMPM Payments, under the GHP.

Master Patient Index (MPI): Unique number that is assigned in the information systems of the Office of Medicaid in Puerto Rico to an individual, when they determine that he is eligible for Medicare Platino and continues to be an identifier number in the ASES information systems.

Medicaid: The medical assistance federal/state joint government program established by Title XIX of the Social Security Act. It also refers to the Program through which, in Puerto Rico, eligibility is determined for the Government Health Insurance Plan for an individual with low income, no income or limited resources, in compliance with regulations established by the Federal government and the Commonwealth of Puerto Rico.

Medicaid Eligible: An individual eligible to receive services under Medicaid, who is eligible, on this basis, to enroll in the GHP.

Medicaid ID: Identifier number assigned to the medical-physician provider after registration in the PEP system of the Medicaid Office in PR

Medically Necessary Services: Those services that meet the definition found in **Section 7 of the Contract.**

Medicare: The Federal Program of medical assistance for persons over sixty-five (65) and certain disabled persons under Title XVIII of the Social Security Act.

Medicare Advantage Organization (MAO): A public or private organization licensed by the Insurance Commissioner Office of Puerto Rico as a risk-bearing entity that under contract with CMS to provide the Medicare Advantage Benefit Package.

Medicare Beneficiaries: People older than sixty-five (65) years of age or disabled or peoplewho have kidney conditions, who are eligible for Medicare Part A coverage which covers hospital services or Parts A and B, which cover hospital, ambulatory and medical care services.

Medicare Part A: The part of the Medicare program that covers inpatient hospitalstays, skilled nursing facilities, home health and hospice care.

Medicare Part B: The part of the Medicare program that covers physician, outpatient,home health, and preventive services.

Medicare Part C: The part of the Medicare program that permits Medicare recipients to select coverage among various private insurance plans.

Medicare Platino: A program administered by ASES for Dual Eligible Beneficiaries, in which Managed Care Organizations (MCOs) or other insurers under contract with ASES function as Part C plans to provide services covered by Medicare and provide a "wraparound" benefit Covered Services and Benefits under the GHP.

National Provider Identifier ("NPI"): The 10-digit unique-identifier numbering system for Providers created by the Centers for Medicare & Medicaid Services (CMS), through the National Plan and Provider Enumeration System.

Notice of Action Taken: Form issued by the Puerto Rico Medicaid Office, entitled "Notice of Action Taken or Application and/or Recertification" containing the Certification decision (whether a person was determined eligible or ineligible for Medicaid Coverage, CHIP, or Commonwealth).

National Provider Identifier (NPI): The unique identifying number system for health care providers created by the Centers for Medicare and Medicaid Services (CMS), through the National Plan and Provider Enumeration System.

PCP Effective Date: Date on which a PCP enrollment becomes effective.

Plan Version: Product identification number that corresponds with the Plan Type. For GHP, the Plan Version will be the same as the code assigned to the beneficiaries by the Puerto Rico Medicaid Office.

PMPM Premium ("Per Member Per Month (PMPM)" Payment): The fixed monthly amount that the Contracted Carrier is paid by ASES for each Enrollee to ensure that benefits under this contract are provided. This payment is made regardless of whether the enrollee receives benefits during the period covered by the payment.

Potential Enrollee: Possible affiliate: A person who has been certified by the Puerto Rico Puerto Rico Medicaid Office as eligible to enroll in the GHP (either Medicaid, CHIP or Commonwealth category coverage), but who has not yet enrolled with a contracted Carrier.

Poverty Level: As required by Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)), the Department of Health and Human Services (HHS) updates the poverty guidelines at least annually and by law these updates are applied to eligibility criteria for programs such as Medicaid and the Children's Health Insurance Program (CHIP). These annual updates increase the Census Bureau's current official poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI–U).

Primary Care Physician (PCP): A licensed medical doctor (MD) who is a Provider and who, within the scope of practice and in accordance with Puerto Rico Certification and licensure requirements, is responsible for providing all required Primary Care to Enrollees. The PCP is responsible for determining services required by Enrollees, provides continuity of care, and provides Referrals for Enrollees when Medically Necessary. A PCP may be a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

Primary Medical Group (PMG): A grouping of associated Primary Care Physicians and other Providers for the delivery of services to GHP Enrollees using a coordinated care model. PMGs may be organized as Provider care organizations, or as another group of Providers who have contractually agreed to offer a coordinated care model to GHP Enrollees under the terms of this Contract.

Prorated Payment: A late payment that covers a fraction of the month prior to the month in which the premium payment is made. Prorated payments only apply to Carriers specifically during the first month of eligibility for the Commonwealth covered population and newborns. The concept of prorated payments also applies to adjusted payments considering the different reasons that trigger cancellations.

Provider: Any physician, hospital, facility, or other Health Care Provider who is licensed or otherwise authorized to provide physical or Behavioral Health Services in the jurisdiction in which they are furnished.

Puerto Rico Puerto Rico Medicaid Office (or "Medicaid Office" or PRMP): Puerto Rico Puerto Rico Medicaid Office (or "Medicaid Office"): The subdivision of the Department of Health that makes eligibility determinations and offers a Carrier selection after a favorable result of said determination under GHP for Medicaid, CHIP and Commonwealth coverage.

Recertification: A determination by the Puerto Rico Medicaid Program that a person previously enrolled in the GHP subsequently received a Negative Redetermination Decision, is again eligible for services under the GHP.

Redetermination: The periodic Redetermination of eligibility of an individual for Medicaid, CHIP and Commonwealth coverage, conducted by the Puerto Rico Medicaid Office.

Re-enrollment: Refers to the process of re-enrollment for a Beneficiary of Federal GHP (Medicaid or CHIP) or State GHP (State Population) or Medicare Platino who has lost eligibility for a period of six (6) months. A Medicare Platino Beneficiary that recovers his/her eligibility within a period of two (2) consecutive months, may be enrolled automatically and prospectively under the Medicare Platino plan of the Contractor in question.

Retroactive Payment: Refers to a payment that corresponds to a period prior to the month in which the PMPM Payment is made.

State Population (or "Commonwealth Population"): A group eligible to participate in the GHP as Other Eligible Persons, with no Federal participation supporting the cost of their coverage, which is comprised of low-income persons and other groups mentioned in Section 1 of the contract.

III. MEDICAID ELIGIBILITY PROCESSES

A. Eligibility Determination

The Medicaid Office, which administers the Puerto Rico Medicaid Assistance Program, is the state plan agency with authority to determine if a person is eligible to receive services covered under the GHP. Members can be determined eligible to participate in the GHP as a recipient of Medicaid funded with Federal (Federal), CHIP, or Commonwealth funds. For the Medicaid and CHIP populations, the eligibility criteria are established in the State Plan and in cooperation with CMS. For state beneficiaries, eligibility requirements are set by the Medicaid Program, except for public employees and pensioners included in Other Eligible Populations, which are determined by independent ASES policies.

B. NOTICE OF DECISION

The Puerto Rico Medicaid Office's determination that a person is eligible for the GHP is contained on Form Notice of Decision, titled "Notification of Action Taken on Application and/or Recertification." A person who has received a Notice of Decision is referred to as a "Potential Enrollee."

The Potential Enrollee may access Covered Services using the Notice of Decision as a temporary Enrollee ID Card from the first day of the eligibility period specified on the Notice of Decision even if the person has not received an Enrollee ID Card. Only Medicaid, CHIP, and Commonwealth Enrollees receive a Notice of Decision and may access Covered Services with the Notice of Decision as a temporary Enrollee ID Card. A Form Notice of Decision will be provided for each Household Potential Enrollee included in the Application and the authorized contact member.

The Notice of Decision report is valid for the eligibility period identified on Form Notice of Decision and may be used for a period of thirty (30) calendar days from the date of Certification for the purpose of demonstrating eligibility. See **Addendum 1- Notice of Decision Form**.

C. Eligibility date

Federal Program Enrollee (Medicaid category)

The Eligibility Date for purposes of a Medicaid or CHIP Potential Enrollee is the first day of the month in which the Puerto Rico Puerto Rico Medicaid Office determines eligibility. This should be the same date indicated as the eligibility period on the document Notice of Decision.

The eligibility period specified in the Decision Notification Report may be a retroactive eligibility period, up to three (3) months before the first day of the month, in which the Potential Affiliate submits his / her application for eligibility to the Office of Puerto Rico Medicaid with Federal Medicaid and CHIP coverage where services can be covered retroactively. Retroactivity, on the effective date of eligibility, is granted when the prospective member indicates that they incurred medical expenses prior to the current eligibility period, including any services covered by Federal Medicaid or CHIP coverage, that relate to drugs or services, where pharmacy expenses are generated and have not been paid. The effective date of eligibility will be within the three (3) months prior to the month in which the prospective member submits the application. If the prospective member is eligible for Federal Medicaid or CHIP coverage in the month the service was eligible, the prospective member will receive retroactive eligibility. Retroactive benefit does not apply to Commonwealth covered beneficiaries. Retroactive eligibility is evaluated for all potential members with Federal Medicaid and CHIP coverage who notify the Puerto Rico Medicaid Office about their medical expenses and/or utilization of services during the allowed period of three (3) months.

When an Enrollee re-certification is filed, and the Enrollee is again eligible, as determined by the Puerto Rico Medicaid Office, the Eligibility Date for the subsequent period is generally the 1st of the month after eligibility expires from the previous eligibility period. If an Enrollee does not apply for Re-certification at the Puerto Rico Medicaid Office once his/her eligibility period has expired, the eligibility for the GHP is lost. This will happen even in cases in which the Enrollee's eligibility was lost for at least one (1) day. The Eligibility Date for a new eligibility period for these cases will be the first (1st) day of the month of the new application for certification.

A person can apply for Federal Medicaid / CHIP coverage on behalf of a person who has died, during the same month they applied or up to three (3) months retroactively if the person was eligible in those months. The eligibility period will be from PRMP determine to the date of death. This provision does not apply to Commonwealth covered beneficiaries.

All pregnant women with federal, Commonwealth and CHIP coverage may have an eligibility period greater than twelve (12) months by adding the required sixty (60) days of postpartum coverage. The expiration date will be the last day of the month, at the end of these sixty (60) days.

Commonwealth Enrollees (Commonwealth Category Beneficiaries)

The Commonwealth effective date of eligibility is the eligibility period specified on the decision of notification report, and potential members are eligible to enroll as of that date. Note that a potential member may be classified as a Commonwealth covered member for their current eligibility period but may be classified as a federally covered member for any of the retroactive eligibility periods.

Recertification for members of Commonwealth coverage, in which the member is re-eligible, the eligibility date is the first (1st) day of the month after the expiration of current eligibility. The certification date for beneficiaries of coverage in the Commonwealth will be when the certification is completed. If a Commonwealth coverage member's eligibility period expires prior to recertification, the Commonwealth coverage member's eligibility will be processed as a new case and the eligibility effective date will be the new eligibility effective date provided on the document Notice of Decision. The member of Commonwealth coverage can request a Carrier at the Puerto Rico Medicaid Office for the new period of eligibility at the time of certification.

D. Enrollee Recertification

After a period of eligibility is granted to a member, two (2) or three (3) months prior to the expiration date of eligibility, the member will undergo a recertification process, for a new period of eligibility, which will be carried out by the Puerto Rico Medicaid Office. This will allow for the renewal of covered services during the next twelve (12) month period. The effective date of recertification refers to the date that the Puerto Rico Medicaid Office reevaluates the eligibility of an enrollee. This date is provided on the decision notification report. The Eligibility Expiration Date refers to the expiration date of the eligibility period granted to the member by the Puerto Rico Medicaid Office. A federal and Commonwealth covered member who is recertified will have their current eligibility period noted and will have a future Eligibility Effective Date in the Decision Notice for their next eligibility period beginning the day after the period expires. current eligibility.

E. Eligibility End Date

The cancellation or termination of an eligibility period is notified in the data transferred in the journal files in the standard 834 format. The specifications of these data and processes are determined in the current 834 Companion Guide.

Daily base, all insurers contracted by ASES and ASES will receive from Puerto Rico Medicaid Office a file, in 834 formats, with the eligibility, change of circumstances and enrollment status of the beneficiaries.

Now of a certification or recertification of a member, an Expiration Date is established. If the eligibility of a member is extended for any of the reasons explained later in this document, the expected termination of such extension will be expressed through the Medicaid Cancellation Date. Also, if the eligibility period of a member, extended or not, is terminated before the Expiration Date (for example, by the death of an enrollee, members identified in the PARIS file, or by voluntary resignation) or a previously stated Medicaid Cancellation Date (for example, by a pregnancy that ended prematurely), the date for the real cancellation of the eligibility period of a member will be in 834 daily file.

F. Eligibility Extensions

When the Puerto Rico Medicaid Office grants an extension of eligibility, the date the extension expires is included in the eligibility data in 834 formats.

Extensions of eligibility are caused by different reasons such as pregnancy or natural disasters among others.

Extensions will be notified prior to the expiration date of eligibility.

IV. ENROLLMENT IN GHP CARRIERS

A. General Enrollment Requirements

The Carrier must guarantee the maintenance, functionality, and reliability of all systems necessary for Enrollment and Disenrollment, pursuant to the Contract and this Manual.

B. Effective Date of Enrollment

The effective date of enrollment (assignment date) will be assigned in the 834 daily data. For new and recertification cases, the effective date must be equal to the date stipulated in the Notice of Decision

document set forth in the Contract or based on carrier and other changes such as PCP and/or PMG changes. In addition to this section of the contract, please refer to the 834 Companion Guide.

The effective date of enrollment for a newborn whose mother is eligible for Federal Medicaid or CHIP coverage begins from the date of birth. The Effective Date of Enrollment for a newborn whose mother is an Affiliate of the Commonwealth coverage is the Effective Date of Eligibility established by the Puerto Rico Medicaid Program. A newborn will be automatically enrolled in accordance with the procedures established in the Contract.

C. Term of Enrollment

The Term of Enrollment with the Carrier shall be a period of twelve (12) consecutive months for all GHP Enrollees. The enrollees may change platinum carriers for periods of not less than three months. The beneficiary has the right to disenroll from the platinum carrier and enroll in a Vital carrier at any time he/she deems necessary.

Members enrolled in a Platinum carrier cannot make changes through the Enrollment Counselor. Such a shortened eligibility period may apply, at the discretion of the Puerto Rico Medicaid Program, when an Enrollee is pregnant, is homeless, or anticipates a change in status (such as receipt of unemployment benefits or in family composition). Refer to Article 3 of The Contract on regarding the Effective Date of Disenrollment.

Pregnant Enrollees with a Term of Enrollment that expires during pregnancy or within sixty (60) Calendar Days of the post-partum period have an extended Term of Enrollment that expires on the last day of the month after sixty (60) Calendar days counted from the beginning of the post-partum period.

Except as otherwise provided in the Article 3 of The Contract on regarding the, and notwithstanding the Term of Enrollment provided in the Article 3 of The Contract, Enrollees remain enrolled with the same Carrier until the occurrence of an event listed in Section 3 of the Contract (Disenrollment).

D. Carrier Notification Procedures Related to Redetermination

The Carrier must inform Enrollees who are Federal Medicaid and CHIP Eligible and coverage Commonwealth of an impending Redetermination through written notices. Such notices shall be provided ninety (90) Calendar Days, sixty (60) Calendar Days, and thirty (30) Calendar Days before the scheduled date of the Redetermination pursuant on The Contract.

E. Enrollment Procedures

For all Enrollees the Carrier must comply with the Auto-Enrollment process and issue to the Enrollee a notice informing the Enrollee of the PCP (and PMG if apply) they are assigned to and their rights to change the PCP without cause during the applicable Open Enrollment Period, on 834 formats.

The new enrollees for a Carrier could change his/her Auto-Assigned or Selected PCP (and PMG if apply) without cause through the Carrier. The Carrier can offer counseling and assistance to the Enrollee in selecting a different PCP (and PMG if apply). The no new enrollees could change de the PCP (and PMG if apply) but with just cause. For both, the Carrier has the responsibility to notify PCP (and PMG if apply) changes to PRMP by the 834 transactions.

For new enrollees, the Carrier must issue the Enrollee ID Card and a notice of Enrollment, as well as an Enrollee Handbook and Provider Directory either in paper or electronic form, within five (5) Business Days of Enrollment pursuant to the Article 4 of The Contract. The notice of enrollment must clearly state the Effective Date of Enrollment. The notice of Enrollment will explain that the Enrollee is entitled to receive Covered Services through the Carrier.

All Enrollees must be notified at least annually of their disenrollment rights as set forth in the Article 3 of The Contract and 42 CFR 438.56.

F. Enrollee Selection of Carrier

Dual Population

When an enrollee loses some or all portions of Medicare and remains eligible, he or she is entitled to select a Carrier Vital with eligibility on the day he or she becomes ineligible for Medicare Platino coverage. This process is handled by ASES Customer Service technicians.

If a beneficiary with Medicare AB parts is enrolled in a Medicare Platino Plan and wishes to move to a Vital Plan, he/she may do so through the ASES or PRMP Customer Service technicians.

V. DATA EXCHANGE BETWEEN PRMP AND CARRIERS

The following sections provide an overview of data exchange information between PRMP, ASES and Carriers. For specific data layout information, refer to Attachment K with the referenced layout files.

A. Data Exchange Between Medicaid and MAOs

1. PRMP and MAOs Data Exchange (834 file)

When a new beneficiary enters the PRMP System, he/she automatically enters a Vital carrier selected by the beneficiary. If the beneficiary has Medicare Parts A & B benefits, he/she has the right to remain on Vital or select a platinum carrier.

In the case of selecting a Platinum carrier, the carrier may send PRMP a query file in 270 format (see Attachment 12) for the purpose of confirming the member's eligibility. PRMP then evaluates the eligibility of the members included in the query file 270 and responds with another file in 271 format (see annex 12).

For the members that PRMP identified as eligible in the Respose File 271, the Medicare Platino insurer will proceed to send a membership in the 834 format.

When the Platino's carrier enrolls an eligible member must assign a PCP (and PMG if applicable), then it must notify PRMP in the 834 Inbound log files including all data required by the 834 formats. The Carrier is required to send ID cards along with a GHP Welcome Packages, to the new enrollees by postal mail in five (5) business days pursuant to Section 4 of the Contract.

The Enrollee, in turn, has ninety (90) days to request a change of MCO, PCP (and PMG if applicable). Then, the Carrier produces the electronic registration record and sends to PRMP in a file (834), If the member's Coverage Code, PCP or PMG changes, the Carrier must send an enrollment record to PRMP that reflects the change as confirmation of the issuance of a new plan identification card and its shipment to the member.

Generally, Carriers have one business day to remit enrollment records. They must notify information about the new Enrollees and send information about any changes made to a record previously enrolled. Such notification must be sent on the next business day.

When an enrollee changes the carrier, data sent to the current Carrier include the is received the carrier termination date. In this case, the previous Carrier must perform a disenrollment of the enrollee in its database. The new Carrier will receive the effective date.

In the case that the Carrier must update the information previously in relation to a new enrollment, or when it is appropriate to add a new enrollee that has been previously omitted, that update must occur the next business day after the information has been updated or that a new enrollee has been added. In these cases, reserves the right not to accept new additions or corrections to the enrollment data after two (2) business days after the Effective Date of the Enrollment indicated in the Carrier's notification.

Records that are accepted without errors during the editing process are updated in the databases and the beneficiaries are duly enrolled confirmed.

PRMP will validate data sent from Carrier. The records for the rejected enrollments are returned to the Carrier with the applicable reject codes in a CSV file daily. The Carrier must correct any errors in the enrollment record and send the information back within two (2) business days. ASES will only pay the premiums related to those beneficiaries who are enroll confirmed. Therefore, the execution of the payment of the corresponding premium for these rejected records will be delayed until the enrollment records are sent back with the correction of the indicated errors

During the premium payment process, confirmation received during the month prior to the execution of the process is considered. The Carrier must make sure to complete the reconciliation of beneficiaries every month.

This process is established in the Companion Guide for the requirement of format 834 – PRMMIS – **Reference Addendum 3**

B. GHP Enrollment

For an enrollment record to be accepted during the editing and validation processes, it is important to consider the following considerations regarding concepts related to the enrollment processes:

Effective Date of Enrollment

a. The Carrier Effective Date

Please consult Section IV of this Manual and Section 5.2.2 of the Contract for a discussion of Effective Dates of Enrollment.

b. The PCP1 and PMG information

In the case of new Enrollees, the PCP1 and PMG Effective Dates will match the Eligibility Effective Date. If a change for any of the PCPs or the PMG is performed through the Carrier, the Carrier will follow the specifications described under Section 5.4 of the contract where the management of those changes is defined.

c. Plan Version/Coverage Code Effective Date

The coverage code will only change during the recertification process performed and in the change of circumstances registered by PRMP. When a recertification is performed, the Effective Date of Eligibility changes to that of the next period, hence the Plan Version Effective Date will match the Eligibility Effective Date. These changes require insurers to send a new health plan ID card to members, since changing the coverage code changes the co-payments.

VIII. GHP DISENROLLMENT (CANCELLATION/TERMINATION OF ELIGIBILITY)

A. Disenrollment from the GHP

The process of disenrollment from the GHP occurs when the Puerto Rico Medicaid Office determines that an enrollee is no longer eligible for GHP.

A GHP disenrollment occurs when the Puerto Rico Medicaid Office determines that (1) Termination of Benefits (the eligibility period expired or not comply to requirements to eligibility, (2) death of the member, and (3) voluntary withdrawal.

Medicaid will notify of cancellation of eligibility for the appropriate reason. See the 834 Companion Guide.

B. GHP Disenrollment Effective Date

The effective date of cancellations will be determined by the Puerto Rico Medicaid Office and expressed in the 834 files data. See the 834 Companion Guide for more details.

IX. CARRIER DISENROLLMENT

A. Disenrollment Initiated by the Enrollee

All Enrollees must be notified at least annually of their disenrollment rights as set forth in Section 3 of the Contract and 42 CFR 438.56. Such notification must clearly explain the process for exercising this disenrollment right, as well as the coverage alternatives available to the Enrollee based on their specific circumstance.

An Enrollee wishing to make a change of carrier should contact the desired Platino carrier. The new Platino carrier sends the enrollment to PRMP in 834 daily files.

B. Effective Date of Temporary Payment Suspension

In order for the premium payment process to make the corresponding payment, confirmation of the beneficiaries' affiliation is indispensable. If the beneficiary does not have a confirmed affiliation, the payment will not be made. This temporary suspension takes place in those cases in which the Puerto Rico Medicaid Office has sent a change of coverage code for an enrollee and the Carrier has not submitted an enrollment with the new version of the plan related to the change of coverage, but the enrollee continues to be eligible and enrolled with the Carrier.

Although in cases of Temporary Payment Suspension the eligibility period will continue for the beneficiaries on behalf of whom the PRMP has sent a change of coverage code for an enrollee and the Contractor has not submitted an enrollment with the new plan version related to the change of coverage, the premium payment cannot be processed until a new enrollee enrollment is sent by the Contractor with the information of the new plan version related to the change of coverage. Once the new plan version is received, retroactive premium payments will resume.

This process is established in the Companion Guide for the requirement of format 834 – PRMMIS – **Reference Addendum 3**

X. PREMIUM PAYMENTS

The premium payment system operates under the concept that premiums are calculated and paid only in relation to beneficiaries who are already enrolled to which the payment corresponds. Beneficiaries enrolled after that date will be considered for the next payment of the corresponding premium.

ASES will not pay premiums for beneficiaries whose membership has not been confirmed or for expired members.

The payment system calculates several payment categories as listed below:

A. Types of Payments

Monthly Payments

In this case the system produces a payment for those beneficiaries whose enrollment has already taken effect before the first day of the month for which the payment transaction is executed. The execution of premium payment is run on the first day of the month.

Retroactive Payments

These payments are calculated when the Effective Date of Enrollment falls on a period prior to the month for which the premium payment process is being executed. In other words, this type of payment is executed when payments are identified corresponding to months prior to the month in which a premium payment is made. The retroactive payments will be computed based on the enrollment effective date or carrier effective date. The system will process the premiums for enrolled beneficiaries with an effective date prior to the payment date in the case of monthly premiums or prorated premiums that have not been previously paid within the time limits for retroactive payments. Retroactive payments may result in an adjusted payment if they are the result of a PRMP's cancellation of a previous enrollment.

Adjustments

A payment adjustment is calculated when there is a need to reverse a payment that was awarded to a Carrier during a previous premium payment process. It occurs when, because of a retroactive payment calculation, a payment made in relation to the same enrollee is identified within the same period that has been affected under a Carrier change or Plan Version change. The adjustments are calculated for those cases where an enrollee changes Carrier and the Carrier executed a late

enrollment after ASES had disbursed payment to the first Carrier in a previous payment transaction. In these cases, an adjustment of the premium paid to the first Carrier is made.

Other adjustments are generated by retroactive cancellations leading to the recovery of payments already made.

B. Reasons for not Executing a Premium Payment

A premium payment will not be executed in favor of a Carrier in the following circumstances:

(1) If the enrollee is not confirmed enroll
(2) If the enrollment had been rejected and a new enrollment was not submitted by the Carrier with the relevant corrections
(3) If PRMP eligibility and enrollment data demonstrates that the enrollee had a disenrollment eligibility cancellation, eligibility expiration or changed the Carrier.
(4) If for late eligibility enrollment.

C. EDI 820 Payment File

The EDI 820 files are prepared for each run of the premium payment process to enable insurers to reconcile payments made to them. It includes the details of the types of payment corresponding to each of the beneficiaries assigned to the Carriers contracted. See **Attachment 2, 820 Companion Guide.pdf.**

ADDENDUM

Addendum 1 Notice of Decision
Addendum 2 PRMMIS_820_Companion Guide_v2.6
Addendum 3 PRMMIS_834_Companion_Guide_20260123
Addendum 4 PRMMIS_835_Companion_Guide_Payment_v1.8
Addendum 5 PRMMIS_PHASE_I_837_D_Companion_Guide_v7.1
Addendum 6 Carrier to ASES ver 4.1C_rev20230221
Addendum 7 Carrier to ASES ver 5.1A_rev20230221
Addendum 8 EFT Folder Organization Insurance Carrier
Addendum 9 Electronic Data Interchange (EDI) Process
Addendum 10 Query and Response file 270 & 271 Companion Guide

XV. APPROVALS

Revision Sheet

Date: 3/26/2026

Gabriel E. González Maldonado, MEM, PMP
Chief Technology Officer

ADDENDUM 1
Notice of Decision

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 00002

NÚMERO DE CONTRATO

GOBIERNO DE PUERTO RICO

You can get this notice in English, or in another way that's best for you. Call us at **1-787-641-4224** (TTY: 1-787-625-6955).
Usted puede obtener esta notificación en inglés, o en otro formato que sea mejor para usted. Llámenos al **1-787-641-4224** (TTY: 1-787-625-6955).

Número de caso: 32858
Fecha de la carta: 25 de mayo de 2021

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 00002

NÚMERO DE CONTRATO

Jerry Rosas Mcquire
737 Main Street
San Juan, PR 00901

Notificación de Decisión - Solicitud de Beneficios Médicos

Procesamos su solicitud y determinamos la elegibilidad para los solicitantes que se muestran a continuación en el Resumen de Decisiones de Elegibilidad. Después del resumen encontrará detalles de los resultados de elegibilidad que pueden continuar en páginas adicionales. Asegúrese de leer ambos lados de cada página.

Resumen de Decisiones de Elegibilidad

Nombre	MPI	Elegibilidad	Fecha de Efectividad	Fecha de Vencimiento
Rosas Mcquire, Jerry	96000002846	Medicaid	1 de mayo de 2021	30 de septiembre de 2021

Nombre	MPI	Código Cubierta	Tope de Copagos	MCO/ MAO
Rosas Mcquire, Jerry	96000002846	100	0.00	MEN

MCO	FMH = First Medical Health Plan, MEN = Plan de Salud Menonita, MMH = MMM Multi Health, MOL = Molina Health Care, TSS = Triple-S Salud
MAO	HUM = Humana Health Plans, MCS = MCS Advantage, MMM = Medicare y Mucho Mas, TSA = Triple-S Advantage

Cómo Tomamos Nuestras Decisiones de Elegibilidad

Utilizando la información proporcionada en su solicitud, determinamos el tamaño del núcleo familiar y los ingresos de cada persona que se muestra en el Resumen de Decisiones de Elegibilidad. Se utilizo la información de cada persona con el propósito de corroborar si cumplía con los criterios para los programas de cubierta de salud y se determino a qué categoría pertenecen. Los ingresos fueron verificados para determinar si estaban dentro de los límites de la categoría correspondiente con los siguientes resultados:

Debido a la actual emergencia de salud pública, Rosas Mcquire, Jerry: determinamos que el tamaño de su núcleo familiar "Medicaid" es 1 y su ingreso "Medicaid" es $0.00 por mes. El límite de ingresos "Medicaid" para este tamaño de núcleo familiar es $1,247.00 por mes, por lo tanto, Jerry es elegible para la cubierta "Medicaid" desde 1 de mayo de 2021 a 30 de septiembre de 2021. Para copagos, contamos el tamaño de su núcleo familiar MAGI de 1 y un ingreso MAGI de $0.00 por mes, lo que resulta en un código de cubierta de 100

Uso de Su Cubierta de Beneficios Médicos

El/Los individuo(s) mostrado(s) anteriormente como elegible(s) puede(n) recibir servicios de salud de los proveedores de servicios médicos que acepten el plan de la compañía de seguros (MCO o MAO) bajo el cual está cubierto. La aseguradora le proveerá un Manual de Beneficiario donde explica en detalle cómo acceder a los servicios médicos.

El/Los nuevo(s) beneficiario(s) recibirá(n) de su compañía aseguradora una tarjeta de identificación para cada beneficiario. Mientras espera su tarjeta de identificación, cada persona puede acceder a servicios de salud utilizando su MPI, como se muestra arriba en el Resumen de Decisiones de Elegibilidad, o mostrándole al proveedor de servicios médicos una copia de esta notificación.

Si esta notificación es el resultado de una reevaluación debido a un cambio notificado que afecte su cubierta de beneficios, el/los beneficiario(s) recibirá(n) una nueva tarjeta de identificación.

Servicios y Costos de Salud

Los beneficiarios elegibles pueden obtener servicios de salud a través de sus compañías de seguros, como visitas al médico, atención hospitalaria y recetas médicas. No se deben pagar primas (costos mensuales) por esta cobertura de salud. Usted puede tener copagos para algunos servicios. Pero hay un límite a los posibles costos cada trimestre para aquellas personas elegibles bajo Medicaid o CHIP. La cantidad que cada persona puede pagar por copagos y el límite de costos trimestrales dependen del tamaño del núcleo familiar y de los ingresos calculados para determinar la elegibilidad de la persona. Hay más detalles sobre copagos y los topes de copago al final de esta sección. La compañía de seguros enviará para cada persona información más detallada sobre los servicios de salud y copagos.

Si no está de acuerdo con las decisiones reportadas en esta notificación, como el cálculo del tamaño del núcleo familiar o los ingresos de cualquier persona en esta notificación y cree que afecta la elegibilidad o el nivel de copagos, puede apelar. Consulte la sección al final de esta notificación para obtener más información sobre el proceso y los plazos para las apelaciones.

Copagos: Los copagos que se pueden cobrar por los servicios se basan en el ingreso MAGI y el tamaño del núcleo familiar MAGI para cualquier persona elegible como Medicaid o CHIP. Para cualquier persona elegible bajo el Programa Estatal, los cálculos se basan en los cálculos del Programa Estatal de ingreso y tamaño del núcleo familiar.

Tope de Copagos: (1) las regulaciones federales establecen que las personas elegibles para Medicaid o CHIP tienen un tope en los copagos totales que están obligados a hacer. (2) El límite es del 5% por trimestre, basado en el Ingreso MAGI tamaño del núcleo familiar MAGI del Individuo y para alcanzar el tope, los copagos pagados durante un trimestre por cada beneficiario en el núcleo familiar del Individuo que es Medicaid o CHIP se suman. Los trimestres se determinan a partir de la fecha de elegibilidad inicial del individuo. (3) Si, en el transcurso de un período de elegibilidad para Medicaid o CHIP, un beneficiario de Medicaid o CHIP cree que los copagos en un trimestre se han pagado por encima del tope, puede presentar una Solicitud de Reembolso de Copagos, que será evaluada por la Administración de Seguros de Salud de Puerto Rico (ASES). (4) La información sobre el Proceso de Reembolso y sobre la Solicitud está disponible en las oficinas locales del Programa Medicaid, en el sitio web del Programa de Medicaid (https://www.medicaid.pr.gov/) y en el sitio web de ASES (http://www.ases.pr.gov/). (5) La regla federal que exige límites máximos en copagos no se aplica a nadie que sea elegible bajo el Programa Estatal.

Debe Reportar Cambios

Debe notificar cualquier cambio que pueda afectar su cubierta de salud. Favor de reportar sus cambios y los de otras personas en su núcleo familiar, tales como:

- Si alguien se muda.
- Si los ingresos de alguien cambian.
- Si la composición de su hogar cambia.

Por ejemplo, alguien en su núcleo familiar se casa o se divorcia, queda embarazada, tiene o adopta un hijo.

Para reportar los cambios, llámenos al **1-787-641-4224** (TTY: 1-787-625-6955) o acceda a **www.medicaid.pr.gov**.

Si No Está de Acuerdo con las Decisiones Informadas en Esta Notificación

Puede apelar nuestras decisiones sobre su cubierta médica. Por ejemplo, puede apelar si está en desacuerdo con la determinación del tamaño del núcleo familiar, los ingresos, la ciudadanía, el estatus migratorio o el domicilio de cualquiera persona. También puede apelar qué tipo de cubierta de salud (Medicaid, CHIP o Estatal) se le otorgó o denegó, o el nivel de costo compartido (deducibles, copagos) requerido, basado en el código de cubierta.

Si tiene una necesidad urgente de atención médica, puede solicitar una apelación expedita (más rápida) para una pronta respuesta. Una necesidad urgente de atención de salud se define como una que podría resultar en un grave daño a la salud de la persona interesada si no se trata pronto. Si solicita una apelación expedita, es posible que deba proporcionar documentación de la necesidad de atención médica urgente.

Para solicitar una apelación, debe presentar la apelación por escrito dentro de los 30 días contados a partir de la fecha de esta notificación (que se encuentra en la parte superior de esta notificación). La solicitud de apelación se puede hacer: 1) en persona en cualquier oficina local del Programa Medicaid de Puerto Rico; 2) por correo a la siguiente dirección – Programa Medicaid de Puerto Rico, Departamento de Salud, P.O. Box 70184, San Juan, PR 00936-8184; 3) por fax (Fax) a – (787) 759-8361. El plazo que tiene para presentar una apelación expira el 24 de junio de 2021. La determinación en esta notificación será definitiva si usted no apela dentro del plazo de 30 días.

Una vez que solicite una apelación, trataremos de solucionar el desacuerdo por teléfono o personalmente. Si una llamada telefónica o una reunión no solucionan el asunto, usted tiene derecho a una audiencia justa.

Una audiencia es una reunión entre usted, personal del Programa Medicaid de Puerto Rico y un oficial de audiencias. En la audiencia puede explicar por qué no está de acuerdo con la decisión.
Para prepararse para su audiencia, puede:

- Solicitar una copia de su expediente antes de la audiencia.
- Traiga a alguien con usted a la audiencia, como un amigo, pariente o abogado, o venga solo.
- Traiga documentos, información o testigos para explicar su desacuerdo con la decisión.

Si una persona tiene cubierta de salud, y la decisión en esta notificación la elimina o la reduce, puede conservarla durante el período de apelación, siempre que la solicitud de apelación se realice dentro de los primeros 10 días a partir del recibo de esta notificación.
Decidiremos su apelación dentro de los 90 días de su solicitud.

Sinceramente,
Programa Medicaid de Puerto Rico
Departamento de Salud de PR
P.O. Box 70184
San Juan, PR 00936-8184

Siempre mantendremos su información segura y privada.

ADDENDUM 2

*.820 Premium Payment Companion Guide and Prempay ADJ File Layout

ADMINISTRACIÓN DE SEGUROS DE SALUD

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DEPARTAMENTO DE SALUD

Puerto Rico Medicaid Management Information System – Phase III

820_Companion_Guide_v2.6

Technical Report Type 3 Implementation for 820

HIPAA Transaction Standard Companion Guide

Version 2.6

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The communications/connectivity component is included in the companion guide when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

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This companion guide is subject to change without prior notice. Trading Partners are responsible for periodically checking for companion guide updates on the Puerto Rico Department of Health (PRDoH) website.

Preface

This companion guide to the v5010 ASC X12N Technical Report Type 3 (TR3) Implementation Guide, and associated errata and addenda, adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with Puerto Rico Medicaid Program. Transmissions based on this companion guide, used in tandem with the TR3, also called Health Care Payroll Deducted and Other Group Premium Payment for Insurance Products (820) ASC X12N (version 005010X218), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. This companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

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Contents

1 Introduction 1
1.1 Purpose 1
1.2 Scope 2
1.3 Overview 2
1.4 References & Applicable Web Sites 3
1.5 Additional Information 4
1.5.1 National Provider Identifier 4
1.5.2 Acceptable Characters 4
1.5.3 Acknowledgements 4
1.5.4 File/System Specifications 4
2 Getting Started 6
2.1 Testing Overview 6
3 Connectivity With Puerto Rico Medicaid Program / Communications 7
3.1 Process Flows 7
3.2 Transmission Administrative Procedures 7
3.3 Re-transmission Procedure 7
4 Contract Information 8
4.1 Electronic Data Interchange Helpdesk 8
5 Control Segments / Envelopes 9
5.1 ISA - Interchange Control Header 9
5.2 IEA – Interchange Control Header 10
5.3 GS - Functional Group Header 11
5.4 GE - Functional Group Trailer 11
5.5 ST-SE 12
5.5.1 Transaction Set Header (ST) 13
5.5.2 Transaction Set Trailer (SE) 13
5.6 File Delimiters 13
6 Puerto Rico Medicaid Program-Specific Business Rules And Limitations 14
6.1 Trading Partner Identification Number 14
6.2 Testing 14
6.3 Terminology 14
6.4 Limits 14
6.5 Scheduled Maintenance 14
7 Notes on 820 Premium Payment Order/Remittance Advice 15
7.1 820 – Monthly 15
8 Acknowledgements And/Or Reports 16
8.1 Acknowledgements 16

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8.2 Report Inventory 16
9 Transaction-Specific Information 17
10 Disclosure Statement 25
11 Change Summary 27
Version 2.6 Revision Log 28
Version 2.5 Revision Log 29
Version 2.4 Revision Log 30
Version 2.3 Revision Log 31
Version 2.2 Revision Log 32
Version 2.1 Revision Log 33
Version 2.0 Revision Log 34
Version 1.9 Revision Log 35
Version 1.8 Revision Log 36
Version 1.7 Revision Log 37
Version 1.6 Revision Log 38
Version 1.5 Revision Log 39

Figure

Figure 1: File Naming Convention for 820 Premium Payment Used by PRMMIS 5
Figure 2: Retrieval of Puerto Rico Medicaid Program's 820 via Carrier's folder SFTP Site. 7

Tables

Table 1: Sample TR3 Table 1
Table 2: Explanation of File Name Elements in Figure 1 5
Table 3: ISA Interchange Control Header Fields 9
Table 4: IEA Interchange Control Trailer Fields 11
Table 5: GS Functional Group Header Fields 11
Table 6: GE Functional Group Trailer Fields 12
Table 7: ST Transaction Set Header Fields 13
Table 8: SE Transaction Set Trailder Fields 13
Table 9: 005010X218 – 820 Payroll Deduction and Other Group Premium Payments 17

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1 Introduction

This document is the HIPAA Transaction Standard Companion Guide for the Puerto Rico Medicaid Management Information System – Phase III project. This section describes how TR3, also called 820 Accredited Standards Committee (ASC) X12N (005010X218), which was adopted under HIPAA, will be detailed with the use of a table. The table contains a Notes/Comments column for each segment that Puerto Rico Medicaid Program (PRMP) has additional information to provide over and above the information in the TR3. That information can do the any of the following:

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

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

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column for each segment that PRMP has additional information to provide, over and above the information in the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in *Section 9: Transaction Specific Information*.

Table 1: Sample TR3 Table

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
37			BPR	Beginning Segment		
37	½		BPR01	Transaction Handling Code		I – Remittance Information Only Indicates to the payee that the remittance detail is moving separately from the payment. This also includes when the resulting payment would be zero.

1.1 Purpose

This companion guide to the v5010 ASC X12N Technical Report Type 3 (TR3) Implementation Guide, and associated errata and addenda, adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with Puerto Rico Medicaid Program. Transmissions based on this companion guide, used in tandem with the TR3, also called Health Care Payroll Deducted and Other Group Premium Payment for Insurance Products (820) ASC X12N (version 005010X218), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. This companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

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1.2 Scope

PRMP developed 5010 Companion Guides to supplement each 5010 Transaction Implementation Guide, based on Version 5, Release 1, with regards to Specific Codes and/or Values that PRMP will default on Outbound Transactions. PRMP Companion Guides will not create a Non-Compliant Transaction.

This companion guide will provide compliance for PRMP within the CAHQ CORE Premium Payment (820) Infrastructure Rule for the X12 v5010 820 transaction.

This companion guide is intended to be used in conjunction with the ASC X12N/005010X218 Implementation Guide (IG). The IG provides standardized data requirements and content to all users of the American National Standards Institute (ANSI) ASC X12 Premium Payment Order/Remittance Advice (820) Transaction Set for the purpose of reporting payroll deducted and other group premiums.

It provides supplementation instructions not included in the IG that must be followed for implementation and conducting the transaction with PRMP. It does not change the requirements of the IG in any way.

Refer to the companion guide first if there is a question about how PRMP processes a HIPAA transaction. For further information, contact

PRMMIS-Internal-EDI-HD-Support@gainwelltechnologies.com. This document is intended as a resource to assist providers, clearinghouses, service bureaus, and all other trading partners with PRMP interChange in successfully conducting EDI of administrative health care transactions.

This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.3 Overview

PRMP and all other covered entities are required by HIPAA to comply with the EDI standards for health care, as established by the Secretary of the federal Department of Health and Human Services (HHS). The Secretary of the HHS is required by HIPAA to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. The Health Insurance Portability and Accountability Act of 1996 directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

The Health Insurance Portability and Accountability Act of 1996 serves to:

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

The payer refers to a third-party entity that pays claims or administers the insurance benefit. A sponsor is the party that ultimately pays for the coverage or benefit. A member is an individual eligible for coverage because of his or her association with a sponsor. An insured individual is a member who has been enrolled for coverage under PRMP. The 820 transaction is used for the purpose of reporting payroll deducted and other group premiums to pay the carrier for the coverage .

This Companion Guide contains the format and establishes the data contents of the payroll deducted and other premiums (820) for use within the context of an EDI environment. The 820 can be used by premium remitters to report premium payment remittance information, as well as premium payment to a premium receiver. The premium receiver is a health care organization (MCO/MAO).

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1.4 References & Applicable Web Sites

For more information regarding the ASC X12 standards for EDI 820 (version 005010X218) and to purchase copies of the TR3 documents, consult the Washington Publishing Company Web site at http://www.wpc-edi.com/.

For information about EDI software and services, visit: http://www.1edisource.com/.

Additional information is available on the following Web sites:

- Accredited Standards Committee X12N develops and maintains X12 EDI and XML standards, standards interpretations and guidelines as they relate to all aspects of insurance and insurance-related business processes: http://www.x12.org/.
- Centers for Medicare and Medicaid Services (CMS) is the unit within the HHS that administers the Medicare and Medicaid programs. The CMS provides the Electronic Health Care Transactions and Code Sets Model Compliance Plan at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code- Sets/index.htm.
- Designated Standard Maintenance Organizations (DSMO) is a resource for information about the standard-setting organizations and transaction change request system: http://www.hipaa-dsmo.org/.
- Health Level Seven (HL7) is one of several ANSI-accredited Standards Development Organizations (SDOs) and is responsible for clinical and administrative data standards: www.hl7.org.
- Healthcare Information and Management Systems (HIMSS) is an organization exclusively focused on providing global leadership for the optimal use of IT and management systems for the betterment of health care: www.himss.org.
- National Committee on Vital and Health Statistics (NCVHS) was established by Congress to serve as an advisory body to the HHS on health data, statistics and national health information policy; for more information, refer to: www.ncvhs.hhs.gov.
- Office for Civil Rights (OCR) is the office within the federal HHS responsible for enforcing the Privacy Rule under HIPAA, which can be found at: www.hhs.gov/ocr/hipaa.
- The federal HHS is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA, which can be found at: www.aspe.hhs.gov/admnsimp.
- Washington Publishing Company (WPC) is a resource for HIPAA-required transaction implementation guides and code sets, which can be found at: www.wpc-edi.com/.
- The Workgroup for Electronic Data Interchange (WEDI) is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA: www.wedi.org.
- The registry for the NPI is the National Plan and Provider Enumeration System (NPPES), at: https://nppes.cms.hhs.gov/NPPES/Welcome.do.
- Implementation guides and non-medical code sets are at: store.x12.org/.
- The HIPAA statute, Final Rules, and related Notices of Proposed Rulemaking (NPRMS) are available at: https://www.cms.gov/Regulations-and-Guidance/Administrative- Simplification/Code-Sets/index.html.
- The CMS online manuals system and Internet only manuals (IOM) system, including transmittals and program memoranda, can be found at: www.cms.hhs.gov/Manuals/.

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1.5 Additional Information

The ANSI is the coordinator for information on national and international standards. In 1979, ANSI chartered the ASC X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standard is recognized by the United States as the standard for North America. Electronic Data Interchange adoption has been proved to reduce the administrative burden on providers.

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

1.5.1 National Provider Identifier

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

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

PRMP has determined that all providers, except for non-emergency transportation, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. PRMP requires all health care providers to submit their NPI on electronic transactions.

1.5.2 Acceptable Characters

The HIPAA transactions must not contain any carriage returns, nor line feeds; the data must be received in one, continuous stream. PRMP accepts the extended character set. Uppercase characters are recommended.

1.5.3 Acknowledgements

An accepted 999 Implementation Acknowledgement (999), rejected 999 Implementation Acknowledgement, or rejected TA1 InterChange Acknowledgement (TA1) will be generated in response to all submitted files. Trading partners are responsible for retrieving acknowledgments from their "response" folder to determine the status of their files.

1.5.4 File/System Specifications

EDI only accepts Windows/PC/DOS formatted files. Any file transmitted to EDI must be named in accordance to standard file naming conventions, including a valid three character file extension. The following standards should be used:

- To avoid accidently overwriting files, do not send multiple files with the same name on the same day.
- All files will have the number sequence. If Carrier Payment exceeds 99 Million the 820 will be split.
- If ENT Carrier records exceed 999,999 records, the 820 will be split.
- File Names should not be longer than 45 characters – the first 20 characters will be used to identify the file through PRMMIS (see below for naming convention).
- Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file.
- Zip files must contain the extension .zip (not case sensitive).

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Figure 1: File Naming Convention for 820 Premium Payment Used by PRMMIS

- BATCHID_<TPID>_MTH_820_YYYYMMDD_hhmmss_01.X12 for monthly 820
- BATCHID_<TPID>_RLS_820_YYYYMMDD_hhmmss_01.X12 For Release 820

Table 2: Explanation of File Name Elements in Figure 1

Element	Description
BatchID	This is the unique ID assigned by PRMMIS to each file.
TradingpartnerID	This is the "carrier's" Trading PartnerID.
CCYYMMDD	This is the date code in century, year, 2-digit month and 2-digit day.

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2 Getting Started

2.1 Testing Overview

Test transactions (ISA15 value of "T") must be sent to our Testing (UAT) environment.

Production transactions (ISA15 value of "P") must be sent to our Production environment (PROD).

Reminder: Submitters are responsible for the preservation, privacy, and security of data in their possession. While using production data that contains Personal Health Information (PHI) to conduct testing, the data must be guarded and disposed of appropriately.





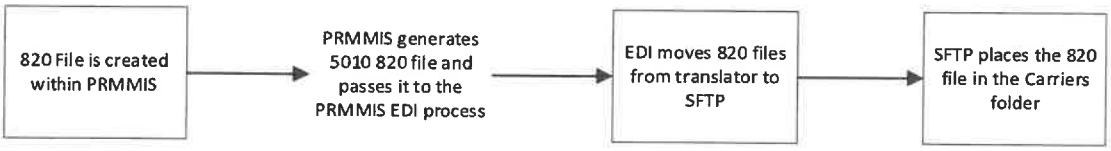
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3 Connectivity With Puerto Rico Medicaid Program / Communications

This section describes the process for sending the HIPAA 820 transactions, along with various security requirements and exceptions to handling procedures.

3.1 Process Flows

Figure 2: Retrieval of Puerto Rico Medicaid Program's 820 via Carrier's folder SFTP Site.



3.2 Transmission Administrative Procedures

PRMP is available only to authorized users. Submitters are required to be PRMP trading partners.

3.3 Re-transmission Procedure

In the event of an interrupted communications session, PRMMIS will re-initiate the file transfer.

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4 Contract Information

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

4.1 Electronic Data Interchange Helpdesk

If you have questions related to PRMP's 820, contact the EDI Helpdesk by email at prmmis_edi_support@gainwelltechnologies.com or by phone at 1-833-209-8326.

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5 Control Segments / Envelopes

5.1 ISA - Interchange Control Header

This section describes PRMP's use of the ISA. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

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

- Each trading partner is assigned a six-digit trading partner ID.
- All dates are in the CCYYMMDD format.
- All date/times are in the CCYYMMDDHHMM format.
- Payer ID can be found in all companion guides.
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Transactions transmitted are identified by an ISA and trailer segment (IEA) which form the envelope enclosing the transmission. The ISA marks the beginning of the transmission (batch) and provides sender and receiver identification.

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

The following table shows the fields that PRMP will be sending.

Note: PRMP sends files with one ISA/IEA loop per file.

Table 3: ISA Interchange Control Header Fields

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.3	**None**	**ISA**	**Interchange Control Header**		**The ISA is a fixed-length record with fixed-length elements.**
C.4		ISA01	Authorization Information Qualifier	00	00=No authorization information present.
C.4		ISA02	Authorization Information		[10 spaces] Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier.
C.4		ISA03	Security Information Qualifier	00	00 – No Security Information Present
C.4		ISA04	Security Information		[10 spaces] This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier
C.4		ISA05	Interchange ID (Sender) Qualifier	30	30 = US Federal Tax Identification Number
C.4		ISA06	Interchange Sender ID	PRMMIS	Identification code published by the sender for other parties to use as the receiver ID to route data to

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					them; the sender always codes this value in the sender ID element.
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	ZZ = Mutually Defined
C.5		ISA08	Interchange Receiver ID		Trading Partner ID
C.5		ISA09	Interchange Date		Date of interchange. The date format is YYMMDD.
C.5		ISA10	Interchange Time		Time of the interchange. The time format is HHMM
C.5		ISA11	Repetition Separator		Type is not applicable; the repetition separator is a delimiter and not a data element; this field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure; this value must be different than the data element separator, component element separator, and the segment terminator.
C.5		ISA12	Interchange Control Version Number	00501	00501 – Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003
C.5		ISA13	Interchange Control Number		The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.
C.6		ISA14	Acknowledgement Requested	1	1 – Interchange Acknowledgment Requested (TA1)
C.6		ISA15	Usage Identifier	T & P	Code indicating whether data enclosed by this interchange envelope is test or production.
			Production Data	T	T - File from PRMMIS test environment.
			Production Data	P	P - File from PRMMIS production environment.
C.6		ISA16	Component Element Separator	:	A colon ":" will be sent.

5.2 IEA – Interchange Control Header

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

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Table 4: IEA Interchange Control Trailer Fields

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.10		**IEA**	**Interchange Control Trailer**		
C.10		IEA01	Number of Included Functional Groups		Number of included Functional Groups
C.10		IEA02	Interchange Control Number.		Must be identical to the value in ISA13

5.3 GS - Functional Group Header

This section describes PRMP's use of the functional group control segments. It includes a description of expected application sender and receiver codes.

The following table shows the fields that PRMP will be sending.

Table 5: GS Functional Group Header Fields

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	**None**	**GS**	**Functional Group Header**		
C.7		GS01	Functional ID Code	RA	RA = 820 Payroll Deducted and Other Group Premium Payment (820)
C.7		GS02	Application Sender's Code	PRMMIS	PRMMIS = Application Sender's Code [6 characters left justified and 9 spaces]
C.7		GS03	Application Receiver's Code		Carrier's Trading Partner ID supplied by PRMP.
C.7		GS04	Date		The date format is CCYYMMDD.
C.8		GS05	Time		The time format is HHMM.
C.8		GS06	Group Control Number		Group Control Number – Must be identical to GE02.
C.8		GS07	Responsible Agency Code	X	X = Responsible Agency Code
C.8		GS08	Version/ Release/Industry Identifier Code	005010X218	005010X218 = Version/ Release/ Industry Identifier Code

5.4 GE - Functional Group Trailer

The following table shows the fields that Puerto Rico Medicaid will be sending.

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Table 6: GE Functional Group Trailer Fields

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.9	**None**	**GE**	**Functional Group Trailer**		
C.9		GE01	Number of Transaction Sets Included		Total number of transaction sets
C.9		GE02	Group Control Number		Must be identical to the value in GS06

5.5 ST-SE

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

PRMP recommends that trading partners follow the guidelines set forth in the TR3 — start the first ST02 in the first file with 000000001 and increment from there. The TR3 should be reviewed for how to create compliant transaction set control segments.

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5.5.1 Transaction Set Header (ST)

The TR3 should be reviewed for specific information.

Table 7: ST Transaction Set Header Fields

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
70	**None**	**ST**	**Transaction Set Header**		
70		ST01	Transaction Set Identifier Code	820	820 = Payment Order/Remittance Advice
70		ST02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA).
70		ST03	Implementation Guide Version Name	005010X218	00501018 = Version/ Release/ Industry Identifier Code This field contains the same value as GS08.

5.5.2 Transaction Set Trailer (SE)

The TR3 should be reviewed for specific information.

Table 8: SE Transaction Set Trailder Fields

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
496	**None**	**SE**	**Transaction Set Trailer**		
496		SE01	Transaction Segment Count		Total number of segments included in a transaction set including the ST and SE segments
496		SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical.

5.6 File Delimiters

PRMP uses the following delimiters in the 820 file:

- **Data Element**: Byte 4 in the ISA segment defines the data element separator to be used throughout the entire transaction. The data element delimiter is an asterisk (*).
- **Repetition Separator**: ISA11 defines the repetition separator to be used throughout the entire transaction. The repetition separator is a caret (^).
- **Component-Element**: ISA16 defines the component element delimiter to be used throughout the entire transaction. The component-element delimiter is a colon (:).
- **Data Segment**: Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The data segment delimiter is a tilde (~).

These characters (* : ~ ^) cannot be present within the data content of the transaction elements.

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6 Puerto Rico Medicaid Program-Specific Business Rules And Limitations

6.1 Trading Partner Identification Number

The EDI team will create any needed Trading Partner Profiles during the PRMP's implementation of the PRMMIS.

6.2 Testing

Production Authorization Testing will be available for PRMMIS 820 files.

6.3 Terminology

The term "subscriber" will be used as a generic term throughout the companion guide.

6.4 Limits

There is no file size restriction on how many records will be reported in an 820.

6.5 Scheduled Maintenance

PRMMIS recycles the servers every night between 00:00 a.m. to 01:00 a.m. Atlantic Standard Time (AST).

PRMMIS schedules regular maintenance every Sunday from 00:00 a.m. to 04:00 a.m. AST.

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7 Notes on 820 Premium Payment Order/Remittance Advice

7.1 820 – Monthly

An 820 monthly Capitation file is produced once a month. Additional 820 files will be produced if the withholding funds are released.

The 820 files will be available for retrieval for six months. If an 820 file is needed after six months, contact the EDI Helpdesk via e-mail using PRMMIS-Internal-EDI-HD-Support@gainwelltechnologies.com.

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8 Acknowledgements And/Or Reports

8.1 Acknowledgements

999 — Functional Acknowledgement

This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a batch X12 file.

8.2 Report Inventory

There are no acknowledgement reports at this time.

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9 Transaction-Specific Information

This section describes how ASC X12N implementation guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that PRMP has something additional, over and above, the information in the implementation guides. That information can:

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

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

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column for each segment that PRMP has additional information to provide, over and above the information in the TR3.

Table 9: 005010X218 – 820 Payroll Deduction and Other Group Premium Payments

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
37			BPR	Beginning Segment		
37	1/2		BPR01	Transaction Handling Code	I	I = Indicates to the payee that the remittance detail is moving separately from the payment. This also includes when the resulting payment would be zero.
37	1/18		BPR02	Total Premium Payment Amount		The ACH system cannot support dollar amounts greater than 11 characters (including the decimal point). This provides an ACH limit of $99,999,999.99. for the 820. Dollar limits vary by the clearing system used, e.g ACH vs. wire.
38	1/1		BPR03	Credit or Debit Flag Code	C	C = Credit This indicates a credit to the payee's account, and a debit to the Payer's account.
38	3/3		BPR04	Payment Method Code	NON	
				Non-Payment Data	NON	NON = This value will be used if the payment is zero.

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
42	8/8	BPR16	Check Issue or EFT Effective Date			For check payment, this data element specifies the check issuance date. For payments other than check this data element specifies the date the originator (premium payer) intends to provide funds to the receiver (premium receiver) Date format will be CCYYMMDD
43			TRN	Reassociation Trace Number		The purpose of this segment is to uniquely identify this transaction set and aid in the reassociating payment and remittance data that have been separated.
43	1/2		TRN01	Trace Type Code	3	3 = Financial Reassociation Trace Number The payment and remittance information have been separated and need to be reassociated by the receiver.
43	1/50		TRN02	Reference Identification		This field is used to re-associate the payment with the remittance information.
44	10/10		TRN03	Originating Company Identifier		Required when the receiver needs an originating company identification to reassociate a payment to a remittance. The Check Number will be used to reassociate the 820 to the check.
48			REF	Premium Receivers Identification Key		Note: Segment can repeat as needed.
48	2/3		REF01	Reference Identification Qualifier	18	18 = Plan Number
49	1/50		REF02	Premium Receiver Reference Identifier		For U.S. Treasury Department Financial Management Service Disbursed payments, this code indicates a payment schedule number will follow. Carrier Medicaid ID will be used for Puerto Rico.

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
50			DTM	Process Date		Date the payment was processed by the premium payer. CCYYMMDD format
50	3/3		DTM01	Date Time Qualifier	009	009 = Process
50	8/8		DTM02	Payer Process Date		CCYYMMDD format
51			DTM	Delivery Date		Relays the date the payment was delivered to the Originating Depository Financial Institution by the premium payer or a third party processor.
51	3/3		DTM01	Date Time Qualifier	035	035 = Delivered
51	8/8		DTM02	Premium Delivery Date		CCYYMMDD format
53			DTM	Coverage Period		Segment communicates the start and end date of the coverage period associated with this premium payment.
53	3/3		DTM01	Date Time Qualifier	582	582 = Report Period
54	2/3		DTM05	Date Time Period Format Qualifier	RD8	RD8 = Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
54	1/35		DTM06	Date Time Period		CCYYMMDD-CCYYMMDD format
55			DTM	Creation Date		This segment is used to relay the date that the premium payment was created.
55	3/3		DTM01	Date Time Qualifier	097	097 = Transaction Creation
55	8/8		DTM02	Date		CCYYMMDD format
56		1000A	N1	Premium Receiver's Name		
56	2/3	1000A	N101	Entity Identifier Code	PE	PE = **Payee**
56	1/60	1000A	N102	Premium Receiver's Last Or Organization Name		Carrier's Name
62		1000A	RDM	Premium Receiver's Remittance Delivery Method		

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
62	1/2	1000A	RDM01	Remittance Delivery Method Code	FT	FT - File Transfer will be used by Puerto Rico
64		1000B	N1	Premium Payer's Name		
64	2/3	1000B	N101	Entity Identifier Code	PR	PR - **Payer**
64	1/60	1000B	N102	Premium Payer Name		'PRMMIS'
67		1000B	N3	Premium Payer's Address		
67	1/55	1000B	N301	Premium Payer's Address Line		Payer's address line 1
67	1/55	1000B	N302	Premium Payer's Address Line2		Payer's address line 2
68		1000B	N4	Premium Payer's City, State, ZIP Code		
68	2/30	1000B	N401	Premium Payer's City Name		Payer's City
69	2/2	1000B	N402	Premium Payer's State Code		Payer's State
69	3/15	1000B	N403	Premium Payer's Zip Code		Payer's Zip +4 Note: If zip +4 is unknown send 9998.
70		1000B	PER	Member Communications Numbers		Note: Segment can repeat as needed
71	2/2	1000B	PER01	Contact Function Code	IC	IC - Information Contact
71	1/60	1000B	PER02	Premium Payer Contact Name		Payer's Contact Name
71	2/2	1000B	PER03	Communication Number Qualifier	TE	TE - Telephone
71	1/256	1000B	PER04	Communication Number		Payer's telephone number
71	2/2	1000B	PER05	Communication Number Qualifier	EM	EM - Email

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
71	1/256	1000B	PER06	Communication Number		Required when additional communication numbers are available. If not required by the implementation guide, do not send. Payer's email address
72	2/2	1000B	PER07	Communication Number Qualifier	FX	FX – Facsimile
72	1/256	1000B	PER08	Communication Number		Required when additional communication numbers are available. If not required by the implementation guide, do not send. Payer's facsimile number
87		2300A	RMR04			Specifies the amount of the adjustment due to AR, negative amount to reduce the payment amt. If there is no AR, the amt will be 0. Set RMR01 = "IK", RMR02 = "Outstanding AR"
110	2/2	22000A	ADX01			This field is used to balance the AR to the total premium (BPR02). ADX01 = BPR02 - RMR04. Set ADX02 = "WO".
105		2000B	ENT	Individual Remittance		Required When Providing Remittance Line Items That Pertain To An Individual Enrolled In A Group Plan. Loop can repeat up to 999,999 records based on the ENT01 field size limitations. Once this limit is reached, a new file will be created.
106	1/6	2000B	ENT01	Assigned Number		Number assigned for differentiation within a transaction set. Field size is 6 bytes. Record count per file can only be up to 999,999.
106	2/3	2000B	ENT02	Entity Identifier Code	2J	2J - Individual
106	1/2	2000B	ENT03	Identification Code Qualifier	34	34- Social Security Number

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
106	2/80	2000B	ENT04	Receiver's Individual Identifier		This is the identification number of the individual used by the receiver. Puerto Rico will use the Member's SSN **Note if there is no SSN sent the ENT04 Segment won't be created*
107		2100B	NM1	Individual Name		Loop can repeat as needed.
107	2/3	2100B	NM101	Entity Identifier Code	IL	IL – Insured or Subscriber
108	1/1	2100B	NM102	Entity Type Qualifier	1	1 - Person
108	1/60	2100B	NM103	Individual Last Name		Last name & last name 2 with pipe '|' delimiter to separate
108	1/35	2100B	NM104	Individual First Name		
108	1/25	2100B	NM105	Individual Middle Name		
108	1/2	2100B	NM108	Identification Code Qualifier	N	N- Insured's Unique Identifier
108	2/80	2100B	NM109	Individual Identifier		Puerto Rico will use the Member's Medicaid ID
110		2200B	ADX	Individual Premium Adjustment For Previous Payment		This ADX loop contains adjustment items which are not netted to an RMR segment in this transaction set.
110	1/18	2200B	ADX01	Premium Payment Adjustment Amount		ADX01 specifies the amount of the adjustment and must be signed if negative. If negative, it reduces the payment amount; if positive, it increases the payment amount. For Puerto Rico, this field will contain the amount returned from the 2% withholding for Vital Carriers Only. For all Carriers, if an adjustment needs to be made to a previous period Capitation cycle, the Adjusted Amount will be recorded within this field.

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
110	2/2	2200B	ADX02	Premium Payment Adjustment Reason	52, 53, H6	52 - Credit for Previous Overpayment 53 - Remittance for Previous Underpayment H6 – Partial Payment Remitted
112		2300B	RMR	Individual Premium Remittance Detail		*Note: Loop can repeat as needed.*
112	2/3	2300B	RMR01	Reference Identification Qualifier	AZ	AZ - Health Insurance Policy Number For Puerto Rico, the Medicaid Id will be used.
113	1/15	2300B	RMR02	Insurance Remittance Reference Number		This is the Member's Medicaid ID number
113	1/18	2300B	RMR04	Detail Premium Payment Amount		This is the amount being paid on this remittance item. This will reflect the 98% for members within Vital Carriers Only and 100% for members within Platino Carriers. On Release 820 it will default to 0
113	1/18	2300B	RMR05	Billed Premium Amount		Any difference between the RMR05 and the RMR04 would be explained by the ADX at loop 2320B.This will reflect the 100%. On Release 820 it will default to 0.
114		2300B	REF			
114	2/3	2300B	REF01	Reference Identification Qualifier	ZZ	ZZ – Mutually Defined
114	1/50	2300B	REF02	Organizational Reference Identifier		Capitation Type – 2 bytes Capitation Reason – 2 bytes Internal Capitation Control Number – number up to 10 bytes Internal Capitation Adjustment Control Number – number up to 10 bytes Rate Cell – 3 bytes Risk Score – 7 bytes (111.123) Region – 1 byte These fields are delimited by the '|'.

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
115		2300B	DTM	Individual Coverage Period		Required when the premium payer is not paying from an invoice but paying on account for a coverage period.
115	3/3	2300B	DTM01	Date Time Qualifier	582	582 – Report Period
116	2/3	2300B	DTM05	Date Time Period Format Qualifier	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
116	1/35	2300B	DTM06	Coverage Period		CCYYMMDD-CCYYMMDD format
117		2320B	ADX	Individual Premium Adjustment For Current Payment		Required when the paid amount differs from the billed amount (RMR05 is present) in the related RMR segment. Loop can repeat as needed.
103	1/18	2320A	ADX01	Adjustment Amount		ADX01 specifies the amount of the adjustment and must be signed if negative. If negative, it reduces the payment amount; if positive, it increases the payment amount. For Puerto Rico, this field will contain the 2% withholding amount for members within Vital Carriers.
103	2/2	2320A	ADX02	Adjustment Reason Code	H6	H6 – Partial Payment Remitted

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Appendix A.

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11 Change Summary

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Version 2.6 Revision Log

Companion Guide: 820 HIPAA Transaction Standard

Name: Gainwell Date: 01/23/2025

Loop ID	Page(s) Revised	Reference	Name	Comment	Text Revised
2300B	23	REF02	Organizational Reference Identifier	Added new value to this field.	Region – 1 byte

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Version 2.5 Revision Log

Companion Guide: 820 HIPAA Transaction Standard

Name: Gainwell Date: 10/28/2024

Loop ID	Page(s) Revised	Reference	Name	Comment	Text Revised
2000B	21	ENT	Individual Remittance	Added clarification to the file size limit based on the ENT01 Assigned Number field.	Loop can repeat up to 999,999 records
2000B	21	ENT01	Assigned Number	Added field size	Field size is 6 bytes. Record count per file can only be up to 999,999.

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Version 2.4 Revision Log

Companion Guide: 820 HIPAA Transaction Standard

Name: Gainwell Date: 08/16/2024

Loop ID	Page(s) Revised	Reference	Name	Comment	Text Revised
2300A	114	RMR04		*Updated per PRMP Request to add both 2300A and 2300B. TR3 states one or the other on page 12.	"Specifies the amount of the adjustment due to AR, negative amount to reduce the payment amt. If there is no AR, the amt will be 0. Set RMR01 = ""IK"", RMR02 = ""Outstanding AR"" If ar_amt is present, SET ENT01 = 1 SET ENT02 = 2L SET ENT03 = 24 SET ENT04 = <EIN> - needs to be provided by PR"
2200A	110	ADX01	Calculated Amount	*Updated per PRMP Request to add both 2300A and 2300B. TR3 states one or the other on page 12.	This field is used to balance the AR to the total premium (BPR02). ADX01 = BPR02 - RMR04. Set ADX02 = "WO".

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Version 2.3 Revision Log

Companion Guide: 820 HIPAA Transaction Standard

Name: Gainwell Date: 04/16/2024

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300B	114	REF02	Organizational Reference Identifier		Risk Score updated to reflect 7 Bytes instead of 8

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Version 2.2 Revision Log

Companion Guide: 820 HIPAA Transaction Standard

Name: Gainwell Date: 02/22/2024

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
Naming					Updated Naming Convention for Monthly 820 and Release 820 to reflect X12

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Version 2.1 Revision Log

Companion Guide: 820 HIPAA Transaction Standard

Name: Gainwell Date: 02/15/2024

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
Naming					Updated Naming Convention for Monthly 820 and Release 820
2000B	106	ENT04	Receiver's Individual Identifier		Corrected to Member's SSN
2100B	108	NM109	Individual Identifier		Changed Qualifier to N and corrected to state Member's Medicaid ID
2000B	106	ENT03	Identification Code Qualifier		Updated Qualifier to 34

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Version 2.0 Revision Log

Companion Guide: 820 HIPAA Transaction Standard

Name: Gainwell Date: 01/11/2024

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
Naming					Updated Naming Convention for Monthly 820 and Release 820
2300B	23	RMR02	Insurance Remittance Reference Number		Corrected Field Length to 15 to match the flat file and updated description

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Version 1.9 Revision Log

Companion Guide: 820 HIPAA Transaction Standard

Name: Gainwell Date: 12-11-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300B	23	REF02	Organizational Reference Identifier		Added field lengths.

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Version 1.8 Revision Log

Companion Guide: 820 HIPAA Transaction Standard

Name: Gainwell Date: 11-29-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2200B	22	ADX01	Premium Payment Adjustment Amount		Added the statement: For all Carriers, if an adjustment needs to be made to a previous period Capitation cycle, the Adjusted Amount will be recorded within this field.

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Version 1.7 Revision Log

Companion Guide: 820 HIPAA Transaction Standard

Name: Gainwell Date: 11-28-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	15		Section 7 – Notes on 820 Premium Payment Order/Remittance		Updated the narrative to reflect the PRMP 820.
	16		Section 8 – Acknowledgements And/Or Reports		Updated the narrative to reflect the PRMP 820.
2300B	23	REF02	Organizational Reference Identifier		Added delimited by statement.
2300B	23	RMR02	Insurance Remittance Reference Number		Corrected 'Member's PBG Location ID' to be 'Member's PMG Location ID'
2200B	22	ADX01	Premium Payment Adjustment Amount		Added a statement to indicate that this field will contain the 2% released amount for members within Vital Carriers and the statement to include Adjustments to PMPM payments.
2200B	22	ADX02	Premium Payment Adjustment Reason	52, 53, H6	Added Reason Codes: 52 - Credit for Previous Overpayment and 53 - Remittance for Previous Underpayment
2320A	24	ADX01	Adjustment Amount		Added a statement to indicate that this field will only be populated for members within Vital Carriers.

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Version 1.6 Revision Log

Companion Guide: 820 HIPAA Transaction Standard

Name: Gainwell Date: 11-06-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	17	BPR04	Payment Method Code	ACH	Removed 'ACH' as a valid value
2200A	21	ADX01	Premium Payment Adjustment Amount		Removed
2200A	21	ADX02	Adjustment Reason Code		Removed
2300A	21	RMR01	Reference Identification Qualifier		Removed
2300A	21	RMR02	Reference Identification		Removed

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Version 1.5 Revision Log

Companion Guide: 820 HIPAA Transaction Standard

Name: Gainwell Date: 09-11-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2000B		ENT03	Identification Code Qualifier	II	II – Standard Unique Health Identifier replaced the 34 – Social Security Number
2100B		NM108	Identification Code Qualifier	34	34 – Social Security Number replaced the N – Insured's Unique Identification Number
		ISA			Field notes updated

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DEPARTAMENTO DE SALUD

Puerto Rico Medicaid Management Information System

ICD_MGD_0006_INBOUND_MEMBER_LEVEL_RISK_SCORE_RESPONSE

MANAGED CARE 0006 Member Level Risk Score Response

Phase III Release 2

Interface Control Document

Version 3.3

Change History

Version #	Date	Modified By	Description
1.0	03/23/2023	Gainwell Technologies	Initial creation
2.0	05/04/2023	Gainwell Technologies	NA
3.0	12/18/2023	Gainwell Technologies	• Removed two leading zeroes from Member ID field on the Detailed Specifications for Record Type 1 • Added Region field on Detailed Specifications for Record Type 0 and Record Type 1
3.2	05/24/2024	Gainwell Technologies	For CR 35 updates; updated frequency
3.3	05/31/2024	Gainwell Technologies	Corrected Versioning: merged historical changes

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Contents

1 Acronyms 1
2 Interface Overview 2
2.1 Use Requirements 2
2.2 Communication Methods and Format 2
2.3 Timing and Frequency 2
2.4 Monitoring and Reporting 2
2.5 Error Handling 2
2.6 Assumptions 2
3 Process Flow 3
4 Detailed Specifications 4
4.1 Header Record Type 0 4
4.2 Detail Format Record Type 1 – Member Level Risk Score 4

Figures

Figure 1 - Member Level Risk Score Response Process Flowchart 3

Tables

Table 1 – Acronyms 1
Table 2 - Header Record Specifications 4
Table 3 - Detail Record Specifications 4
Table 4 - Capitation Rate Codes (Effective January 01, 2023) 5
Table 5 - Carrier Medicaid IDs 6

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1 Acronyms

The following table contains the list of abbreviations used within this document.

NOTE: This acronym list will not include all potential HIPAA-related transaction information.

Table 1 – Acronyms

Acronyms	Definition
CMS	Centers for Medicare & Medicaid Services
PSV	Pipe-Separated Values
HIPAA	Health Insurance Portability and Accountability Act
ICD	Interface Control Document
MEDITI	Medicaid Integrated Technology Initiative
PRMP	Puerto Rico Department of Health
PRMMIS	Puerto Rico Medicaid Management Information System

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2 Interface Overview

This document is the definition of the triannual Member Level Risk Score Response layout (PSV file) that will be provided by the Actuary. This interface file will contain the active PRMMIS members for which the Actuary has calculated Member Level Risk Scores, which should include all members found in the Member Risk Score Request file sent to the Actuary. The member risk score will be calculated by the Actuary based on the results of the CDPS + Rx risk adjustment tool and shared with PRMMIS.

2.1 Use Requirements

This triannual interface will be used by PRMMIS to load Member Level Risk Scores in the PRMMIS database T_MC_RE_RISK_SCORE table. This table will be used by the Capitation processes for determining the capitation payment amounts for each member.

2.2 Communication Methods and Format

The file will be provided from the Actuary to PRMMIS. The risk score request file name will be MGD_Risk_Score_Response_CCYYMMDD_HHMMSS.psv.

The inbound file will be in a PSV (Pipe-Separated Values) format. Each field within a record will be separated by pipes ('|') as the delimiter. The file will not contain header or trailer records.

2.3 Timing and Frequency

The risk score request file will be a biannual (2 times per year) file. The schedule will be as follows:

Query File	Response File	Effective From	Effective To
August 1, 2024	August 20, 2024	October 1, 2024	March 31, 2025
February 1, 2025	February 20, 2025	April 1, 2025	September 30, 2025

2.4 Monitoring and Reporting

PRMMIS will create a Member Level Risk Score Response Success Report (Excel file) with the list of records that were successfully processed by the Member Level Risk Score Response process, along with a summary report of the number of successful records per Rate Cell Code.

PRMMIS will also create a Member Level Risk Score Response Error Report (Excel file) with the list of records that had processing errors, along with a summary report of the number of failed records per Error Code.

2.5 Error Handling

The PRMMIS Member Level Risk Score Response Process will automatically generate an email to the Actuary containing the summary of the records that failed processing.

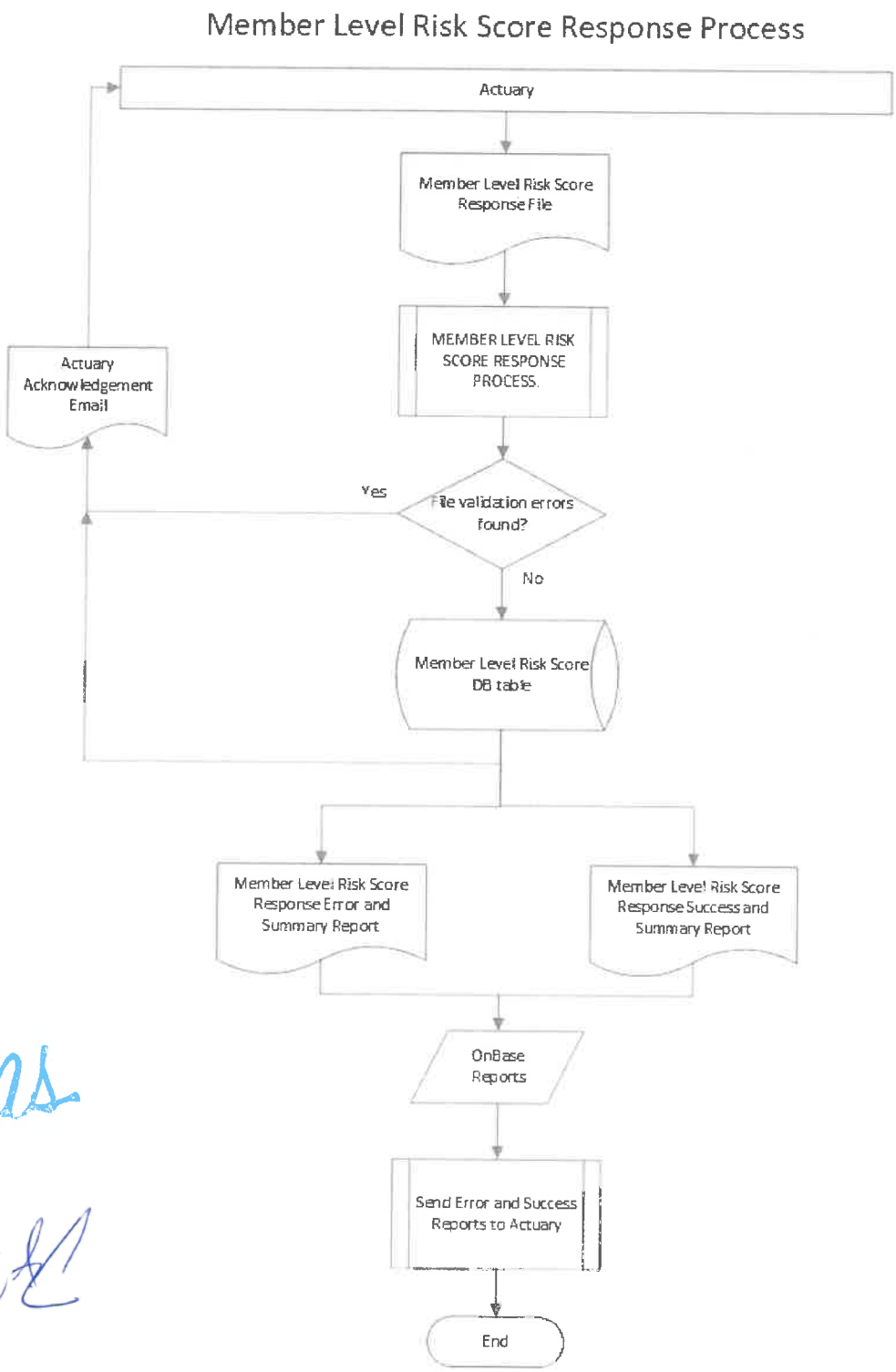
2.6 Assumptions

- Three times per year PRMMIS will generate the Member Level Risk Score Request file for the active managed care PRMMIS members.
- The Member Level Risk Score Response file will contain records for all members sent to the Actuary in the Member Level Risk Score Request file.

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3 Process Flow

Figure 1 - Member Level Risk Score Response Process Flowchart



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4 Detailed Specifications

The Member Level Risk Score Response interface file (PSV format) will be created by the Actuary to send the Member Level Risk Score data to PRMMIS.

4.1 Header Record Type 0 Format

Table 2 - Header Record Specifications

Field #	Field Name	Field Value
1	Member ID	"member_id"
2	Rate Code	"rate_code"
3	Enrollment Snapshot Date	"enrollment_snapshot"
4	Carrier Medicaid ID	"carrier_id"
5	Member Birth Date	"birth_date"
6	Raw Risk Score	"raw_riskscore"
7	Budget Neutral Risk Score	"normalized_riskscore"
8	Effective Start Date	"effective_start_date"
9	Effective End Date	"effective_end_date"
10	Region Code	"region_code"

4.2 Detail Record Type 1 Format – Member Level Risk Score

Table 3 - Detail Record Specifications

Field #	Field Name	Size	Type	Format/Values	Required/ Optional
1	Member ID	11	Numeric	999999999 Note: This is the Member Medicaid ID. No leading zeroes.	Required
2	Rate Code	3	Text	XXX Note: This is the rate cell code to which the Member belongs on the Enrollment Snapshot Date.	Required
3	Enrollment Snapshot Date	8	Text	CCYYMMDD Note: This is the date of the enrollment data used to generate the Risk Score Request file.	Required
4	Carrier Medicaid ID	9	Text	XXXXXXXXX	Required

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				Note: This is the Carrier's Provider Medicaid ID assigned by PRMMIS.	
5	Member Birth Date	8	Text	CCYYMMDD	Required
6	Raw Risk Score	9	Numeric	999.9999 Note: This is the Risk Score generated by the Actuary using the CDPS + Rx risk tool.	Required
7	Budget Neutral Risk Score	9	Numeric	999.9999 Note: This is the Risk Score adjusted for budget neutrality. This is the risk score value used to calculate capitation payments.	Required
8	Effective Start Date	8	Text	CCYYMMDD Note: This is the Risk Score effective start date.	Required
9	Effective End Date	8	Text	CCYYMMDD Note: This is the Risk Score effective end date.	Required
10	Region Code	1	Text	X Note: This is the region code to which the Member belongs on the Enrollment Snapshot Date. Regions are identified as: 'A'=North 'B'=Metro-North 'E'=East 'F'=North-East 'G'=South-East 'J'=San Juan 'P'=Virtual Region 'S'=South-West 'Z'=West	Required

Table 4 - Capitation Rate Codes (Effective January 01, 2023)

Rate Cell	Rate Code
Medicaid - Age 18 and under	V01
Medicaid Age 19+	V02
Medicaid Aged, Blind, Disabled	V03

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CHIP All Ages	V04
Commonwealth - Age 18 and under	V05
Commonwealth - Age 19+	V06
Dual A	V11
Dual AB	V12
Foster or Domestic Abuse	V13
CHIP Aged, Blind, Disabled	V15
Commonwealth Aged, Blind, Disabled	V16

Table 5 - Carrier Medicaid IDs

Carrier Name	Carrier Medicaid ID	ASES Carrier ID
First Medical	000001900	09
MMM Multi Health	000002000	10
Plan de Salud Menonita	000002200	12
Triple-S Salud	000002400	13

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ADDENDUM 3

Eligibility and Enrollment Record Layout

834 format – PRMMIS
V3_00_PRMMIS_834_Companion_Guide_20260123

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 0 0 0 0 2

NÚMERO DE CONTRATO

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3)
Implementation Guides Based on Instructions Related to Benefit Enrollment and Maintenance (834)

Companion Guide Version Number: 3.00

January 2026

Puerto Rico Medicaid Management Information System Services

ADMINISTRACIÓN DE SEGUROS DE SALUD
27 - 00002
NÚMERO DE CONTRATO

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Preface

This companion guide to the v5010 ASC X12N Technical Report Type 3 (TR3) Implementation Guide, and associated errata and addenda, adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with Puerto Rico Medicaid Program. Transmissions based on this companion guide, used in tandem with the TR3, also called Health Care Benefit Enrollment and Maintenance (834) ASC X12N (version 005010X220A1), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. This companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.





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Table of Contents

1 INTRODUCTION 7

Scope 8

Overview 8

References & Applicable Web Sites 10

Additional Information 10

National Provider Identifier 11

Acceptable Characters 11

Acknowledgements 11

File/System Specifications 11

2 GETTING STARTED 13

Testing Overview 13

3 CONNECTIVITY WITH PUERTO RICO MEDICAID PROGRAM / COMMUNICATIONS 13

Process Flows 13

Transmission Administrative Procedures 14

Re-transmission Procedure 14

Batch 14

4 CONTACT INFORMATION 15

Electronic Data Interchange Helpdesk 15

5 CONTROL SEGMENTS / ENVELOPES 16

ISA - Interchange Control Header 16

IEA – Interchange Control Header 17

GS - Functional Group Header 18

GE - Functional Group Trailer 18

ST-SE Transaction Set 19

File Delimiters 19

6 PUERTO RICO MEDICAID PROGRAM-SPECIFIC BUSINESS RULES AND LIMITATIONS 20

Trading Partner Identification Number 20

Testing 20

Terminology 20

Limits 20

Scheduled Maintenance 20

7 Notes on 834 Benefit Enrollment and Maintenance 21

8 ACKNOWLEDGEMENTS AND/OR REPORTS 22

Acknowledgements 22

Report Inventory 22

9 TRANSACTION-SPECIFIC INFORMATION 23

APPENDICES 39

Appendix A – Maintenance Reason Codes (INS04) 39

Appendix B – Member Level Date Qualifiers (DTP01) 42

Appendix C – Race Code (DMG05-1) 43

Appendix F – County Codes in Puerto Rico (N406) 44

Appendix G – Plan Coverage Description (HD04) 45

Appendix H – Member Reporting Category Reference ID (2750 REF02) 47

Appendix I – Managed Care Region 48

Appendix J – Trading Partner IDs and 834 Inbound File Names 49

Appendix K – 834 Business Rules 51

Appendix L – 834 Monthly Audit File Carrier Procedures 52

Appendix M – Ethnicity Codes 54

Appendix N – DMG Loop Examples 55

Change Summary 56

Version 2.06 Revision Log 56

Version 2.05 Revision Log 58

Version 2.04 Revision Log 59

Version 2.03 Revision Log 60

Version 2.02 Revision Log 61

Version 2.01 Revision Log 62

Version 2.00 Revision Log 63

Version 1.12 Revision Log 64

Version 1.11 Revision Log **65**
Version 1.10 Revision Log **67**
Version 1.9 Revision Log **69**
Version 1.8 Revision Log **70**
Version 1.7 Revision Log **73**
Version 1.6 Revision Log **76**
Version 1.5 Revision Log **77**
Version 1.4 Revision Log **80**
Version 1.3 Revision Log **82**
Version 1.2 Revision Log **83**
Version 1.1 Revision Log **84**

1 INTRODUCTION

This section describes how TR3, also called 834 ASC X12N (005010X220A1), which was adopted under HIPAA, will be detailed with the use of a table. The table contains a Notes/Comments column for each segment that Puerto Rico Medicaid Program (PRMP) has additional information to provide over and above the information in the TR3. That information can do the following:

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

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

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column for each segment that PRMP has additional information to provide, over and above the information in the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in Section 10: Transaction Specific Information.

Page#	Loop ID	Reference	Name	Codes	Notes/Comments
193	2100C	NM1	Subscriber Name		This type of row exists to indicate that a new segment has begun. It is shaded at 10 percent and notes or comments about the segment itself go in this cell.
196	2100C	REF	Subscriber Additional Identification		

197	2100C	REF01	Reference Identification Qualifier	18 49 6P HJ N6	These are the only codes transmitted.
			Plan Network Identification Number	N6	This type of row exists when a note for a particular code value is required. For example, this note may say that value "N6" is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information		
231	2110C	EB13-1	Product/Service ID Qualifier	AD	This row illustrates how to indicate a component data element in the Reference column and how to specify that only one code value is applicable.

Scope

PRMP developed 5010 Companion Guides to supplement each 5010 Transaction Implementation Guide, based on Version 5, Release 1, with regards to:

- Specific Codes and/or Values that PRMP will default on Outbound Transactions
- Specific Codes and/or Values that are unique to PRMP to accept an Inbound Transaction

PRMP Companion Guides will not create a Non-Compliant Transaction.

This companion guide is intended to be used in conjunction with the ASC X12N/005010X220A1 Implementation Guide (IG). It provides supplementation instructions not included in the IG that must be followed for implementation and conducting the transaction with PRMP. It does not change the requirements of the IG in any way.

Refer to the companion guide first if there is a question about how PRMP processes a HIPAA transaction. For further information, contact prmmis_edi_support@gainwelltechnologies.com. This document is intended as a resource to assist providers, clearinghouses, service bureaus, and all other trading partners with PRMP interChange in successfully conducting EDI of administrative health care transactions. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

Overview

PRMP and all other covered entities are required by HIPAA to comply with the EDI standards for health care, as established by the Secretary of the federal Department of Health and Human Services (HHS). The Secretary of the HHS is required by HIPAA to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. The Health Insurance Portability and Accountability Act of 1996 directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

The Health Insurance Portability and Accountability Act of 1996 serves to:

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

The 834 transaction is used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy to a payer. The intent is the initial enrollment and subsequent maintenance of individuals who are enrolled in healthcare. This transaction specifically addresses the enrollment and maintenance of healthcare only.

The payer refers to a third party entity that pays claims or administers the insurance benefit. A sponsor is the party that ultimately pays for the coverage or benefit. A member is an individual eligible for coverage because of his or her association with a sponsor. An insured individual is a member who has been enrolled for coverage under PRMP.

This Companion Guide contains the format and establishes the data contents of the Enrollment Transaction Set (834) for use within the context of an EDI environment. The 834 is used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy to a payer. The intent of this implementation guide is to meet the health care industry's specific need for the initial enrollment and subsequent maintenance of individuals who are enrolled in Managed Care Organizations (MCO) or Medicare Advantage Organizations(MAO)-referred to as "carriers" in the rest of this document. This implementation guide specifically addresses the enrollment and maintenance of health care products only.

This guide is designed to help those responsible for testing and setting up electronic Benefit Enrollment and Maintenance transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting, and identifies codes and data elements that do not apply to PRMP. This guide supplements (but does not contradict) requirements in the ASC X12N 834 (version 005010X220A1) implementation. This information should be given to the "carrier's" business area to ensure that Benefit Enrollment and Maintenance transactions are interpreted correctly. This companion guide provides communications-related information a trading partner needs to obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with PRMP.

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist trading partners in implementing electronic Benefit Enrollment and Maintenance transactions that meet PRMP processing standards, by identifying pertinent structural and data-related requirements and recommendations.

As utilized by the PRPM, this transaction is designed to accomplish the function of sending enrollment information to PRMP participating Carriers.

The 834 X12 is the Enrollment Roster for PRMP. There are 2 file types that are sent – the full and the changes file.

834 Full/Audit File: This is a full file extract of the members enrolled with a Carrier at a specific point in time each month. It contains the most current information related to that member. This file is used to keep "carrier's" system in sync with PRMP. As a result, INS03 in Loop 2000 (Member Level Detail) as well as HD01 in Loop 2300 (Health Coverage) will be set to 030 (audit or full file).

834 Changes File: This file reflects any retro changes made to a member's demographic, eligibility or enrollment information. It is generated five days a week (Monday through Friday). The Carriers should not assume that new membership results in the automatic termination of prior coverage. There will be multiple member level details (Loop 2300) to indicate movement from the old to the new coverage, along with changes to other pertinent information that may change at the member level. In the changes file, all retro changes will be provided in the 2300 loop. When multiple changes appear, they are sorted in descending order of date and time.

The 834 file comprises of separate transaction sets (ST-SE) for each Carrier's "assignee" Provider Medicaid ID. Within each set, the member details are grouped in the following sequence:

TERMINATION records (INS03 = 024), followed by ADD records (INS03 = 021), and CHANGE records (INS03 = 001).

References & Applicable Web Sites

For more information regarding the ASC X12 standards for EDI 834 (version 005010X220A1) and to purchase copies of the TR3 documents, consult the Washington Publishing Company Web site at http://www.wpc-edi.com/.

For information about EDI software and services, visit: http://www.1edisource.com.

Additional information is available on the following Web sites:

- Accredited Standards Committee X12N develops and maintains X12 EDI and XML standards, standards interpretations and guidelines as they relate to all aspects of insurance and insurance-related business processes: www.x12.org.
- Centers for Medicare and Medicaid Services (CMS) is the unit within the HHS that administers the Medicare and Medicaid programs. The CMS provides the Electronic Health Care Transactions and Code Sets Model Compliance Plan at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets/index.htmL.
- Designated Standard Maintenance Organizations (DSMO) is a resource for information about the standard-setting organizations and transaction change request system: www.hipaa-dsmo.org.
- Health Level Seven (HL7) is one of several ANSI-accredited Standards Development Organizations (SDOs) and is responsible for clinical and administrative data standards: www.hl7.org.
- Healthcare Information and Management Systems (HIMSS) is an organization exclusively focused on providing global leadership for the optimal use of IT and management systems for the betterment of health care: www.himss.org.
- National Committee on Vital and Health Statistics (NCVHS) was established by Congress to serve as an advisory body to the HHS on health data, statistics and national health information policy; for more information, refer to: www.ncvhs.hhs.gov.
- Office for Civil Rights (OCR) is the office within the federal HHS responsible for enforcing the Privacy Rule under HIPAA, which can be found at: www.hhs.gov/ocr/hipaa.
- The federal HHS is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA, which can be found at: www.aspe.hhs.gov/admnsimp.
- Washington Publishing Company (WPC) is a resource for HIPAA-required transaction implementation guides and code sets, which can be found at: www.wpc-edi.com/.
- The WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA: www.wedi.org.
- The registry for the NPI is the National Plan and Provider Enumeration System (NPPES), at: https://nppes.cms.hhs.gov/NPPES/Welcome.do.
- Implementation guides and non-medical code sets are at: store.x12.org/.
- The HIPAA statute, Final Rules, and related Notices of Proposed Rulemaking (NPRMS) are available at: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets/index.html.
- The CMS online manuals system and Internet only manuals (IOM) system, including transmittals and program memoranda, can be found at: www.cms.hhs.gov/Manuals/.

Additional Information

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979, ANSI chartered the ASC X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards

to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standard is recognized by the United States as the standard for North America. Electronic Data Interchange adoption has been proved to reduce the administrative burden on providers.

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

National Provider Identifier

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

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

PRMP has determined that all providers, except for personal care-only providers, specialized medical vehicle providers, and blood banks, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. PRMP requires all health care providers to submit their NPI on electronic transactions.

Acceptable Characters

The HIPAA transactions must not contain any carriage returns, nor line feeds; the data must be received in one, continuous stream. PRMP accepts the extended character set. Uppercase characters are recommended.

Acknowledgements

An accepted 999 Implementation Acknowledgement (999), rejected 999 Implementation Acknowledgement, or rejected TA1 InterChange Acknowledgement (TA1) will be generated in response to all submitted files. Trading partners are responsible for retrieving acknowledgments from their "response" folder to determine the status of their files.

File/System Specifications

EDI only accepts Windows/PC/DOS formatted files. Any file transmitted to EDI must be named in accordance to standard file naming conventions, including a valid three character file extension. The following standards should be used:

- To avoid accidently overwriting files, do not send multiple files with the same name on the same day
- File Names should not be longer than 45 characters – the first 20 characters will be used to identify the file through PRMMIS
- Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file
- Zip files must contain the extension .zip (not case sensitive)
- The maximum number of members per 834 file is 50,000; this applies to both Audit and Daily files.

File Naming Convention for Managed Care 834 Inbound

Carriers will send an 834 to PRMMIS Monday through Friday.

File naming convention for inbound 834 files from Carriers:

Example:
Submission Date: 06/30/2023

20230630_FM_690150_834DI_##.X12

Date file was created (YYYYMMDD format)
underscore
Two to 4 character abbreviation of Carrier's (MCO/MAO) name
underscore
Trading Partner ID
Underscore
834
D (daily)
I (inbound)
- two digit sequence for multiple files per day

The standards above will avoid accidently overwriting files. Do not send multiple files with the same name on the same day.

See Appendix J for a list of Trading Partner IDs and 834 inbound file names by carrier.
Note: Any data file that is 5MB or larger is required to be zipped or compressed before transmitting it to EDI.

File Naming Convention for Managed Care 834 Outbound

Types of 834 Outbound files for Carriers:

1. 834 Daily runs Monday through Friday every week (834DO).
2. 834 Audit runs on the 3rd business day of every month (834MO).
3. 834 Termination Resends runs daily based on data present within the request table.
4. 834 Retro Change Transactions from the Eligibility Vendor runs daily based on data provided from the Eligibility Vendor. This file will only contain 'retro' change transactions.
5. 834 Retro Add Resends runs daily based on data present within the request table.

File Name format for Outbound 834:

1. BatchID_834DO_TradingPartnerID_YYYYMMDD_##.X12 - Daily
2. BatchID_834MO_TradingPartnerID_YYYYMMDD_##.X12 – Audit
3. BatchID_834TRM_TradingPartnerID_YYYYMMDD_##.X12 – Termination Re-sends
4. BatchID_834CHG_TradingPartnerID_YYYYMMDD_##.X12 – Retro Change Transactions
5. BatchID_834ADD_TradingPartnerID_YYYYMMDD_##.X12 –Add Re-sends

BatchID is the unique ID assigned by PRMMIS to each file.

TradingPartnerID is the Carrier's Trading Partner ID.

- two digit sequence for multiple files per day

Carrier Acknowledgements

PRMMIS will accept 999 Implementation Acknowledgement transactions from trading partners after they have downloaded their 834 Health Care Benefit Enrollment and Maintenance transaction. If you return an acknowledgement file after downloading your 834 X12, we request that you name your file using the 834 X12 file's name and make the extension ".ACK".

Example:
You receive the following X12 file:

BatchID_834DO_TradingPartnerID_YYYYMMDD_##.X12 – Daily
BatchID_834MO_TradingPartnerID_YYYYMMDD_##.X12 – Audit

Acknowledgement file you upload to SFTP:

BatchID_834DO_TradingPartnerID_YYYYMMDD_##.ACK – Daily
BatchID_834MO_TradingPartnerID_YYYYMMDD_##.ACK – Monthly Audit

BatchID is the unique ID assigned by PRMMIS to each file.

TradingPartnerID is the Carrier's Trading Partner ID.

- two digit sequence for multiple files per day.

2 GETTING STARTED

Testing Overview

Test transactions (ISA15 value of "T") must be sent to our Testing (UAT) environment.

Production transactions (ISA15 value of "P") must be sent to our Production environment (PROD).

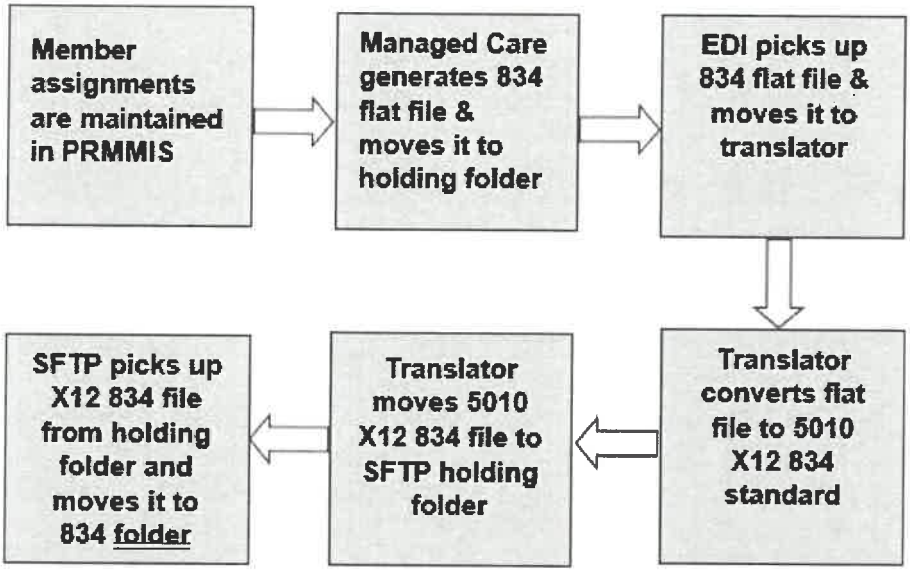
Reminder: Submitters are responsible for the preservation, privacy, and security of data in their possession. While using production data that contains Personal Health Information (PHI) to conduct testing, the data must be guarded and disposed of appropriately.

3 CONNECTIVITY WITH PUERTO RICO MEDICAID PROGRAM / COMMUNICATIONS

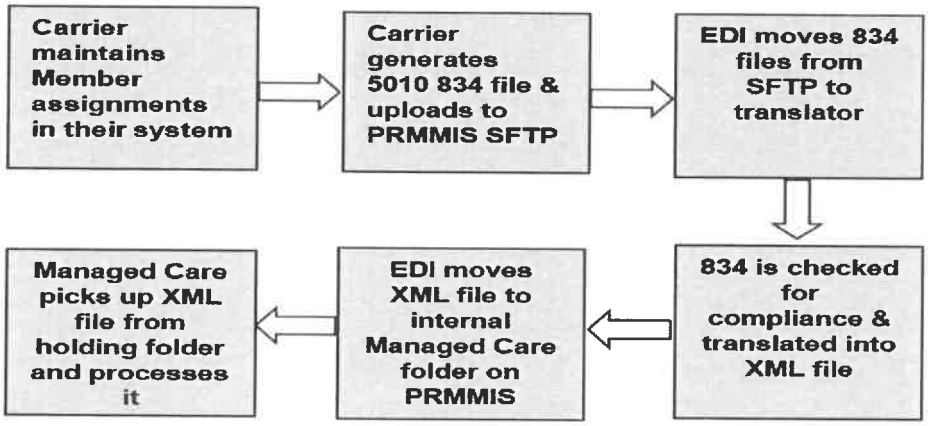
This section describes the process for downloading HIPAA 834 transactions, along with various security requirements and exceptions to handling procedures.

Process Flows

Outbound 834 - Retrieval of Puerto Rico Medicaid Program's Benefit Enrollment and Maintenance daily or monthly 834 file via Carrier's 834 folder on PRMMIS SFTP Site.



Inbound 834 - Submission of Carrier's (MCO/MAO) daily 834 file using their upload 834 folder on PRMMIS SFTP Site. Carrier is responsible for picking up TA1 or 999 acknowledgement, and the HTML error file if file fails compliance, from the "response" folder.



Transmission Administrative Procedures

Access to MoveIT (SFTP) is available only to authorized users. Submitters are required to be PRMP trading partners.

Re-transmission Procedure

In the event of an interrupted communications session, the trading partner only has to reconnect and initiate their file transfer as they normally would.

Batch

Trading partners can submit all batch transactions to PRMMIS and download acknowledgements and response files. The user must have their own internet connection to access the FTP server.

4 CONTACT INFORMATION

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

Electronic Data Interchange Helpdesk

If you have questions related to PRMP's 834, contact the EDI Helpdesk by email at prmmis_edi_support@gainwelltechnologies.com or by phone at 1-833-209-8326.

5 CONTROL SEGMENTS / ENVELOPES

ISA - Interchange Control Header

This section describes PRMP's use of the ISA. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

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

- Each trading partner is assigned a six-digit trading partner ID
- All date/times are in the CCYYMMDDHHMM format (24 hour)
- Payer ID can be found in all companion guides
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file

Transactions transmitted are identified by an ISA and trailer segment (IEA) which form the envelope enclosing the transmission. The ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The table below shows the fields that PRMP will be sending.

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

Note: PRMMIS sends files with one ISA/IEA loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
C.3	None	ISA	Interchange Control Header			The ISA is a fixed-length record with fixed-length elements.
C.4		ISA01	Authorization Information Qualifier	00	IN	No authorization information present.
C.4		ISA02	Authorization Information		IN	[10 spaces]
C.4		ISA03	Security Information Qualifier	00	IN	No security information present.
C.4		ISA04	Security Information		IN	[10 spaces]
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	IN	ZZ=Mutually Defined
C.4		ISA06	Interchange Sender ID		IN	Inbound from Carriers: Carrier's Trading Partner ID supplied by PRMMIS, [6 digits left justified and 9 spaces]. Outbound to Carriers: "PRMMIS" Puerto Rico Medicaid Management System., [6 characters left justified and 9 spaces].
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	IN	ZZ=Mutually Defined
C.5		ISA08	Interchange Receiver ID		IN	Inbound from Carriers: "PRMMIS" Puerto Rico Medicaid Management System., [6 characters left justified and 9 spaces]. Outbound to Carriers: Carrier's Trading Partner ID supplied by PRMMIS, [6 digits left justified and 9 spaces].
C.5		ISA09	Interchange Date		IN	The date format is YYMMDD.

TR3 Page #	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
C.5		ISA10	Interchange Time		IN	The time format is HHMM.
C.5		ISA11	Repetition Separator	^	IN	A Caret "^" will be sent.
C.5		ISA12	Interchange Control Version Number	00501	IN	00501 = Control Version Number
C.5		ISA13	Interchange Control Number		IN	The interchange control number assigned in ISA13 will be identical to the value in IEA02.
C.6		ISA14	Acknowledgement Requested	0	IN	No interchange acknowledgment requested (TA1). ***Note:*** TA1 will be sent if file envelope is corrupted.
C.6		ISA15	Usage Identifier	T & P	IN	Code indicating whether the data enclosed is production or test.
				T		T=Test Data File submitted to PRMMIS test environment.
				P		P= Production Data File submitted to PRMMIS production environment.
C.6		ISA16	Component Element Separator	:	IN	A colon ":" will be sent.

IEA – Interchange Control Header

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.10	None	IEA	Interchange Control Trailer		
C.10		IEA01	Number of Included Functional Groups		Number of included Functional Groups
C.10		IEA02	Interchange Control Number.		Must be identical to the value in ISA13

GS - Functional Group Header

This section describes the use of the functional group control segments. It includes a description of expected application sender and receiver codes.

The table below shows the fields that PRMMIS will be sending.

TR3 Page #	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
C.7	None	GS	Functional Group Header			
C.7		GS01	Functional ID Code	BE	IN	"BE" Health Care Benefit Enrollment and Maintenance (834).
C.7		GS02	Application Sender's Code		IN	Inbound: Carrier's Trading Partner ID supplied by PRMP. Outbound: "PRMMIS"
C.7		GS03	Application Receiver's Code		IN	Inbound: "PRMMIS" Outbound: Carrier's Trading Partner ID supplied by PRMP.
C.7		GS04	Date		IN	The date format is CCYYMMDD.
C.8		GS05	Time		IN	The time format is HHMMSS.
C.8		GS06	Group Control Number		IN	Group Control Number – Must be identical to GE02.
C.8		GS07	Responsible Agency Code	X	IN	"X" Responsible Agency Code
C.8		GS08	Version/ Release/Industry Identifier Code	005010 X220A1	IN	Version/ Release/ Industry Identifier Code

GE - Functional Group Trailer

The table below shows the fields that Puerto Rico Medicaid will be sending.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.9	None	GE	Functional Group Trailer		
C.9		GE01	Number of Transaction Sets Included		Total number of transaction sets
C.9		GE02	Group Control Number		Must be identical to the value in GS06

ST-SE Transaction Set

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

PRMP recommends that trading partners follow the guidelines set forth in the TR3 — start the first ST02 in the first file with 000000001 and increment from there. The TR3 should be reviewed for how to create compliant transaction set control segments.

TRANSACTION SET HEADER (ST)

The TR3 should be reviewed for specific information.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Reqd	Notes/Comments
70	None	ST	Transaction Set Header			
70		ST01	Transaction Set Identifier Code	834	IN	834 Health Care Benefit & Enrollment Maintenance
70		ST02	Transaction Set Control Number		IN	The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA).
70		ST03	Implementation Guide Version Name	005010X 220A1	IN	This field contains the same value as GS08.

TRANSACTION SET TRAILER (SE)

The TR3 should be reviewed for specific information.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Reqd	Notes/Comments
496	None	SE	TRANSACTION SET TRAILER			
496		SE01	Transaction Segment Count		IN	Total number of segments included in a transaction set including the ST and SE segments
496		SE02	Transaction Set Control Number		IN	The Transaction Set Control Number in ST02 and SE02 must be identical.

File Delimiters

PRMMIS uses the following delimiters in the 834 file:

- **Data Element:** Byte 4 in the ISA segment defines the data element separator to be used throughout the entire transaction. The data element delimiter is an asterisk (*).
- **Repetition Separator:** ISA11 defines the repetition separator to be used throughout the entire transaction. The repetition separator is a caret (^).
- **Component-Element:** ISA16 defines the component element delimiter to be used throughout the entire transaction. The component-element delimiter is a colon (:).
- **Data Segment:** Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The data segment delimiter is a tilde (~).

These characters (* : ~ ^) can not be present within the data content of the transaction elements.

6 PUERTO RICO MEDICAID PROGRAM-SPECIFIC BUSINESS RULES AND LIMITATIONS

Trading Partner Identification Number

The EDI team will create any needed Trading Partner Profiles during the PRMP's implementation of the 834.

Testing

Production Authorization Testing will be required for inbound 834 files.

Terminology

The term "subscriber" will be used as a generic term throughout the companion guide.

Limits

There is no file size restriction on how many records will be reported in an 834.

Scheduled Maintenance

PRMMIS recycles the servers every night between 00:00 a.m. to 01:00 a.m. AST.

PRMMIS schedules regular maintenance every Sunday from 00:00 a.m. to 04:00 a.m. AST.

7 Notes on 834 Benefit Enrollment and Maintenance

834 - Daily

A daily 834 is generated to report demographic, eligibility and enrollment changes on existing members. Daily files are produced Monday through Friday, if available.

834 – Monthly Audit

An 834 monthly Audit file is produced on the 3rd business day of the month to provide a full list of members for the Plan for the current month. 834 Audit transactions contain a complete Roster that includes new, current, and terminated members. No past changes will be reported. The 834 daily files will use the same formats as the 834 audit files.

The 834 files will be available for retrieval for six months. If an 834 file is needed after six months, contact the EDI Helpdesk via e-mail using prmmis_edi_support@gainwelltechnologies.com

Usage of REF segment for Recipient IDs

There is guidance around the various recipient identifiers provided using the **REF (Member Supplemental Identifier)** segment in the 2000 loop.

• When REF01 = F6, this is the **recipient's Medicare ID** as provided by the eligibility system. This is provided when the recipient has Medicare. Where possible, this is the new Medicare Beneficiary ID. In other instances, it is still the recipient's HIC Number.

• When REF01 = Q4, this is the **recipient's linked (or secondary) id**. This is an Inactive ID in PRMMIS that is linked to the recipient's primary ID. The secondary ID is usually a historical ID for the recipient. If the recipient is found to have multiple IDs, the recipient IDs are linked and only one ID remains as primary, all other linked IDs become secondary. The 834 will have the most recent linked ID (secondary ID) in the chain when a recipient has multiple linked IDs.

8 ACKNOWLEDGEMENTS AND/OR REPORTS

Acknowledgements

TA1 — Transaction Acknowledgement
PRMMIS will only respond with a TA1 when the batch X12 contains Envelope errors. If a TA1 is produced, then a 999 will not be sent. The submitted 834 will need to be corrected and resubmitted.

999 — Functional Acknowledgement
This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a batch X12 file. PRMMIS will always respond with a 999 for a batch X12 file. The submitted 834 will need to be corrected and resubmitted.

HTML – Compliance Check HTML Report
This file informs the submitter that the transaction had envelope or compliance errors and provides information about the error in a more readable format.

Report Inventory

There are no acknowledgement reports at this time.

9 TRANSACTION-SPECIFIC INFORMATION

This section describes how ASC X12N implementation guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that PRMP has something additional, over and above, the information in the implementation guides. That information can:

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

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

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column for each segment that PRMP has additional information to provide, over and above the information in the TR3.

005010X220A1 — 834 Health Care Benefit Enrollment and Maintenance

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
32			BGN	Beginning Segment			
32	1/1		BGN01	Transaction Set Purpose Code	00 15 22	IN	
				Original	00		Indicates the first time the transaction is sent.
				Resubmission	15		Sent when the original transmission was incorrect, has yet to be processed by the receiver, and a new corrected transmission is being sent.
				Information Copy	22		Sent when the original transmission was lost or not processed, and the sender is passing another transmission that is the same as the original.

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
33	1/50		BGN02	Transaction Set Reference Number		IN	This element is 50 characters of free form text to identify this specific file's information. Example: • Positions 1-7, Report ID, valid values are "INITIAL" or "CHANGE ". • Positions 8–8, Space. • Positions 9–14, Enrollment month in a CCYYMM format. • Positions 15–15, Space. • Positions 16–19, Sequence number of the transaction set indicating the order that the transaction sets are created and the order in which the transaction sets are to be processed. Example: INITIAL 202308 0001 OR CHANGE 202308 0001
33	8/8		BGN03	Transaction Set Creation Date		IN	Date when the X12 file was generated
33	4/8		BGN04	Transaction Set Creation Time		IN	Time when the X12 file was generated. Format used - HHMM
33	2/2		BGN05	Time Zone Code	TT		"TT" = Atlantic Time
35	1/50		BGN06	Original Transaction Set Reference Number			Required when there is a previously sent transaction to cross-reference.
35	1/2		BGN08	Action Code	2 4 RX	IN	
				Change (Update)	2		Used to identify a transaction of additions, terminations and changes to the current enrollment.
				Verify	4		Used to identify a full enrollment transaction to verify that the sponsor's and payer's systems are synchronized.
				Replace	RX		Used to identify a full enrollment transmission to be used to identify additions, terminations and changes that need to be applied to the payer's enrollment system.
36			REF	Transaction Set Policy Number			
36	2/3		REF01	Reference Identification Qualifier	38	IN	"38" = Master Policy Number
36	1/50		REF02	Master Policy Number		IN	Carrier's Trading Partner ID supplied by PRMMIS.
37			DTP	File Effective Date			This segment communicates the start and end date of the coverage period associated with this premium payment. ***Note:*** Segment can be repeated.

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
37	3/3		DTP01	Date Time Qualifier	**007**		
				Effective	007		
37	2/3		DTP02	Date Time Period Format Qualifier	D8		"D8" = Date Expressed in Format CCYYMMDD.
37	1-35		DTP03	Date Time Period			
38			QTY	Transaction Set Control Totals			
38	2/2		QTY01	Trace Type Code	TO		"TO" = Total
38	1/15		QTY02	Record Totals			
39		1000A	N1	Sponsor Name			
39	2/3	1000A	N101	Entity Identifier Code	P5		"P5" = Plan Sponsor
39	1/60	1000A	N102	Plan Sponsor Name	PRMP		
40	1/2	1000A	N103	Identification Code Qualifier	FI		"FI" = Federal Taxpayer's Identification Number
40	2/80	1000A	N104	Sponsor Identifier	660437470		Federal Tax ID of Sponsor (PRMP)
41		1000B	N1	Payer			
41	2/3	1000B	N101	Entity Identifier Code	IN	IN	"IN" = Insurer
41	1/60	1000B	N102	Insurer Name		IN	Name of carrier
42	1/2	1000B	N103	Identification Code Qualifier	FI	IN	"FI" = Federal Taxpayer's Identification Number
42	2/80	1000B	N104	Insurer Identification Code		IN	Federal Tax ID of carrier
43		1000C	N1	TPA/Broker Name			This loop does not meet the situational requirements to be sent by Puerto Rico Medicaid.
45		1100C	ACT	TPA/Broker Account Information			This loop does not meet the situational requirements to be sent by Puerto Rico Medicaid.
47		2000	INS	Member Level Detail			PRMP considers the Member as the Subscriber/Member in all reporting situations.
48	1/1	2000	INS01	Member Indicator	Y	IN	"Y" = Yes
48	2/2	2000	INS02	Individual Relationship Code	18	IN	"18" = Self
49	3/3	2000	INS03	Maintenance Type Code	001 021 024 030	IN	
				Change (Daily)	001		Indicate a change to an existing subscriber/dependent record.
				Addition	021		Add a subscriber.
				Cancellation or Termination	024		Cancellation, termination, or deletion of a subscriber.
				Audit or Compare (Monthly)	030		Outbound only: Sending a full file (BGN08 = '4' or 'RX') to verify that the sponsor and payer databases are synchronized.

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
49	2/3	2000	INS04	Maintenance Reason Code		IN	See Appendix A for list of possible codes. When INS04=03, the date of death is indicated within the INS12 field and as the Medicaid end date in the 2000 loop
51	1/1	2000	INS05	Benefit Status Code	A	IN	"A" = Active
51	1/1	2000	INS06-1	Medicare Plan Code	A B C D E	IN	
				Medicare Part A	A		
				Medicare Part B	B		
				Medicare Part A and B	C		
				Medicare Part D	D		
				No Medicare	E		
52	2/2	2000	INS08	Employment Status Code	AC TE	IN	Status of the subscriber in Medicaid.
				Active	AC		
				Terminated	TE		
53	2/3	2000	INS11	Date Time Period Format Qualifier	D8		"D8" = Date Expressed in Format CCYYMMDD
54	1/35	2000	INS12	Date Time Period			Member / Individual Death Date CCYYMMDD format
55		2000	REF	Subscriber Identifier			
55	2/3	2000	REF01	Reference Identification Qualifier	0F	IN	"0F" = Subscriber Number
55	1/35	2000	REF02	Subscriber Identifier	PRMMIS medicaid id MPI	IN	Subscriber ID as assigned by PRMP. 11 digits as assigned by M3G.
56		2000	REF	Member Policy Number			This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid.
57		2000	REF	Member Supplemental Identifier			Additional details are provided in Section 7 - Notes on 834 Benefit Enrollment and Maintenance. ***Note:*** Segment can repeat 13 times.
57	2/3	2000	REF01	Reference Identification Qualifier	F6 Q4		
				Health Insurance Claim (HIC) Number	F6		MBI
				Prior Identifier Number	Q4		To pass the Identifier Number under which the member had previous coverage with the payer.
57	1/50	2000	REF02	Member Supplemental Identifier			

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
58		2000	DTP	Member Level Dates			Required when enrolling a member or when the sponsor is informed of a change to any applicable date listed in DTP01. Only those dates that apply to the particular insurance contract need to be sent. ***Note:*** Segment can repeat 24 times. DTP01 values 473 (Medicaid Begin Date) and 474 (Medicaid End) date will be present on all 834 Maintenance Type Codes (001, 021, 024 and 030).
58	3/3	2000	DTP01	Date Time Qualifier			See Appendix B for list of valid qualifiers.
59	2/3	2000	DTP02	Date Time Period Format Qualifier	D8		"D8" = Date Expressed in Format CCYYMMDD.
59	1/35	2000	DTP03	Status Information Effective Date			
62		2100A	NM1	Member Name			
62	2/3	2100A	NM101	Entity Identifier Code	74 IL	IN	
				Corrected Insured	74		This code is used if this transmission is correcting the identifier information on a member already enrolled. ***Note:*** Usage of this code requires the sending of an NM1 with code '70' in loop 2100B.
				Insured or Subscriber	IL		This code is used when enrolling a new member or updating a member with no change in identifying information.
63	1/1	2100A	NM102	Entity Type Qualifier	1	IN	"1" = Person
63	1/60	2100A	NM103	Member Last Name		IN	last name #1 & last name #2 with pipe delimiter to separate
63	1/35	2100A	NM104	Member First Name		IN	
63	1/25	2100A	NM105	Member Middle Name			
64	1/2	2100A	NM108	Identification Code Qualifier			"34" = Social Security Number
64	2/80	2100A	NM109	Member Identifier			Social Security Number
65		2100A	PER	Member Communications Numbers			
66	2/2	2100A	PER01	Contact Function Code	IP		"IP" = Insured Party
66	2/2	2100A	PER03	Communication Number Qualifier	TE		"TE" Telephone
66	1/256	2100A	PER04	Communication Number			Member's Telephone Number if on file
66	2/2	2100A	PER05	Communication Number Qualifier	TE		"TE" Telephone

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
66	1/256	2100A	PER06	Communication Number			Member's 2nd Telephone Number if on file
68		2100A	N3	Member Residence Street Address			
68	1/55	2100A	N301	Member Address Line			
68	1/55	2100A	N302	Member Address Line2			
69		2100A	N4	Member City, State, ZIP Code			
69	2/30	2100A	N401	Member City Name		IN	
69	2/2	2100A	N402	Member State Code		IN	
70	3/15	2100A	N403	Member Zip Code		IN	***Note:*** If zip +4 is unknown send 9998.
70	1/2	2100A	N405	Location Qualifier	CY	IN	"CY" = County/Parish
70	1/30	2100A	N406	Location Identifier		IN	Contains 3-digit county code See Appendix F for list of valid codes.
71		2100A	DMG	Member Demographics			
71	2/3	2100A	DMG01	Date Time Period Format Qualifier	D8		"D8" = Date Expressed in Format CCYYMMDD
71	1/35	2100A	DMG02	Member Birth Date			
72	1/1	2100A	DMG03	Gender Code	F M U		
				Female	F		
				Male	M		
				Unknown	U		This code is to be used only when the gender is unknown or when it can not be sent due to reporting restrictions.
72	1/1	2100A	DMG04	Marital Status Code	B D I M R S U W X		
				Registered Domestic Partner	B		
				Divorced	D		
				Single	I		
				Married	M		
				Unreported	R		
				Separated	S		
				Unmarried (Single or Divorced or Widowed)	U		This code should be used if the previous status is unknown.
				Widowed	W		

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
				Legally Separated	X		
72		2100A	DMG05	Composite Race Or Ethnicity Information			***Note:*** Element can repeat up to 10 times.
73	1/1	2100A	DMG05 - 1	Race Code			See Appendix C for list of possible codes. Since this is a repeating field multiple race codes can be entered in this field separated by value in ISA11 ("^"). This can occur up to seven times.
74	1/30	2100A	DMG05 - 3	Ethnicity Information			See Appendix M for list of possible codes. Only one value is allowed.
76		2100A	EC	Employment Class Code			This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid.
79		2100A	ICM	Member Income			This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid.
81		2100A	AMT	Member Policy Amounts			***Note:*** Segment can repeat up to 7 times
81	1/3	2100A	AMT01	Amount Qualifier Code	C1		Co-Payment Amount (maximum monthly out of pocket)
81	1/18	2100A	AMT02	Contract Amount			
82		2100A	HLH	Member Health Information			This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid.
84		2100A	LUI	Member Language			Required if the sponsor knows that the member's primary language is not English, and such transmission is required under the insurance contract between the sponsor and payer and allowed by federal and state regulations. ***Note:*** Segment can repeat as needed.
84	1/2	2100A	LUI01	Identification Code Qualifier	LE		"LE" ISO 639 Language Codes
85	2/80	2100A	LUI02	Language Code			SPA for example
85	1/80	2100A	LUI03	Language Description			Situational Rule: Required if the sender is unable to code the necessary language identification in LUI01 and LUI02.
85	1/2	2100A	LUI04	Language Use Indicator	6 7		
				Language Writing	6		
				Language Speaking	7		

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
86		2100B	NM1	Incorrect Member Name			Required if a corrected name is being sent in loop 2100A or if previously supplied demographics are being changed. If only the demographics are being changed, the code in NM101 in loop 2100A will be IL, and the code in NM101 in this loop will be 70.
86	2/3	2100B	NM101	Entity Identifier Code	70		"70" = Prior Incorrect Insured ***Note:*** This code identifies that the information that follows is previously reported enrollment information that is being corrected.
87	1/1	2100B	NM102	Entity Type Qualifier	1		"1" = Person
87	1/60	2100B	NM103	Prior Incorrect Member Last Name			1st last name & 2nd last name with pipe delimiter to separate
87	1/35	2100B	NM104	Prior Incorrect Member First Name			
87	1/25	2100B	NM105	Prior Incorrect Member Middle Name			Middle initial only in PRMMIS
87	1/2	2100B	NM108	Identification Code Qualifier	34		"34" = Social Security Number
88	2/80	2100B	NM109	Prior Incorrect Insured Identifier			Prior incorrect Social Security Number
89		2100B	DMG	Incorrect Member Demographics			Required when changing previously supplied demographics.
89	2/3	2100B	DMG01	Date Time Period Format Qualifier	D8		"D8" = Date Expressed in Format CCYYMMDD
90	1/35	2100B	DMG02	Prior Incorrect Insured Birth Date			
90	1/1	2100B	DMG03	Prior Incorrect Insured Gender Code	F M U		
				Female	F		
				Male	M		
				Unknown	U		This code is to be used only when the gender is unknown or when it can not be sent due to reporting restrictions.
90	1/1	2100B	DMG04	Marital Status Code	B D I M R S U W X		
				Registered Domestic Partner	B		
				Divorced	D		
				Single	I		
				Married	M		

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
				Unreported	R		
				Separated	S		
				Unmarried (Single or Divorced or Widowed)	U		This code should be used if the previous status is unknown.
				Widowed	W		
				Legally Separated	X		
90		2100B	DMG05	Composite Race Or Ethnicity Information			
90	1/1	2100B	DMG05 – 1	Race Code			See Appendix C for list of possible codes.
92		2100C	NM1	Member Mailing Address			When the member mailing address is different from the residence address sent in loop 2100A.
92	2/3	2100C	NM101	Entity Identifier Code	31		"31" = Postal Mailing Address
92	1/1	2100C	NM102	Entity Type Qualifier	1		"1" = Person
94		2100C	N3	Member Mailing Street Address			
94	1/55	2100C	N301	Member Mailing Address Line		IN	
94	1/55	2100C	N302	Member Mailing Address Line2			
95		2100C	N4	Member Mailing City, State, ZIP			
95	2/30	2100C	N401	Member Mailing City Name		IN	
95	2/2	2100C	N402	Member Mailing State Code		IN	
96	3/15	2100C	N403	Member Mailing ZIP Code		IN	***Note:*** If zip +4 is unknown send 9998.
97		2100D	NM1	Member Employer			This loop does not meet the situational requirements to be sent by Puerto Rico Medicaid.
106		2100E	NM1	Member School			This loop does not meet the situational requirements to be sent by Puerto Rico Medicaid.
114		2100F	NM1	Custodial Parent			This segment does not meet the situational requirements to be sent by Puerto Rico Medicaid.
123		2100G	NM1	Responsible Person			The person(s) who are Responsible for the member. ***Note:*** Loop can repeat up to 13 times.
123	2/3	2100G	NM101	Entity Identifier Code	QD		Responsible Party
124	1/1	2100G	NM102	Entity Type Qualifier	1		"1" = Person
124	1/60	2100G	NM103	Responsible Party Last or Organization Name			
124	1/35	2100G	NM104	Responsible Party First Name			

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
124	1/25	2100G	NM105	Responsible Party Middle Name			
125	1/2	2100G	NM108	Identification Code Qualifier	ZZ		ZZ = mutually defined
125	2/80	2100G	NM109	Responsible Party Identifier			PRMMIS 32Medicaid id/MPI
126		2100G	PER	Responsible Person Communications Numbers			Required when the Responsible Person contact information is provided to the sponsor.
127	2/2	2100G	PER01	Contact Function Code	RP		"RP" = Responsible Person
127	2/2	2100G	PER03	Communication Number Qualifier	TE		"TE" = Telephone
127	1/256	2100G	PER04	Communication Number			
127	2/2	2100G	PER05	Communication Number Qualifier	TE		"TE" = Telephone
128	1/256	2100G	PER06	Communication Number			
129		2100G	N3	Responsible Person Street Address			
129	1/55	2100G	N301	Responsible Person Address Line			
129	1/55	2100G	N302	Responsible Person Address Line2			
130		2100G	N4	Responsible Person City, State, ZIP			
130	2/30	2100G	N401	Responsible Person City Name			
131	2/2	2100G	N402	Responsible Person State Code			
131	3/15	2100G	N403	Responsible Person ZIP			***Note:*** If zip +4 is unknown send 9998.
132		2100H	NM1	Drop Off Location			The Drop Off Location loop does not meet the situational requirements to be used by Puerto Rico Medicaid.
137		2200	DSB	Disability Information			The Disability Information loop does not meet the situational requirements to be used by Puerto Rico Medicaid.
140		2300	HD	Health Coverage			When enrolling a new member or when adding, updating, removing coverage or auditing an existing member. ***Note:*** Loop can repeat up to 99 times.
140	3/3	2300	HD01	Maintenance Type Code	001 021 024 030	IN	**001**, **021**, and **024**, used with the 834 daily files. **030** is used with the monthly 834 full file.
				Change	001		
				Addition	021		
				Cancellation or Termination	024		Use this code for cancelling/terminating a coverage

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
				Audit or Compare	030		Outbound Only.
141	2/3	2300	HD03	Insurance Line Code	**HMO**		HMO – Health Maintenance Organization ***Note:*** The dates on this loop are associated with the assignment plan.
142	1/50	2300	HD04	Plan Coverage Description	**Appendix G**	IN	See Appendix G for layout of HD04. 834 Inbound
142	3/3	2300	HD05	Coverage Level Code	IND		"IND" = Individual
143		2300	DTP	Health Coverage Dates			***Note:*** Segment can repeat up to 6 times.
143	3/3	2300	DTP01	Date Time Qualifier	348 349 695	IN	
				Benefit Begin	348		This is the effective date of coverage. This code must always be sent when adding or reinstating coverage.
				Benefit End	349		The termination date represents the last date of coverage in which claims will be paid for the individual being terminated.
				Previous Period	695		This value is only to be used when reporting Previous Coverage Months.
144	2/3	2300	DTP02	Date Time Period Format Qualifier	D8 RD8	IN	
				Date Expressed in Format CCYYMMDD.	D8		
				Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	RD8		This value is only to be used when reporting Previous Coverage Months.
144	1/35	2300	DTP03	Coverage Period		IN	
145		2300	AMT	Health Coverage Policy			The Health Coverage Policy segment does not meet the situational requirements to be used by Puerto Rico Medicaid.
146		2300	REF	Health Coverage Policy Number			The Health Coverage Policy Number segment does not meet the situational requirements to be used by Puerto Rico Medicaid.
148		2300	REF	Prior Coverage Months			The Prior Coverage Month segment does not meet the situational requirements to be used by Puerto Rico Medicaid.
150		2300	IDC	Identification Card			The Identification Card segment does not meet the situational requirements to be used by Puerto Rico Medicaid.

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
152		2310	LX	Provider Information	If needed this loop repeats in this order: PMG1 PCP1 PCP2		Provide information about the primary care providers and/or managed care organizations selected by the member. ***Note:*** Loop can repeat up to 30 times.
152	1/6	2310	LX01	Assigned Number		IN	This is a sequential number representing the number of loops (providers) for this member.
153		2310	NM1	Provider Name			
153	2/3	2310	NM101	Entity Identifier Code	P3 Y2	IN	
				Primary Care Provider	P3		PCP1/PCP2
				Managed Care Organization	Y2		PMG1
154	1/1	2310	NM102	Entity Type Qualifier	1	IN	Person – All providers will be indicated as a "Person" (1)
154	1/60	2310	NM103	Provider Last or Organization Name			If provider is actually a person this field will contain their 1st last name and 2nd last name with pipe delimiter to separate. If provider is an organization this field will contain the company name.
154	1/35	2310	NM104	Provider First Name		IN	If Provider is an Organization this field will be empty.
154	1/25	2310	NM105	Provider Middle Name		IN	Provider's Medicaid ID as assigned by PRMMIS
154	1/10	2310	NM106	Provider Name Prefix	PCP1 PCP2 PMG1	IN	Used to indicate PCP1, PCP2 or PMG1
155	1/2	2310	NM108	Identification Code Qualifier	XX	IN	
				CMS National Provider Identifier (NPI)	XX		
155	2/80	2310	NM109	Provider Identifier		IN	If provider has an NPI it will go here.
155	2/2	2310	NM110	Entity Relationship Code	25 26 72	IN	
				Established Patient	25		
				Not Established Patient	26		
				Unknown	72		
156		2310	N3	Provider Address			
156	1/55	2310	N301	Provider Address Line		IN	
156	1/55	2310	N302	Provider Address Line			
157		2310	N4	Provider City, State, ZIP			

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
157	2/30	2310	N401	Provider City Name		IN	
157	2/2	2310	N402	Provider State Code		IN	
158	3/15	2310	N403	Provider Postal Zone or ZIP Code		IN	Note: If zip +4 is unknown send 9998.
158	2/3	2310	N404	Country Code			Required when the address is outside the United States of America. Use the alpha-2 country codes from Part 1 of ISO 3166.
159		2310	PER	Provider Communications Number			Segment can repeat twice
160	2/2	2310	PER01	Contact Function Code	IC		IC Information Contact
160	2/2	2310	PER03	Communication Number Qualifier	TE		24 hour Telephone Number
160	1/256	2310	PER04	Communication Number			
162		2310	PLA	Provider Change Reason			To report the reason and the effective date that a member changes providers as described by the NM1 segment in Loop 2310.
162	1/2	2310	PLA01	Action Code	2	IN	"2" Change (Update)
162	2/2	2310	PLA02	Entity Identifier Code	IP	IN	"1P" Provider
162	8/8	2310	PLA03	Effective Date	CCYYMMDD	IN	This is the effective date of the change of PCP. When the Carrier sends the beginning date of the PCP and it is outside of the current Eligibility date, the system will use the Eligibility date to update PRMMIS. If the Carrier sends a PCP begin date that is within the Eligibility date range, PRMMIS will utilize the Carriers date.
163	2/3	2310	PLA05	Maintenance Reason Code	14 22 46 AA AB AC AD AE AF AG AH AI AJ	IN	
				Voluntary Withdrawal	14		
				Plan Change	22		
				Current Customer Information File in Error	46		

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
				Dissatisfaction with Office Staff	AA		
				Dissatisfaction with Medical Care/Services Rendered	AB		
				Inconvenient Office Location	AC		
				Dissatisfaction with Office Hours	AD		
				Unable to Schedule Appointments in a Timely Manner	AE		
				Dissatisfaction with Physician's Referral Policy	AF		
				Less Respect and Attention Time Given than to Other Patients	AG		
				Patient Moved to a New Location	AH		
				No Reason Given	AI		
				Appointment Times not Met in a Timely Manner	AJ		
164		2320	COB	Coordination of Benefits			Required whenever an individual has another insurance plan with benefits similar to those covered by the insurance product specified in the HD segment for this occurrence of Loop ID-2300. Loop can repeat 5 times.
164	1/1	2320	COB01	Payer Responsibility Sequence Number Code	P S T U		
				Primary	P		
				Secondary	S		
				Tertiary	T		
				Unknown	U		
164	1/50	2320	COB02	Member Policy Number			Required when the policy number is available.
164	1/1	2320	COB03	Coordination of Benefits Code	1		"1" Coordination of Benefits

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
165	1/2	2320	COB04	Service Type Code	1 35 48 50 54 89 90 A4 AG AL BB		Required when detailed COB coverage information is agreed to be exchanged. Up to 9 values can be listed separated by value in ISA11 – Repetition Separator. The preferred repetition separator is a caret (^).
				Medical Care	1		
				Dental Care	35		
				Hospital – Inpatient	48		
				Hospital – Outpatient	50		
				Long Term Care	54		
				Free Standing Prescription Drug	89		
				Mail Order Prescription Drug	90		
				Psychiatric	A4		
				Skilled Nursing Care	AG		
				Vision (Optometry)	AL		
				Partial Hospitalization (Psychiatric)	BB		
166		2320	REF	Additional Coordination Of Benefits Identifiers			Required if additional COB identifiers are supplied by the subscriber. Can repeat 4 times.
166	2/3	2320	REF01	Reference Identification Qualifier	60 6P		
				Account Suffix Code	60		
				Group Number	6P		
167	1/50	2320	REF02	Member Group Number			
168		2320	DTP	Coordination Of Benefits Eligibility Dates			Required when the submitter needs to send effective dates for coordination of benefits. Can repeat 2 times.
168	3/3	2320	DTP01	Date/Time Qualifier	344 345		
				Coordination of Benefits Begin	344		

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
				Coordination of Benefits End	345		
168	2/3	2320	DTP02	Date Time Period Format Qualifier	D8		Date Expressed in Format CCYYMMDD
168	1/35	2320	DTP03	Coordination of Benefits Date			
169		2330	NM1	Coordination Of Benefits Related Entity			Required to send the name of the insurance company when provided to the sponsor. Can repeat 3 times.
169	2/3	2330	NM101	Entity Identifier Code	36 GW IN		
				Employer	36		
				Group	GW		
				Insurer	IN		
170	1/1	2330	NM102	Entity Type Qualifier	2		"2" = Non-Person Entity
170	1/60	2330	NM103	Coordination of Benefits Insurer Name			Required to send the insurance company name if no standard identifier is available to pass in NM109. Outbound 834 will include 3 digit insurer code, a space, and then the insurer name.
170	1/2	2330	NM108	Identification Code Qualifier	FI NI		
				Federal Taxpayer's Identification Number	FI		
				National Association of Insurance Commissioners (NAIC) Identification	NI		
170	2/80	2330	NM109	Coordination of Benefits Insurer Identification Code			Required when supplied by the employee to the sponsor.
171		2330	N3	Coordination Of Benefits Related Entity Address			Can repeat 2 times.
171	1/55	2330	N301	Address Information			
171	1/55	2330	N302	Address Information			
172		2330	N4	Coordination Of Benefits Other Insurance Company City, State, Zip Code			
172	2/30	2330	N401	Coordination of Benefits Other Insurance Company City Name			
173	2/2	2330	N402	Coordination of Benefits Other Insurance Company State Code			
173	3/15	2330	N403	Coordination of Benefits Other Insurance Company Postal Zone or ZIP Code			*Note:* If zip +4 is unknown send 9998.

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Reqd	Notes/Comments
173	2/3	2330	N404	Country Code			Required when the address is outside the United States of America. Use the alpha-2 country codes from Part 1 of ISO 3166.
174		2330	PER	Administrative Communications Contact			Required when detailed COB coverage information is agreed to be exchanged.
174	2/2	2330	PER01	Contact Function Code	CN		"CN" = General Contact
175	2/2	2330	PER03	Communication Number Qualifier	TE		"TE" = Telephone
175	1/256	2330	PER04	Communication Number			
176		2700	LS	Additional Reporting Categories			
176	1/4	2700	LS01	Loop Identifier Code	2700		Constant "2700" (start loop)
		2710	LX	Member Reporting Categories			
177	1/6	2710	LX01	Assigned Number	1		Start with 1 and increment by 1
		2750	N1	Reporting Category			
178	2/3	2750	N101	Entity Identifier Code	75		Constant "75" (Participant)
178	1/60	2750	N102	Member Reporting Category Name			Constant "ADDITIONAL MEMBER IDENTIFICATION DATA"
		2750	REF	Reporting Category Reference			
179	2/3	2750	REF01	Reference Identification Qualifier	ZZ		Constant "ZZ" (Mutually Defined)
179	1/50	2750	REF02	Member Reporting Category Reference ID			Multiple values delimited by pipe character. . See Appendix H
		2750	DTP	Reporting Category Date			
181	3/3	2750	DTP01	Date Time Qualifier	007		Constant "007" (Effective)
181	2/3	2750	DTP02	Date Time Period Format Qualifier	RD8		Constant "RD8" (Start thru end dates)
181	1/35	2750	DTP03	Member Reporting Category Effective Dates	CCYYMMDD-CCYYMMDD		CCYYMMDD-CCYYMMDD Contains Coverage Code Effective and End Dates
		2700	LE	Additional Reporting Categories Loop Termination			
183	1/4	2700	LE01	Loop Identifier Code	2700		Constant "2700" (end loop)

APPENDICES

Appendix A – Maintenance Reason Codes (INS04)

(Subject to change/addition by Gainwell, grayed out = not applicable.)

Code	Description	Notes/Comments
1	Divorce	
2	Birth	
3	Death	
4	Retirement	
5	Adoption	
6	Strike	
7	Termination of Benefits	
8	Termination of Employment	
9	Consolidation Omnibus Budget Reconciliation Act (COBRA)	
10	Consolidation Omnibus Budget Reconciliation Act (COBRA) Premium Paid	
11	Surviving Spouse	
14	Voluntary Withdrawal	Inbound Only
15	Primary Care Provider (PCP) Change	
16	Quit	
17	Fired	
18	Suspended	
20	Active	
21	Disability	
22	Plan Change	Outbound Only Use this code when a member changes from one Plan to a different Plan. This is not intended to identify changes to a Plan.
25	Change in Identifying Data Elements (demographic)	Outbound Only Use this code when a change has been made to the primary elements that identify a member. Such primary elements include the following: first name, last name, Social Security Number, date of birth, and employee identification number.
26	Declined Coverage	Use this code when a member declined a previously active coverage.
27	Pre-Enrollment	Use this code when a member has retro-enrollment periods.
28	Initial Enrollment	Use this code the first time the member selected coverage with the Plan Sponsor.
29	Benefit Selection	Outbound Only Use this code when a member changes benefits within a Plan.
31	Legal Separation	
32	Marriage	
33	Personnel Data	Outbound Only Use this code for any data change that is not included in any of the other allowed codes. An example would be change in Coordination of Benefits information.
37	Leave of Absence with Benefits	
38	Leave of Absence without Benefits	
39	Lay Off with Benefits	
40	Lay Off without Benefits	
41	Re-enrollment	
43	Change of Location	Outbound Only Use this code to indicate a change of address.
59	Non Payment	Outbound Only
AA	Dissatisfaction with Office Staff	
AB	Dissatisfaction with Medical Care/Services Rendered	

Code	Description	Notes/Comments
AC	Inconvenient Office Location	
AD	Dissatisfaction with Office Hours	
AE	Unable to Schedule Appointments in a Timely Manner	
AF	Dissatisfaction with Physician's Referral Policy	
AG	Less Respect and Attention Time Given than to Other Patients	
AH	Patient Moved to a New Location	
AI	No Reason Given	Outbound Only
AJ	Appointment Times not Met in a Timely Manner	
AL	Algorithm Assigned Benefit Selection	
EC	Member Benefit Selection	Use this code for initial and subsequent enrollment when an insurance carrier needs to recognize that a member made an explicit plan choice.
XN	Notification Only	Outbound Verify Only Use this code in complete enrollment transmissions. This is used when INS03 is equal to 030 (Audit/Compare).
XT	Transfer	Use this code when a member has an organizational change (i.e. a location change within the organization) with no change in benefits or plan. The 'XT' will indicate that the members information for the date period provided should be 'Voided'.





Appendix B – Member Level Date Qualifiers (DTP01)

(Subject to change/addition by Gainwell, grayed out = not applicable.)

Code	Description	Notes/Comments
50	Received	Used to identify the date an enrollment application is received.
286	Retirement	
296	Initial Disability Period Return To Work	
297	Initial Disability Period Last Day Worked	
300	Enrollment Signature Date	
301	Consolidated Omnibus Budget Reconciliation Act(COBRA) Qualifying Event	
303	Maintenance Effective	This code is used to send the effective date of a change to an existing member's information, excluding changes made in Loop 2300.
336	Employment Begin	
337	Employment End	
338	Medicare Begin	Effective Date for Medicare Coverage
339	Medicare End	The termination date represents the last date of coverage in which claims will be paid for the member being terminated.
340	Consolidated Omnibus Budget Reconciliation Act(COBRA) Begin	
341	Consolidated Omnibus Budget Reconciliation Act(COBRA) End	
344	TPL Begin	TPL Begin Date
345	TPL End	TPL End Date
348	Benefit Begin	Effective Date for Enrollment Coverage
349	Benefit End	The termination date represents the last date of coverage in which claims will be paid for the member being terminated.
350	Education Begin	This is the start date for the student at the current educational institution.
351	Education End	This is the expected graduation date the student at the current educational institution.
356	Eligibility Begin	The date when a member could elect to enroll or begin benefits in any health care plan through the employer. This is not the actual begin date of coverage, which is conveyed in the DTP segment at position 2700.
357	Eligibility End	The eligibility end date represents the last date of coverage for which claims will be paid for the individual being terminated.
383	Adjusted Hire	
385	Credited Service Begin	The start date from which an employee's length of service, as defined in the plan document, will be calculated.
386	Credited Service End	The end date to be used in the calculation of an employee's length of service, as defined in the plan document.
393	Plan Participation Suspension	
394	Rehire	
473	Medicaid Begin	Effective Date for Medicaid Eligibility.
474	Medicaid End	The termination date represents the last date of coverage in which claims will be paid for the member being terminated.
695	Previous Period	This value is only used when reporting previous coverage months.

Appendix C – Race Code (DMG05-1)

Code	Description	Notes/Comments
7	Not Provided	
8	Not Applicable	
A	Asian or Pacific Islander	
B	Black	
C	Caucasian	
D	Subcontinent Asian American	
E	Other Race or Ethnicity	
F	Asian Pacific American	
G	Native American	
H	Hispanic	
I	American Indian or Alaskan Native	
J	Native Hawaiian	
N	Black (Non-Hispanic)	
O	White (Non-Hispanic)	
P	Pacific Islander	
Z	Mutually Defined	

Appendix F – County Codes in Puerto Rico (N406)

CODE	COUNTY
004	Adjuntas
008	Aguada
012	Aguadilla
016	Aguas Buenas
020	Aibonito
024	Anasco
028	Arecibo
032	Arroyo
036	Barceloneta
040	Barranquitas
044	Bayamon
048	Cabo Rojo
052	Caguas
056	Camuy
060	Canovanas
064	Carolina
068	Catano
072	Cayey
076	Ceiba
080	Ciales
084	Cidra
088	Coamo
092	Comerio
096	Corozal
100	Culebra
104	Dorado
108	Fajardo

CODE	COUNTY
112	Florida
116	Guanica
120	Guayama
124	Guayanilla
128	Guaynabo
132	Gurabo
136	Hatillo
140	Hormigueros
144	Humacao
148	Isabela
152	Jayuya
156	Juana Diaz
160	Juncos
164	Lajas
168	Lares
172	Las Marias
176	Las Piedras
180	Loiza
184	Luquillo
188	Manati
192	Maricao
196	Maunabo
200	Mayaguez
204	Moca
208	Morovis
212	Naguabo
216	Naranjito

CODE	COUNTY
220	Orocovis
224	Patillas
228	Penuelas
232	Ponce
236	Quebradillas
240	Rincon
244	Rio Grande
248	SabanaGrande
252	Salinas
256	San German
266	San Juan
276	San Lorenzo
280	SanSebastian
284	Santa Isabel
288	Toa Alta
292	Toa Baja
296	TrujilloAlto
300	Utuado
304	Vega Alta
308	Vega Baja
312	Vieques
316	Villalba
320	Yabucoa
324	Yauco
000	OTHER STATE





Appendix G – Plan Coverage Description (HD04)

Fields will be separated by pipe character " | ". The Record Type will be provided, a "|" and then the value for the field.

Record Type	Health Coverage Information	Value	Loop Type	Carrier	Req on Inbound
01	CARRIER ENROLLMENT DATES	Z	Enrollment	All	YES
02	ENROLLMENT CONFIRMATION	Y or N	Enrollment	All	YES
03	PLAN TYPE (01 or 02) - GHIP (45 Medicaid) and MASNP (45 Medicaid and Medicare)	01 or 02	Enrollment	All	
04	AUTO ASSIGNMENT INDICATOR Y/N (to a specific carrier)	Y or N	Enrollment	Vital and ASES	
05	PLAN VERSION	3 char	Enrollment	Platino and ASES	YES for Platino
06	MANAGED CARE REGION	1 char	Region	All	
30	COVERAGE CODE (AIJ/F will be a separate eligibility segment described in Record Types 37 and 38)	3 char	Coverage	All	
31	GROUP CODE	3 char	Coverage	All	
32	GROUP VIII INDICATOR	Y or N	Coverage	ASES only	
33	EMERGENCY INDICATOR (00 = no, 01 = COVID19, 02 = COVID192) (future use TBD)	00,01,02	Coverage	Vital and ASES	
34	INCARCERATION INDICATOR (I = Incarcerated, A = AIJ, F = Forensic Psychiatric, space = not incarcerated)	I, A, F, SPACE	Coverage	Vital and ASES	
35	FOSTER CARE INDICATOR	Y or N	Coverage	Vital and ASES	
36	DOMESTIC ABUSE INDICATOR	Y or N	Coverage	All	
37	HYBRID COVERAGE CODE (Incarceration AIJ and Forensic Psychiatric)	3 char	Coverage	Vital and ASES	
38	HYBRID GROUP CODE (Incarceration AIJ and Forensic Psychiatric)	3 char	Coverage	Vital and ASES	
50	RATE CELL – 8/31 will be derived based on ASES rules until post P3	3 char	Rate Cell	All	
60	RAW RISK SCORE (123.5678)	8 char	Risk	Vital and ASES	
61	MEMBER RISK SCORE (as provided by actuary and stored in PRMMIS) (123.5678)	8 char	Risk	Vital and ASES	

Below are some samples of how the 2300 Loop HD segment will look for changes. The begin date of the change transaction will be used to determine the end date for the previous record. Basically, if the change transaction begin date is 01/01/2024, the end date for the previous record will be 12/31/2023, or begin date minus one day.

The change transactions will also be grouped for the 834 Outbound transactions. This means that if any value within the same 'Loop Type' changes, a loop will be created for each of those within that 'Loop Type'. Example if the Record Type – 01 (Carrier Enrollment Dates) changes, the Enrollment Confirmation, Plan Type, Auto Assignment and Plan Version loops will be produced. This is necessary because the begin date and end date for these fields are the same within the PRMMIS table.

Example of the record types within the Enrollment Loop Type:

Z = CARRIER ENROLLMENT DATES

```
HD*001**HMO*01|Z*IND~
DTP*348*D8*20230901~
DTP*349*D8*20240831~
```

x = Enrollment Confirmation

```
HD*001**HMO*02|x*IND~
DTP*348*D8*20230901~
DTP*349*D8*20240831~
```

xx = Plan Type

```
HD*001**HMO*03|xx*IND~
DTP*348*D8*20230901~
DTP*349*D8*20240831~
```

x = Auto Assignment

```
HD*001**HMO*04|x*IND~
DTP*348*D8*20230901~
DTP*349*D8*20240831~
```

xxx = Plan Version

```
HD*001**HMO*05|xxx*IND~
DTP*348*D8*20230901~
DTP*349*D8*20240831~
```

The Carrier Enrollment Dates field, Record Type 01, is always required.

The monthly 834 Audit file, Maintenance Code 030, and Add Transactions, Maintenance Code 021, will contain a loop for every value within Appendix G.

HD04 Loop:

For multiple updates to the same Record Type within HD04 Loop, there will be a new loop started. Record Type 01 will begin each new loop. There can be up to 99 occurrences.

Example of a Daily 834 2300 Loop Change Transaction (2 occurrences), current date within October 2025. First occurrence the region, coverage and Rate Cell changed. Second occurrence the coverage changed:

```
HD*001**HMO*01|Z*IND~
DTP*348*D8*20241101~
DTP*349*D8*20251231~
HD*001**HMO*06|B*IND~
DTP*348*D8*20251001~
DTP*349*D8*20251231~
HD*001**HMO*30|110*IND~
DTP*348*D8*20251001~
DTP*349*D8*20251031~
HD*001**HMO*50|V12*IND~
DTP*348*D8*20251001~
DTP*349*D8*20251231~
HD*001**HMO*01|Z*IND~
DTP*348*D8*20241101~
DTP*349*D8*20251231~
HD*001**HMO*30|100*IND~
DTP*348*D8*20251101~
DTP*349*D8*20251231~
```

As you can see, only the record types that had an additional change would be included within the loop, besides the required record Type 01.

Appendix H – Member Reporting Category Reference ID (2750 REF02)

Fields will be separated by pipe character " | ".

Order	ADDITIONAL MEMBER IDENTIFICATION DATA	value	size	+ pipe
1	GENDER IDENTITY (M or F or U)	M, F, U	1	2
2	TRADING PARTNER id of previous carrier	9 char	9	10
3	TRADING PARTNER id of future carrier	9 char	9	10
4	ACTIVE STATE POLICE	Y or N	1	2
5	POLICE SPOUSE	Y or N	1	2
6	POLICE CHILD < 26 YRS OLD	Y or N	1	2
7	REHABILITATION CENTER	Y or N	1	2
8	MENTAL HEALTH FACILITY	Y or N	1	2
9	ADOPTION ASSISTANCE	Y or N	1	2
10	HOMELESS	Y or N	1	2
11	UNIVERSITY EMPLOYEE	Y or N	1	2
12	PUBLIC CORPORATION EMPLOYEE	Y or N	1	2
13	PUBLIC EMPLOYEE OR PENSIONER	Y or N	1	2
14	EMPLOYMENT MUNICIPALITY	3 char	3	3

45

Note: Employment Municipality contains the municipality which is the same as county. See Appendix F for values.

Appendix I – Managed Care Region

Region	Puerto Rico Region Name
A	North
B	Metro-North
E	East
F	North-East
G	South-East
Z	West
J	San Juan
S	South-West
P	Virtual Region

Appendix J – Trading Partner IDs and 834 Inbound File Names

Carrier Name	File Abbreviation	Trading Partner
ADMINISTRACION DE SEGUROS DE SALUD DE PUERTO RICO	ASES	680100
TrueNorth	TrueNorth	680200
FIRST MEDICAL HEALTH PLAN, INC.	FM	690150
HUMANA PLATINO	HUMA	690700
MCS ADVANTAGE	MCS	690800
MEDICARE Y MUCHO MAS	MMMP	690320
MMM MULTI HEALTH, LLC	MMMV	690350
PLAN DE SALUD MENONITA	PSM	690900
PREFERRED MEDICARE CHOICE	PMC	690330
TRIPLE-S ADVANTAGE	TPA	690410
TRIPLE-S SALUD, INC.	TPS	690450

20230630_FM_690150_834DI_01.X12
20230630_MMMV_690350_834DI_01.X12
20230630_PSM_690900_834DI_01.X12
20230630_TPS_690450_834DI_01.X12
20230630_MMMP_690320_834DI_01.X12
20230630_PMC_690330_834DI_01.X12
20230630_MCS_690800_834DI_01.X12
20230630_HUMA_690700_834DI_01.X12
20230630_TPA_690410_834DI_01.X12

20230630_ASES_690150_834DI_01.X12
20230630_ASES_690350_834DI_01.X12
20230630_ASES_690900_834DI_01.X12
20230630_ASES_690450_834DI_01.X12
20230630_ASES_690320_834DI_01.X12
20230630_ASES_690330_834DI_01.X12
20230630_ASES_690800_834DI_01.X12
20230630_ASES_690700_834DI_01.X12
20230630_ASES_690410_834DI_01.X12

20230630_TNORTH_690150_834DI_01.X12
20230630_TNORTH_690350_834DI_01.X12
20230630_TNORTH_690900_834DI_01.X12
20230630_TNORTH_690450_834DI_01.X12
20230630_TNORTH_690320_834DI_01.X12
20230630_TNORTH_690330_834DI_01.X12
20230630_TNORTH_690800_834DI_01.X12
20230630_TNORTH_690700_834DI_01.X12
20230630_TNORTH_690410_834DI_01.X12

Appendix K – 834 Business Rules

All extension elements should be part of the same transaction.

HD04 Record Type 01 (Appendix G – Plan Coverage Description): The Region sent on the 834 Inbound Files will not be used to update PRMMIS. The Region is part of the demographic information that is provided by the Eligibility Vendor. The Region can only be updated by the Eligibility Vendor. If a Region provided on the 834 Inbound File does not match what is on the PRMMIS system, an information message will be provided. This informational message will communicate to the Carrier that the Region within their system does not match PRMMIS.

Enrollment Confirmation flag is used for Capitation Payments. The Carrier validates the members eligibility and sends a 'Y' on the Inbound 834. Once received, PRMMIS stores the value. All members with a 'Y' in the Enrollment Confirmation Flag will be picked up within the Capitation Payment Process.





Appendix L – 834 Monthly Audit File Carrier Procedures

Processing of the 834 Monthly Audit File
The 834 Monthly Audit File contains all active members at the specific point in time of the job execution. The data shows exactly the structure of the member, including the begin and end dates.

All Carriers should reconcile their data with the 834 Monthly Audit File. To do this, we advise the Carriers to read the file, member by member. There are several possibilities of updates based on what is contained within the Carriers system compared to the 834 Audit file.

1) If the member is found within the Carriers system
    a. The Carriers data should be compared to the 834 Audit file.
    b. If differences are found, the Carriers data should be updated with the information provided on the 834 Audit file.
2) If the member is not found within the Carriers system
    a. The member should be added utilizing the data provided on the 834 Audit file.

Note (2/01/2024): *At this time, it is recommended for Carriers to review members NOT on the 834 Audit file, but 'active' within the Carriers system. These member examples should be sent to the EDI Helpdesk for analysis. Do Not automatically term these members.*

At this time, if Carrier system limitations exist and if you are not able to Add or Change members systematically, CTN requests can be made by utilizing the EDI Helpdesk.

These extra steps will only be necessary until data stabilization is achieved.

Example of 834 Audit Data:

```
INS*Y*18*030*XN*A*E**AC~
REF*0F*80000000000~
DTP*473*D8*20201101~
DTP*474*D8*20241231~
NM1*IL*1*FRED                    |HEEENNEEE*JJHHJJHH****34*595959595~
PER*IP**TE*7872418615~
N3*AAAAAA CCCCC*CARR 000 R 000O0 O0~
N4*XXX XXXXXXXX*PR*000009998**CY*176~
DMG*D8*19850912*M*I*C :RET:00^8^A^B^D^E^F~
LUI*LE*SPA**6~
LUI*LE*SPA**7~
NM1*31*1~
N3*PO BOX 000~
N4*XXX XXXXXXXX*PR*000000000~
NM1*QD*1*FRED                    | HEEENNEEE*JJHHJJHH ****ZZ*80000000000~
PER*RP**TE*7879999999~
N3*PO BOX 000~
N4* XXX XXXXXXXX*PR*000000000~
HD*030**HMO*01|Z*IND~        HD04 Segments begin here, each have begin and end dates
DTP*348*D8*20181101~
DTP*349*D8*20231231~
HD*030**HMO*02|Y*IND~
DTP*348*D8*20181101~
DTP*349*D8*20231231~
HD*030**HMO*03|01*IND~
DTP*348*D8*20181101~
DTP*349*D8*20231231~
HD*030**HMO*04|N*IND~
```

DTP*348*D8*20181101~
DTP*349*D8*20231231~
HD*030**HMO*06|A*IND~
DTP*348*D8*20230101~
DTP*349*D8*20231231~
HD*030**HMO*30|100*IND~
DTP*348*D8*20231101~
DTP*349*D8*20231231~
HD*030**HMO*31|MTM*IND~
DTP*348*D8*20231101~
DTP*349*D8*20231231~
HD*030**HMO*32|Y*IND~
DTP*348*D8*20231101~
DTP*349*D8*20231231~
HD*030**HMO*33|00*IND~
DTP*348*D8*20231101~
DTP*349*D8*20231231~
HD*030**HMO*34|*IND~
DTP*348*D8*20231101~
DTP*349*D8*20231231~
HD*030**HMO*35|N*IND~
DTP*348*D8*20231101~
DTP*349*D8*20231231~
HD*030**HMO*36|N*IND~
DTP*348*D8*20231101~
DTP*349*D8*20231231~
HD*030**HMO*50|V02*IND~
DTP*348*D8*20230101~
DTP*349*D8*20231231~
HD*030**HMO*60|1.8687*IND~
DTP*348*D8*20230501~
DTP*349*D8*20231231~
HD*030**HMO*61|1.9300*IND~
DTP*348*D8*20230501~
DTP*349*D8*20231231~ HD04 Segments End Here
LX*1~
NM1*Y2*1*XXXXXX, INC.**000000000*PMG1**XX*1111111111*25~
N3*XXXXXX XXXXXXXXXX XXXXXXXXXX 0*XXXX 0000 KM. 0.3~
N4*XXXXXXXXXX*PR*00000998~
PLA*2*1P*20230801**AI~
LX*2~
NM1*P3*1*XXXXXXXX|XXXXXXXX*XXXXX*000000000*PCP1**XX*1111111111*25~
N3*XXXXXXXXXXXXXXXXX 111 Km. 11.1 XXXXXXXXXXX~
N4*XXXXXX*PR*000000000~
PLA*2*1P*20230801**AI~
LS*2700~
LX*1~
N1*75*ADDITIONAL MEMBER IDENTIFICATION DATA~
REF*ZZ*M| | |N|N|N|N|N|N|N|N|N|~
DTP*007*RD8*20231101-20231231~
LE*2700~

Appendix M – Ethnicity Codes

Code	Description	Notes/Comments
00	Not of Hispanic or, Latino/a, or Spanish origin	
01	Mexican, Mexican American, Chicano/a	
02	Puerto Rican	
03	Cuban	
04	Another Hispanic, Latino, or Spanish origin	
05	Hispanic or Latino Unknown	
06	Ethnicity Unspecified	

Appendix N – DMG Loop Examples

Race Code:

- Example [^ is the repetition separator]
  - DMG*D8*19780101*F**7^8^A^B^C^D^E~
    - ^ This example shows the 7 race codes reported (and no ethnicity codes) using 7 **iterations** of the *DMG05 element*.

Ethnicity Code:

- Examples [: is the component element separator, ^ is the repetition separator]
  - DMG*D8*19780101*F**7:RET:00^8^A^B^C^D^E~
    - ^ This example shows the 1 ethnicity code, and 7 race codes reported using **7 iterations** of the *DMG05 element*.
  - DMG*D8*19780101*F**:RET:06~
    - ^ This example shows only the 1 ethnicity code (and no race codes) reported using just **1 iteration** of the *DMG05 element*.

Change Summary

Version 3.00 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 01/23/2026

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised	Reason/ Identified By
N/A	9		Overview		Within the '834 Changes File', the details of the contents of this file were updated.	
N/A	12		File Naming Convention for Managed Care 834 Outbound		Within the 'Types of 834 Outbound Files for Carriers' #4 was updated to contain all Retro transactions.	
2100A	29	DMG05 - 3	Ethnicity Information		Corrected the MIN/MAX values.	This was incorrectly documented. The change has been verified against the TR#.
2310	34	LX01	Assigned Number		Added the Reqd value for this field – 'IN', for Inbound Transactions.	
2310	34	NM104	Provider First Name		Added the 'IN' within the required column. This needs to be populated if the Carrier is providing PCP data.	
2300	33	HD04	Plan Coverage Description		Removed: *Managed Care Region is required for INBOUND.*	
N/A	46	Appendix G – Plan Coverage Description (HD04)			Added information regarding the use of the 2300 Loop in relation to the HD04 segment.	

Version 2.06 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 09/26/2025

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised	Reason/ Identified By
N/A	12		File Naming Convention for Managed Care 834 Outbound		Added text describing the new file for resending Retro ADD transactions.	Automated a process to resend Retro Add transactions when needed. Gainwell

Version 2.05 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 07/01/2025

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised	Reason/ Identified By
N/A	12		File Naming Convention for Managed Care 834 Outbound		Added new file type for 834 Multiple Change Transactions from the Eligibility Vendor runs daily based on data provided from the Eligibility Vendor	Gainwell updated per Defect 73067

Version 2.04 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 04/14/2025

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised	Reason/ Identified By
N/A	44		Appendix G – Plan Coverage Description (HD04)		Corrected Record Type 06 – Region: removed the 'Required – Y' flag. Corrected the description under the HD04 table.	Gainwell updated per CR 25-1131
N/A	45		Appendix G – Plan Coverage Description (HD04)	Record Type 01	CARRIER ENROLLMENT DATES Also, update the value of this record type to be 1 character. It will be defaulted to 'Z'. This value will not be used.	Update Record Type 01 name to be clearer. Removed 'span'. The size of the field was reduced back to one byte to allow for fewer impacts to existing logic. The value will not be used. It is a default due to a Record Type 01 always needing to be present.
2100A	29	DMG	Ethnicity Information	See Appendix M	See Appendix M for list of possible codes. Only one value is allowed.	Gainwell updated per CR 24-1081
N/A	54		Appendix M – Ethnicity Codes		List of valid Ethnicity Codes	Gainwell updated per CR 24-1081
N/A	52		Appendix L – 834 Monthly Audit File Carrier Procedures		DMG and HD04 Record 01 and Record 06	Updated the 834 Audit example to include the changes to the DMG loop and the HD04 Record Types 01 & 06
N/A	55		Appendix N – DMG Loop Examples		Added examples on how to code the DMG loop	Gainwell updated per CR 24-1081

Version 2.03 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 03/26/2025

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised	Reason/ Identified By
N/A	50		Appendix K – 834 Business Rules		A Business Rule describing the Enrollment Confirmation Flag was added.	Gainwell updated per Intervoice direction.
N/A	40		Appendix A – Maintenance Reason Codes		Remove 'Inbound Only' from Maintenance Reason Code '28'	Gainwell updated per CR 24-1010; Platino Carriers may receive an Add transaction
N/A	44		Appendix G – Plan Coverage Description (HD04)		Renamed the record type 01 and added a new record type, 06, to contain the Region Dates	Gainwell updated per CR 25-1131
N/A	48		Appendix J – Trading Partner IDs and 834 Inbound File Names		Added the Trading Partner, TrueNorth for direct transmissions to PRMMIS. (Enrollment Counselor)	Gainwell updated per CR 25-1132

Version 2.02 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 05-17-2024

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised	Reason/ Identified By
2000	12	File/System Specifications	File Naming Convention for Managed Care 834 Outbound		Added text describing the new file for resending Termination transactions.	Automated a process to resend terminations when needed. Gainwell

Version 2.01 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 02-28-2024

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised	Reason/ Identified By
2000	26	INS04	Maintenance Reason Code		When INS04=03, the date of death is indicated within the INS12 field and as the Medicaid end date in the 2000 loop	Text revised to clarify that the date of death is contained within the INS12 field and as the Medicaid end date. Carrier asked for clarification
N/A	40		Appendix A	XT	The 'XT' will indicate that the members information for the date period provided should be 'Voided'.	Including 'XT' for Termination transactions when the members information needs to be 'Voided'. Gainwell introduced this as part of the Data Clean-up effort.

Version 2.00 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 02-01-2024

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised	Reason/ Identified By
N/A	12		1 Introduction File/System Specifications		Corrected the Carrier Acknowledgements File Names (acknowledgements sent to PRMMIS in response to the 834 Daily Outbound File and the 834 Monthly Audit File that are sent from PRMMIS)	Gainwell updated the Carrier Acknowledgements File Names to specify the daily and monthly acknowledgement files.
2000	26	DTP	Member Level Dates		Added clarification: DTP01 values 473 (Medicaid Begin Date) and 474 (Medicaid End) date will be present on all 834 Maintenance Type Codes (001, 021, 024 and 030).	Gainwell updated based on Carrier feedback.
N/A	49		Appendix K – 834 Business Rules		Appendix K was created to provide the 834 Business Rules.	Gainwell added for clarification of Business Processes
N/A	49		Appendix K – 834 Business Rules		A Business Rule regarding the Region was added.	Gainwell updated per PRMP direction.
2000	26	INS12	Date Time Period		Member / Individual Death Date CCYYMMDD format	Clarification/update based on Carrier feedback.
2310	35	PLA03	Effective Date		This is the effective date of the change of PCP. When the Carrier sends the beginning date of the PCP and it is outside of the current Eligibility date, the system will use the Eligibility date to update PRMMIS. If the Carrier sends a PCP begin date that is within the Eligibility date range, PRMMIS will utilize the Carriers date.	Added clarification on when the date provide by the Carrier will be used.

Version 1.12 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 10-30-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised	Reason/ Identified By
N/A	44		Appendix G		Record Type 02 – Enrollment Confirmation Carrier Column - All	Gainwell updated the Carrier Column for the Enrollment Confirmation field to be 'All'. This had been discussed for months that all Carriers were to send the Enrollment Confirmation Flag. The documentation within this column was updated to reflect those conversations. - Carrier Identified

Version 1.11 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 10-04-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised	Reason/ Identified By
	18	GS05	Time		Added the SS to the format. The time format is HHMMSS.	Added the SS for the seconds to the time format. Logic has been sending HHMMSS. This is a CG documentation update. Carrier Identified.
	24	BGN05	Time Zone Code	TT	Changed Code to "TT" = Atlantic Time	The CG stated 'TS' – Atlantic Standard Time. The process is sending 'TT' – Atlantic Time. This is a CG documentation update. Carrier Identified.
2100A	29	LUI03	Language Description		*SPANISH for example was the text.* The previous statement was changed to indicate that this field is not always necessary. New text below - Situational Rule: Required if the sender is unable to code the necessary language identification in LUI01 and LUI02.	*SPANISH for example was the text.* It was changed to indicate that this field is not always necessary. This is a CG documentation update. Carrier Identified.
N/A	44		Appendix G		Added Record Types 37 – HYBRID COVERAGE CODE and 38 – HYBRID GROUP CODE for the Incarceration AIJ and Forensic Psychiatric	Changes required due to the Incarceration identification of the members. Gainwell Identified
2100A	27	N401	Member City Name		Added the "IN" within the REQ column. This is a required field.	The "IN" was missed within the REQ column for Inbound transactions. The TR3 is clear that it is required. Carrier Identified
2100A	27	N402	Member State Code		Added the "IN" within the REQ column. This is a required field.	The "IN" was missed within the REQ column for Inbound transactions. The TR3 is clear that it is required. Carrier Identified
2100A	27	N403	Member Zip Code		Added the "IN" within the REQ column. This is a required field.	The "IN" was missed within the REQ column for

						Inbound transactions. The TR3 is clear that it is required. Carrier Identified
2310	33	NM106	Provider Name Prefix	PCP1 PCP2 PMG1	Added 'PMG1' to list of valid values for this field.	'PMG1' was being populated in this field. It was not identified as a valid value in the Companion Guide. Carrier Identified
2310	34	N402	Provider State Code		Added the "IN" within the REQ column. This is a required field.	The "IN" was missed within the REQ column for Inbound transactions. The TR3 is clear that it is required. Gainwell Identified
2310	34	N403	Provider Postal Zone or ZIP Code		Added the "IN" within the REQ column. This is a required field.	The "IN" was missed within the REQ column for Inbound transactions. The TR3 is clear that it is required. Gainwell Identified

Version 1.10 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 09-27-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised	Reason/ Identified By
2100A	27	N3	Member Residence Street Address		Removed comment from notes column	The notes column contained a note stating that this is required when enrolling a new member. The REQ column did not have an "IN" value stating that this segment is required. This segment is not required, so comment was removed. Carrier Identified.
2100A	27	N4	Member City, State, ZIP Code		Removed comment from notes column	The notes column contained a note stating that this is required when enrolling a new member. The REQ column did not have an "IN" value within all the fields within this segment. The complete segment is not required, only the fields identified with the "IN" in the REQ column. Comment removed from notes section. Carrier Identified.
2100A	28	DMG	Member Demographics		Removed comment from notes column	The notes column contained a note stating that this is required when enrolling a new member. The REQ column did not have an "IN" value stating that this segment is required. This segment is not required, so comment was removed. Carrier Identified.

2310	33	NM105	Provider Middle Name		Added "IN" to the REQ column.	This field is required and should contain the Provider's Medicaid ID as assigned by PRMMIS. Indicator, "IN" was missing from the REQ column. Carrier Identified
2750	38	REF02	Member Reporting Category Reference ID		Removed note regarding Plan Version.	Plan Version was removed from Appendix H. The note within the field was not removed. Carrier Identified.
2100A	29	AMT01	Member Policy Amounts		Removed inadvertently from Companion Guide. Has always been within the code. Added back.	The logic has always been within the 834 code. Only the CG was updated inadvertently. No logic changes were made. Gainwell identified.

Version 1.9 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 09-21-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised	Reason/ Identified By
2750	38	REF02	Member Reporting Category Reference ID		Removed "IN" from REQ column.	Gainwell moved the Enrollment Confirmation Indicator from this loop. Required for Inbound identification needed to be removed. – Carrier Identified
2100A	29	AMT01	Member Policy Amounts		Segment not used by PRMMMIS – grayed out this segment	Carrier Identified
2300	32	DTP01	Date Time Qualifier		Removed value '303' – not used.	This qualifier is not used based on the newest updates to the 2300 Loop – Carrier Identified
N/A	46		Appendix H		Renumbered elements within the table.	Gainwell Identified
N/A	44		Appendix G	I	Replace the 'I' – incarcerated	Gainwell replaced the Incarcerated value. The Enrollment Counselor will provide this to Gainwell, which will be able to be passed back to the Carriers. – PRMP Identified
N/A	44		Appendix G		Added column to indicate which Health Coverage Items are required on Inbound 834 files from the Carriers	Gainwell Identified

Version 1.8 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 09-19-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised	Reason/ Identified By
N/A	40	INS04	Appendix A	27	Updated notes to: Use this code when a member has retro-enrollment periods. Removed 'gray' highlight since the code will be used.	Gainwell added clarification to this value.
N/A	42	DTP01	Appendix B	303	Added Maintenance Effective	Gainwell added to specify dates for Risk Score and Rate changes.
N/A	42	DTP01	Appendix B	344, 345	Added Codes for TPL Begin and End dates	Gainwell added to specify TPL Begin and End Dates.
N/A	42	DTP01	Appendix B	695	Added Previous Coverage Months	Gainwell added to specify Previous Coverage Months
N/A	45		Appendix G	I	Removed the 'I' - incarcerated	Gainwell removed the Incarcerated value, not being used at this time.
N/A	45		Appendix G		Replaced the Gender Identity with Enrollment Confirmation	The Enrollment Confirmation is considered part of the health coverage information – Carrier Identified
N/A	45		Appendix G		Added Plan Version	With the revamp of the 2300 loop, the addition of the Plan Version was included here and removed from the 2750 loop. – Gainwell Identified
N/A	45		Appendix G		Removed string of data for this field usage. Each type of change will be identified individually. A Record Type has been assigned to each type of change allowed. The data string for the Health Coverage Loop 2300 will utilize the Record Type separated by the "|" and then the field value.	Additional information needed to be contained within the 2300 Health Coverage Loop. Appendix G is used to detail those items that will be part of this loop. – Carrier Identified.
N/A	46		Appendix H		Replaced Enrollment Confirmation with Gender Identity	Switched with Enrollment Confirmation as

						part of the Health Coverage Loop changes – Carrier Identified
N/A	46		Appendix H		Removed Plan Version.	Placed the Plan Version within the 2300 loop. – Gainwell Identified.
2100A	27	N405	Location Qualifier	CY	Added the 'IN' to the Req column.	The location identifier(N406) was indicated as being required for Inbound. The designation for the Location Qualifier (N405) to be required for Inbound was missing. – Carrier Identified
2100C	31	N402	Member Mailing State Code		Added the 'IN' to the Req column.	The 2100C NM1 segment is required for the Inbound files. The N402 fields was not marked with 'IN' in the REQ column. – Carrier Identified
2100C	31	N403	Member Mailing Zip Code		Added the 'IN' to the Req column.	The 2100C NM1 segment is required for the Inbound files. The N403 fields was not marked with 'IN' in the REQ column. – Carrier Identified
2300	32	DTP01	Date Time Qualifier	303	Added the data qualifier 303 – Maintenance Effective	The date qualifier 303 was added to identify dates for the Risk Score and Rate changes. – Carrier Identified
2300	32	DTP01	Date Time Qualifier	695	Added the data qualifier 695 – Previous Period	The date qualifier 695 was added to identify dates for the previous periods. – Gainwell Identified
2750	38	REF02	Member Reporting Category Reference ID		Removed the statement indicating that the Enrollment Confirmation is required.	Updates due to the 2300 loop enhancement – Gainwell Identified

	11		File Naming Convention for Managed Care 834 Inbound		Added a seq number to the Inbound file to allow for multiple Inbound files per day.	Carrier Identified

Version 1.7 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 08-18-2023

Loop ID	Page(s) Revised	Reference	Name	Code(s)	Text Revised	Reason / Identified by
N/A	12, 21	N/A	834 – Monthly Audit	N/A	Schedule change for the 834 monthly audit files from the first working day of the month to the third business day of the month	A Carrier was concerned about the initial audit file being executed on a Friday. Also, changed to ensure the M3G extensions were processed prior to the 834 Audit.
N/A	16	ISA05, ISA07	Interchange ID (Receiver and Sender) Qualifier	ZZ	ZZ=Mutually Defined	Gainwell changed this to clarify what the value 'ZZ' represented.
N/A	17	ISA15	Usage Identifier	T, P	T=Test Data P= Production Data	Gainwell changed this to clarify what the values 'T' and 'P' represented.
N/A	19	ST03	Implementation Guide Version Name		Field is Required added 'IN'	Gainwell added the 'IN' (inbound required) value to clarify that this field is needed to pass X12 compliance checks.
N/A	24	REF01	Reference Identification Qualifier		Field is Required added 'IN'	Gainwell added the 'IN' (inbound required) value to clarify that the qualifier field is required.
N/A	24	REF02	Master Policy Number		Field is Required added 'IN'	Gainwell added the 'IN' (inbound required) value to clarify that the Master Policy Number field is required.
N/A	24	DTP01	Date Time Qualifier	090 091 303 382 388	Removed Values from the Companion Guide; Not used Code used for Outbound only	Based on conversations with a Carrier regarding valid values not used within PRMMIS, values not used in multiple fields were removed.
2000	25	INS03	Maintenance Type Code 'Reinstatement'	025	Removed Value from the Companion Guide; Not used	Based on conversations with a Carrier regarding valid values not used within PRMMIS, values not

						used in multiple fields were removed.
2000	26	REF02	Subscriber Identifier		Added clarification that the Subscriber ID should be 11 digits as assigned by M3G.	Gainwell discovered during the testing of the Carrier's Inbound files that the Subscriber ID was containing leading zeroes. Added this clarification for consistency.
2300	32	HD01	Maintenance Type Code : Delete (002) Reinstatement (025) Corrections (026) Employee Information (032)	002 025 026 032	Removed Values from the Companion Guide; Not used	Based on conversations with a Carrier regarding valid values not used within PRMMIS, values not used in multiple fields were removed.
2300	32	DTP01	Date Time Qualifier: Enrollment Signature Date (300) Maintenance Effective Date (303) Premium Paid to Date End (343) Last Premium Paid Date (543)	300 303 343 543	Removed Values from the Companion Guide; Not used	A Carrier asked about the Signature Date valid value. Gainwell does not provide a Signature Date within the 834. Discussed with a Carrier that the values not used would be removed.
2310	33	NM106	Provider Name Prefix	PCP1 PCP2	Updated Note and Removed the Word 'Change'	Gainwell corrected the note on this field. This field will be populated with PCP1 or PCP2 when applicable, not just for changes.
2310	33	NM107	Provider Name Suffix		Removed this field, not used.	Gainwell discovered during testing that this field was not required.
2310	33	NM108	Identification Code Qualifier: Social Security Number (34) Federal Taxpayer's Identification Number (FI) Service Provider Number (SV)	34 FI SV	Updated Existing Value as a Required Field 'IN" and Removed Other Values from the Companion Guide; Not used (34, FI, SV)	Based on conversations with a Carrier regarding valid values not used within PRMMIS, values not used in multiple fields were removed.
2310	35	PLA05	Appointment Times not Met in a Timely Manner	AJ	Last "Maintenance Reason Code" for	A Carrier identified that we were missing the 'AJ'

					Change Physician was missing.	value within the valid value list.
2330	37	NM103	Coordination of Benefits Insurer Name		Outbound 834 will include 3-digit insurer code a space and then the insurer name	A Carrier required the 3-digit insurer code. Change was made to include this code as the first portion of the name field.
2750	38	DTP03	Member Reporting Category Effective Dates	CCYYMMDD-CCYYMMDD	Defined Field	A Carrier identified that the begin and end dates for the Coverage Codes were missing. Gainwell utilized this field for that purposed.

Version 1.6 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 08-09-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised

	24	BGN02	Transaction Set Reference Number		**Replace all text with:** This element is 50 characters of free form text to identify this specific file's information. Example:
					• Positions 1-7, Report ID, valid values are "INITIAL" or "CHANGE ".
					• Positions 8–8, Space.
					• Positions 9–14, Enrollment month in a CCYYMM format.
					• Positions 15–15, Space.
					• Positions 16–19, Sequence number of the transaction set indicating the order that the transaction sets are created and the order in which the transaction sets are to be processed.
					Example:
					`INITIAL 202308 0001`
					OR
					`CHANGE 202308 0001`

2000	26	INS08	Employment Status Code	AC TE	Change to Required field
2000	26	REF01	Reference Identification Qualifier	0F	Change Code from OF to 0F

Version 1.5 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 07-26-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	11	Naming convention for inbound files			Suffix of file name changed from .DAT to .X12
	12	Naming convention for outbound files			Suffix of file name changed from .DAT to .X12
	16	ISA06	Interchange Sender ID		Inbound from Carriers: Carrier's Trading Partner ID supplied by PRMMIS, [6 digits left justified and 9 spaces]. Outbound to Carriers: "PRMMIS" Puerto Rico Medicaid Management System., [6 characters left justified and 9 spaces].
	16	ISA08	Interchange Receiver ID		Inbound from Carriers: "PRMMIS" Puerto Rico Medicaid Management System., [6 characters left justified and 9 spaces]. Outbound to Carriers: Carrier's Trading Partner ID supplied by PRMMIS, [6 digits left justified and 9 spaces].
	18	GS02	Application Sender's Code		Inbound: Carrier's Trading Partner ID supplied by PRMMIS. Outbound: "PRMMIS"
	18	GS03	Application Receiver's Code		Inbound: "PRMMIS" Outbound: Carrier's Trading Partner ID supplied by PRMMIS.
	24	BGN02	Transaction Set Reference Number		**Replace all text with:** This element is 50 characters of free form text to identify this specific file's information. Example: • Positions 1-7, Report

					ID, valid values are "INITIAL" or "CHANGE" or "FINAL". • Positions 8–8, Space. • Positions 9–14, Enrollment month in a CCYYMM format. • Positions 15–15, Space. • Positions 16–19, Sequence number of the transaction set indicating the order that the transaction sets are created and the order in which the transaction sets are to be processed. Example: INITIAL 202308 0001 OR CHANGE 202308 0001 OR FINAL 202308 0001
1000B	25	N104	Sponsor Identifier	660437470	Add PRMP Tax ID to code column
2100A	29	DMG05 - 1	Race Code		See Appendix C for list of possible codes. Since this is a repeating field multiple race codes can be entered in this field separated by value in ISA11 ("^").
2100A	29	DMG05 - 2	Code List Qualifier Code		Remove element.
2100A	29	DMG05 - 3	Race or Ethnicity Code		Remove element.
2100B	30	DMG05 - 2	Code List Qualifier Code		Remove element.
2100B	30	DMG05 - 3	Race or Ethnicity Code		Remove element.
2310	34	NM102	Entity Type Qualifier	1	Person – All providers will be indicated as a "Person" (1).
2310	34	NM103	Provider Last or Organization Name		**Change text to:** If provider is actually a person this field will contain their 1st last name and 2nd last name with pipe delimiter to

					separate. If provider is an organization this field will contain the company name.
2310	34	NM104	Provider First Name		**New text:** If Provider is an Organization this field will be empty.
2310	35	NM105	Provider Middle Name		**New text:** Provider's Medicaid ID as assigned by PRMMIS.
2310	35	NM107	Provider Name Suffix		**New text:** If Provider is an Organization this field will be empty.
2310	35	NM109	Provider Identifier		**New text:** If provider has an NPI it will go here.
	48	Sample file naming examples			Suffix of file names changed from .DAT to .X12.

Version 1.4 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 06-30-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	9	Last paragraph before **References & Applicable Web Sites**	Gainwell		The order of transactions in the 834 outbound file changed to (1) terminations, (2) adds, (3) changes.
	9	Last bullet on page	Gainwell		Corrected link for CMS website – added "l."
	11	New paragraph after **File/System Specifications** File Naming Convention for Managed Care 834 Inbound	Gainwell		Changed inbound file naming convention.
	12	New paragraph before **Getting Started**	Gainwell		Added "Carrier Acknowledgements."
	17	ISA06 - Interchange Sender ID	Gainwell		Outbound value changed to "PRMMIS"
	19	GS02 - Application Sender's Code	Gainwell		Outbound value changed to "PRMMIS"
	23	Section 8 Acknowledgement 999	Gainwell		Removed this statement as it is not valid for 834: *If a "rejected" 999 is produced, then claims/encounters will not be sent to the claims engine for adjudication.*
	25	BGN02	Gainwell		Translation has been revised to retain spaces in this field.
2310	36	Provider Last or Organization Name	Gainwell		New text in Notes "If a person, field will contain last name | last name 2".
2310	36	Provider First Name	Gainwell		New text in Notes "If an organization, will contain "X."
	47	HD04	Gainwell		Removed "TBD ASES" from field 3 – coverage code
	48	Appendix H	Gainwell		Added "TRADING PARTNER ID of future carrier" as item #4 and renamed the list below

	50	Appendix J	Gainwell		list of Trading Partner IDs and 834 inbound file names by carrier

Version 1.3 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: 05-05-2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
			Gainwell		Removed DRAFT watermark
	47	HD04	Gainwell		Removed "TBD ASES" from field 3 – coverage code
	8	Scope	Gainwell		Corrected EDI HelpDesk email address.
	40	Appendix A	Gainwell		Removed "DRAFT" and changed statement to "Subject to change/addition by Gainwell, grayed out = not applicable."
	42	Appendix B	Gainwell		Removed "DRAFT" and changed statement to "Subject to change/addition by Gainwell, grayed out = not applicable."
	44 & 45	Appendixes D & E	Gainwell		Removed Appendix D and Appendix E as not applicable for PRMP
	47	HD04	Gainwell		Removed "TBD ASES" from field 3 – coverage code

Version 1.2 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Approved by: _____ Date: 04/17/2023

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
ALL					Added column "Req'd" to indicate fields required for 834 INBOUND.
	47	Appendix G, HD04	Gainwell		Removed "TRADING PARTNER id of previous carrier". Added "Raw Risk Score". Removed comment regarding rate cell calculation as it will be a part of 834. Moved Managed Care Region to order #1 and renumbered. This data element is required on INBOUND 834.
2750	48	Appendix H, Loop 2750	Gainwell		Added "Enrollment Confirmation". Added "Plan Version".. Added "TRADING PARTNER id of previous carrier". Renumbered. Added notes regarding INBOUND required data elements.
		Title Page Footer	Gainwell		Changed version to 1.2 and updated other references to April instead of March.
2310	34	NM106 Provider Name Prefix	Gainwell	PCP1 PCP2	Added this as a place to indicate add/change for PCP1 or PCP2
	49	Appendix I	Gainwell		New to identify Managed Care Region valid values

Version 1.1 Revision Log

Companion Guide: 834 Health Care Benefit Enrollment and Maintenance

Name: Gainwell Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					Initial Submission
	11-12		Gainwell		10/27/2022: Revised file name conventions
	9	834 Audit File 834 Changes File	Gainwell		02/01/2023: Corrected INS01 to INS03
	45	Appendix G HD04	Gainwell		02/03/2023: Removed "plan version" from HD04, Appendix G, and renumbered
	9	834 Changes File	Gainwell		Removed sentence *"Membership spans should not be used to process changes (INS03 = 001)."* as it does not provide any value.
		Appendix G HD04	Gainwell		03/07/2023: Added data element #14 for Trading partner id of previous carrier
			Gainwell		03/07/2023: Version changed to "1.1"

gainwell

GOVERNMENT OF PUERTO RICO
Department of Health
Medicaid Program

Puerto Rico Medicaid Management Information System

ICD_PRMMIS_MGD_0015_834_INBOUND_CARRIER_ERROR_REPORT

MANAGED CARE 0015 834 INBOUND CARRIER ERROR REPORT

Interface Control Document

Version 2.6

Change History

Version #	Date	Modified By	Description
1.0	10/27/2023	Gainwell Technologies	Initial submission
2.0	1/30/2024	Gainwell Technologies	Post Implementation Update
2.1	2/21/2024	Gainwell Technologies	New Error Code - 4034
2.2	3/20/2024	Gainwell Technologies	New Error Codes - 4035 and 9002
2.3	4/23/2024	Gainwell Technologies	New Error Codes - 4036 and 9003
2.4	5/23/2024	Gainwell Technologies	Added Missing Error Code – 4003 New Error Codes – 4037, 4038, 4039 and 4040
2.5	2/18/2025	Gainwell Technologies	Added Error Type 'S' within section 4.2 Detail Format
2.5	9/18/2025	Gainwell Technologies	Added information to define clearly the Error process within Section 2.5 'Error Handling'. A new report example was added within Section 4.2 'Detail Format'.

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Contents

1 Acronyms 1
2 Interface Overview 2
2.1 Use Requirements 2
2.2 Communication Methods and Format 2
2.3 Timing and Frequency 2
2.4 Monitoring and Reporting 2
2.5 Error Handling 2
2.6 Assumptions 4
3 Process Flow 5
4 Detailed Specifications 6
4.1 Header Format 6
4.2 Detail Format 6
5 Appendix A – List of .CSV Message Description / Action 8

Figures

Figure 1 – Carrier - 834 CSV Error File 5

Tables

Table 1 – Acronyms 1

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1 Acronyms

The following table contains the list of abbreviations used within this document.

Note: This acronym list will not include all potential HIPAA-related transaction information.

Table 1 – Acronyms

Acronyms	Definition
ASES	Administracion De Seguros De Salud De Puerto Rico
CMS	Centers for Medicare & Medicaid Services
CSV	Comma-Separated Values
FM	First Medical
HIPAA	Health Insurance Portability and Accountability Act of 1996
HUMA	Humana Platino
MCS	MCS Advantage
MMMP	Medicare Y Mucho Mas
MMMV	MMM Multi Health, LLC
PSM	Plan De Salud Menonita
PMC	Primary Medicare Choice
PRMMIS	Puerto Rico Medicaid Management Information System
PRMP	Puerto Rico Medicaid Program
TPA	Triple-S Advantage
TPS	Triple-S Salud, Inc.

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2 Interface Overview

This file will be transmitted from Puerto Rico Medicaid Management Information System (PRMMIS) to the Puerto Rico Carriers and will contain errors identified while processing 834 inbound transactions. The CSV report will contain the errors identified.

2.1 Use Requirements

PRMMIS will send the CSV error file to notify the Carriers of errors that are identified when processing their 834 inbound file. It is the responsibility of Puerto Rico Carriers to correct the source data and re-send using the 834 inbound transaction.

2.2 Communication Methods and Format

The file will be transmitted from PRMMIS to Carriers after the 834 carrier inbound processing is complete.

The first line of the error file will contain header information. Each field within a record will be separated by comma as the delimiter. If a field value contains a comma as part of the value, the field will be enclosed in quotation marks. If a field contains a quotation mark, it will be escaped by preceding it with a quotation mark. A field that does not have a value does not need to contain a single space.

The fields will be written to a Comma-Separated Values (CSV) file as per the layout listed later in this document.

File name format will be: *######_ABRV_ZZZZZZ_834DI_yyyymmdd_01.csv*

######	internal number assigned by the report program
ABRV	carrier abbreviation
ZZZZZZ	Trading Partner ID
yyyymmdd	date report is produced

2.3 Timing and Frequency

The file will be transmitted to the carriers on a daily basis (Monday – Friday) after the 834 inbound process is complete. Each 834 inbound file will produce an error report and include only 'header' data if no errors are found.

2.4 Monitoring and Reporting

The report will reflect the field for the error and the reason for failure of the transactions sent. The CSV file is created as part of the 834 inbound processing job stream in PRMMIS.

2.5 Error Handling

All records that pass validity checks will be applied to the PRMMIS database. There are 3 separate processes within the 834 Inbound application that can produce an error or informational code. These are driven by the type of data supplied within the 834 Inbound transaction.

The first process is triggered by a change within the Confirmation Indicator. The second process is triggered by a Plan Version value and the third process is triggered by a PMG, PCP1 or PCP2 value. Each of these processes will evaluate the data and provide an Error Code if an error within the data is indicated. An error code will contain a value of 'I', 'P' or 'V' followed by a colon and then the error / informational description within the Error Field to indicate which process triggered the error. The 'I' will indicate an error within the first process, Confirmation Indicator. The 'P' will indicate an error within the

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second process, Plan Version. The 'V' will indicate an error within the third process, PMG, PCP1 or PCP2.

The breakdown of each of these processes and the recording of the error within these processes will assist in analyzing the data. If a transaction has more than one process performed, there could be the same type of error code or information code for each process.

Records with errors will not be applied to the PRMMIS database. Errors should be corrected by each carrier and retransmitted when the member data is corrected. Warnings are records that have been processed, but need carrier updates to be made. Informational messages are considered informational only.

Below is the list of the errors and warnings that will be sent:

ERROR CODE	ERROR TYPE	MESSAGE
4000	Error	Medicaid ID not valid - REF02
4001	Error	Invalid or empty Trading Partner ID - ISA06
4002	Error	Invalid or empty Maintenance Type Code - HD01
4003	Error	Invalid or empty Region Code HD04_Region
4005	Error	Invalid or empty Carrier End Date - DTP01_349
4006	Error	Invalid or empty Provider Type - NM101
4007	Error	Invalid or empty Entity Qualifier - NM108
4008	Error	Invalid or empty Provider Prefix - NM106
4013	Error	Invalid or empty Provider Maintenance Reason - PLA05
4014	Error	Enrollment not found on Change transaction - 001
4017	Error	Invalid dates End Date is Before Effective Date
4019	Error	Member is not eligible for the Benefit/Assignment Plan
4023	Error	Maintenance Type Code on Loops 2000 and 2300 are different
4024	Error	Invalid or empty Municipality Code – N406
4025	Error	Invalid or empty member coverage date
4026	Error	Invalid or empty Enrollment Confirmation indicator
4027	Error	Member is not a Virtual Region member in PRMMIS
4028	Error	Inconsistent dates on loop 2300 it needs to be the same
4029	Error	Member already enroll with this carrier .021 not allowed
4030	Error	Add txn from a Vital carrier .021 not allowed
4031	Error	Oxi834TransSet node does not exist
4032	Error	No carrier match on 1 or more assign segments
4034	Error	Invalid incoming effective date, greater than 24 months
4035	Error	Found GAP on Elig segments
4036	Error	Carrier termed
4037	Error	Termination transaction 024 not allowed
4038	Error	Platino carrier cannot enroll an ISO benefit plan
4039	Error	ISO benefit plan is not correct for this member
4040	Error	Platino carrier incoming date greater than 3 month
0010	Informational	No changes in incoming Assignments

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0011	Informational	No changes in incoming Assignments for Platino carrier
0012	Informational	No change on incoming Terminate Assignment
0013	Informational	No change on incoming ASES Assignment
0014	Informational	Member with no PRV loop info
0015	Warning	Plan Version is empty or not valid
9001	Informational	Incoming Region does not match PRMMIS Region
9002	Informational	Virtual region members not allowed for the carrier
9003	Informational	PMG/PCP information not required for Virtual Region Members

2.6 Assumptions

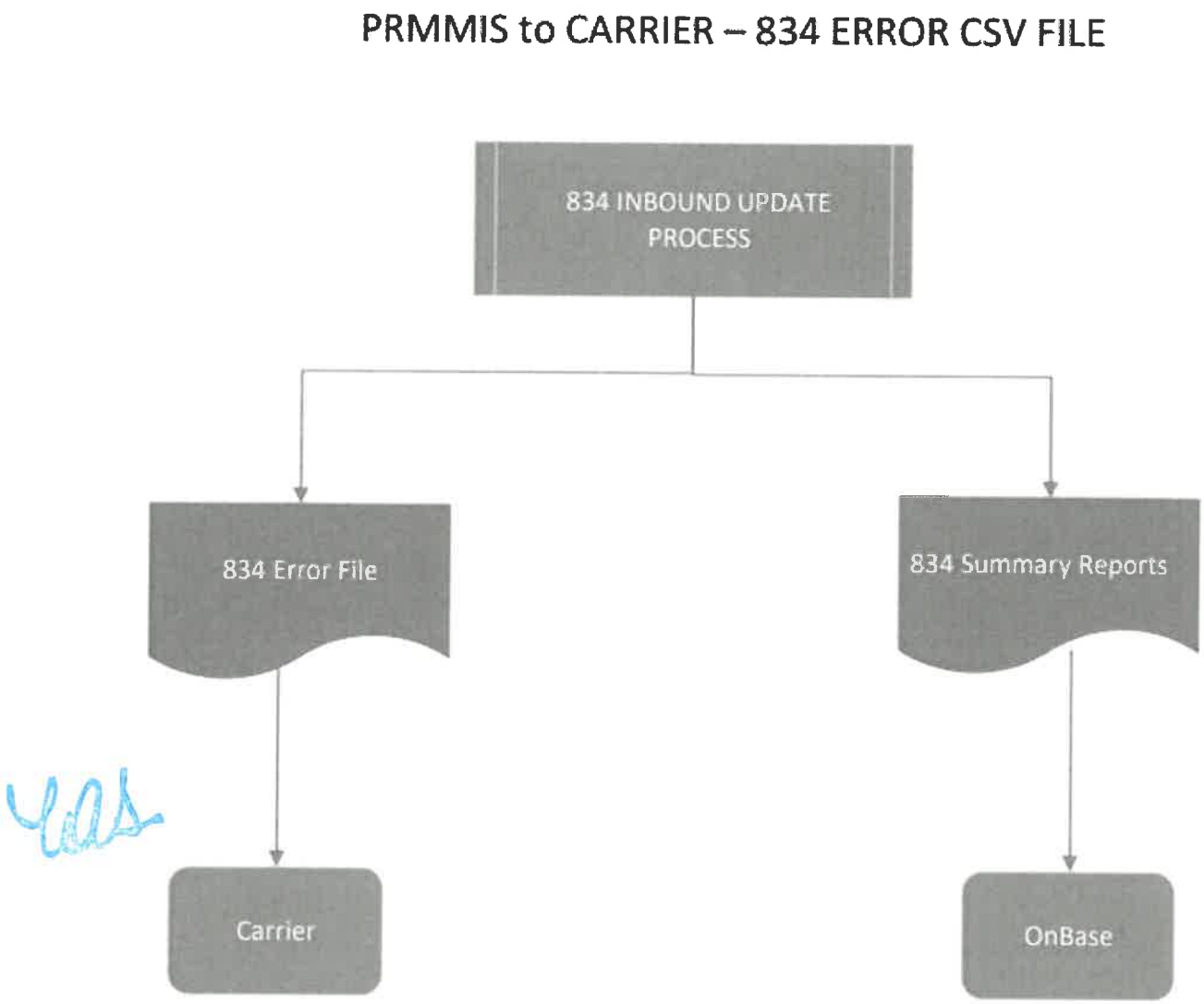
The CSV daily file will contain all errors identified during the inbound 834 update process.

It is expected that each Carrier will review the CSV file and make necessary updates to ensure that the data in PRMMIS is accurate.

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3 Process Flow

Figure 1 – Carrier - 834 CSV Error File



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4 Detailed Specifications

The CSV file will be comma-delimited with the fields below. The CSV header will have the format below.

There is no trailer record.

4.1 Header Format

Field #	Field Name	Report Value
1	Date	"Date"
2	Medicaid ID	"Medicaid ID"
3	Last Name	"Last Name"
4	Last Name2	"Last Name2"
5	First Name	"First Name"
6	Maintenance Code	"Maintenance Code"
7	Manage Care Region	"Manage Care Region"
8	Effective Date	"Effective Date"
9	End Date	"End Date"
10	Error Type	"Error Type"
11	Error Field	"Error Field"
12	Error Value	"Error Value"
13	Error Code	"Error Code"
14	Error Description	"Error Description"

Example:

"Date", "Medicaid ID", "Last Name", "Last Name2", "First Name", "Maintenance Code", "Manage Care Region", "Effective Date", "End Date", "Error Type", "Error Field", "Error Value", "Error Code", "Error Description"

4.2 Detail Format

Field #	Description	Size	Type	Comments
1	Date	10	Text	Format: MM/DD/YYYY
2	Medicaid ID	11	Text	
3	Last Name	20	Text	
4	Last Name2	20	Text	
5	First Name	15	Text	
6	Maintenance Code	3	Text	
7	Manage Care Region	1	Text	
8	Effective Date	8	Text	Format: YYYYMMDD

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Field #	Description	Size	Type	Comments
9	End Date	8	Text	Format: YYYYMMDD
10	Error Type	1	Text	E=Error; W=Warning; S=Successful
11	Error Field	50	Text	This field will contain the value 'I', 'P' or 'V' to indicate which process the error was identified.
12	Error Value	100	Text	Value in the field where there is an error.
13	Error Code	4	Text	
14	Error Description	100	Text	

Report Example (shown as spreadsheet):

Date	Medicaid	Last Nam	Last Nam	First Nam	MaIntena	Manage C	Effective D	End Date	Error Ty	Error Field	Error Valu	Error Cod	Error Description
8/26/2025	8E+10	RIOS		ISRAEL	001	A	20250301	20260430	W	I: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	HERNAND	MENDEZ	TOMAS	001	Z	20250401	22991231	E	P: id_m dicaid not elegible	8E+10	4019	Member is not Eligible for the Benefit/Assignme
8/26/2025	8E+10	NIEVES	MONTANE	IRMA	001	F	20240101	20260331	W	I: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	NIEVES	MONTANE	IRMA	001	F	20240101	20260331	W	I: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	NIEVES	MONTANE	IRMA	001	F	20240101	20260331	W	I: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	NIEVES	MONTANE	IRMA	001	F	20240101	20260331	W	I: No C ange on any incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	NIEVES	MONTANE	IRMA	001	F	20240101	20260331	W	V: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	NIEVES	MONTANE	IRMA	001	F	20240701	20260331	W	P: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	RIOS		ISRAEL	001	A	20250301	20260430	W	I: No C ange on any incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	RIOS		ISRAEL	001	A	20250301	20260430	W	V: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	RIOS		ISRAEL	001	A	20250301	20260430	W	P: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	YI		JANNETTE	001	E	20250101	20260430	W	I: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	YI		JANNETTE	001	E	20250101	20260430	W	I: No C ange on any incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	YI		JANNETTE	001	E	20250101	20260430	W	V: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	YI		JANNETTE	001	E	20250101	20260430	W	P: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	CORTES	CARRION	IVETTE	001	E	20250101	20260331	W	I: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	CORTES	CARRION	IVETTE	001	E	20250101	20260331	W	I: No C ange on any incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	CORTES	CARRION	IVETTE	001	E	20250101	20260331	W	V: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	CORTES	CARRION	IVETTE	001	E	20250101	20260331	W	P: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	MUNOZ	MARTINEZ	JUAN	001	Z	20250101	20260430	W	I: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	MUNOZ	MARTINEZ	JUAN	001	Z	20250101	20260430	W	I: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	MUNOZ	MARTINEZ	JUAN	001	Z	20250101	20260430	W	I: No C ange on any incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	MUNOZ	MARTINEZ	JUAN	001	Z	20250101	20260430	W	V: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	MUNOZ	MARTINEZ	JUAN	001	Z	20250101	20260430	W	P: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	NEGRON	FONTAN	MARIA	001	A	20250401	20260331	W	I: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	NEGRON	FONTAN	MARIA	001	A	20250401	20260331	W	I: No C ange on any incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	NEGRON	FONTAN	MARIA	001	A	20250401	20260331	W	V: No C ange on incoming assignment	001	0010	No changes on incoming assignments
8/26/2025	8E+10	NEGRON	FONTAN	MARIA	001	A	20250401	20260331	W	P: No C ange on incoming assignment	001	0010	No changes on incoming assignments

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5 Appendix A – List of .CSV Message Description / Action

Error Code	Error Message	Error Description	What to do to resolve error
4000	Medicaid ID not valid - REF02	Medicaid ID not valid	Verify Medicaid ID, correct transaction and resend.
4001	Invalid or empty Trading Partner ID - ISA06	Trading Partner ID does not match x12 envelope Trading Partner ID (does not apply to ASES)	Trading Partner within the ISA, GS and REF header segments must match. Correct segments and resend.
4002	Invalid or empty Maintenance Type Code - HD01	Invalid Maintenance Type Code	Correct the Maintenance Type Code and resend.
4003	Invalid or empty Region Code HD04_Region	4003 error is generated when the Region Code sent in on the 834 Inbound is invalid format or empty.	Correct the Region Code and resend.
4005	Invalid or empty Carrier End Date - DTP01_349	Carrier End Date is NULL	Correct the Carrier End Date and resend.
4006	Invalid or empty Provider Type - NM101	Provider MCD is not numeric.	Verify Provider MCD, correct transaction and resend.
4007	Invalid or empty Entity Qualifier - NM108	Identification Code Qualifier must be 'XX'.	Correct the Identification Code Qualifier and resend.
4008	Invalid or empty Provider Prefix - NM106	Provider Prefix is invalid.	Provider Prefix must be PCP1, PCP2 or PMG1. Correct the Provider Prefix and resend.
4013	Invalid or empty Provider Maintenance Reason - PLA05	Maintenance reason code is not valid. Must be one of these values: "14", "22", "46", "AA", "AB", "AC", "AD", "AE", "AF", "AG", "AH", "AI", or "AJ".	Correct the Maintenance Reason Code and resend.
4014	Enrollment not found on change transaction.001	The enrollment begin date used for record types 01 through 05 needs to match the enrollment begin date provided on the 834 Outbound record for these record types.	Update the record with the dates provided on the 834 Outbound file and resend.
4017	Invalid dates End Date is Before Effective Date	The end date provided is previous to the begin date.	Correct dates and resend.
4018	Invalid or empty Plan Version for Platino carrier – 2750_REF02	Plan Version is null on a Platino 834 Inbound file or the Plan Version is not found within PRMMIS.	Verify the Plan Version, correct and resend.
4019	Member is not Eligible for the Benefit/Assignment Plan	The date sent in on the 834 Inbound does not fall within the member's eligibility dates within PRMMIS.	Correct the dates and resend.
4023	Maintenance Type Code on Loops 2000 and 2300 are different	The Maintenance Type Code must match between the 2000 and 2300 loops.	Correct the Maintenance Type Code and resend.
4024	Invalid or empty Municipality Code – N406	Municipality Code is an invalid value or null.	Verify the Municipality Code, correct and resend.
4025	Invalid or empty member coverage date	The effective date for Record Type 01 within the HD04 2300 loop must contain the enrollment effective date.	Correct the effective date for Record Type 01 and resend.
4026	Invalid or empty Enrollment Confirmation Indicator	The Enrollment Confirmation Indicator (Record Type 02) is empty or not valid.	Correct the Enrollment Confirmation Indicator value and resend.
4027	Member is not a Virtual Region member in PRMMIS	Member is not within a Virtual Region in PRMMIS.	Correct the Region Code and resend.
4028	Inconsistent dates on loop 2300 it needs to be the same	Within the HD04 2300 Loop, the dates within each record type must be the same.	Correct the dates and resend.

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Error Code	Error Message	Error Description	What to do to resolve error
4029	Member already enroll with this carrier .021 not allowed	Cannot send an Add (021) transaction for a member that is already active within the Carrier.	Change the transaction to a 001 (Change) transaction and resend.
4030	Add txn from a Vital carrier .021 not allowed	Vital Carriers cannot send Add (021) transactions.	Change the transaction to a 001 (Change) transaction and resend.
4031	Oxi834TransSet node does not exist	The Oxi834 TransSet Node is missing.	Create the Oxi834 TransSet Node within the 834 Inbound file and resend.
4032	No carrier match on 1 or more assign segments	4032 error is generated when a change (001) record is sent from a Carrier for a specific segment with its specific date period and for that date period the member is with a different Carrier.	The Carriers who receive this error should validate that the member is actually valid for that date range within that Carrier.
4034	Invalid incoming effective date, greater than 24 months	An Add transaction cannot have a begin date greater than 24 months in the past.	The Carrier needs to correct the begin date and resend.
4035	Found GAP on Elig segments	4035 error is generated when a member has gap in eligibility within PRMMIS for the date sent in on the 834 Inbound.	Correct the dates and resend.
4036	Carrier termed	4036 error is generated when the Carrier is termed on PRMMIS for the date sent in on the 834 Inbound.	For Enrollment Counselor, correct the Carrier and resend.
4037	Termination transaction 024 not allowed	Termination transactions are not allowed on the Inbound 834 files from the Carriers. Only the Enrollment Counselor can send 024, Termination Transactions.	Open a CTN if there is a need for a member to be termed.
4038	Platino carrier cannot enroll an ISO benefit plan	The Platino Carrier sending an Add transaction is not the Virtual Region Carrier and the Add transaction cannot be completed.	Validate that the member is not within Foster Care or Domestic Abuse. Open CTN if the member does not fall into either of these categories.
4039	ISO benefit plan is not correct for this member	The member is not within the Foster Care or Domestic Abuse category. The benefit plan sent is invalid for this member.	Validate that the member is within Foster Care or Domestic Abuse. Open CTN if the member is within one of these categories.
4040	Platino carrier incoming date greater than 3 month	Add transaction with incoming date greater than 3 months in the future is not allowed for Platino Carrier.	The Platono Carrier needs to correct the begin date and resend.
0010	No changes on incoming assignments	Informational message	No action needed
0011	No changes in incoming Assignments for Platino carrier	Informational message	No action needed
0012	No change on incoming Terminate Assignment	Informational message	No action needed
0013	No change on incoming ASES Assignment	Informational message	No action needed
0014	Member with no PRV loop info	Informational message	No action needed
0015	Plan Version is empty or not valid	Remaining 834 Inbound record was processed.	Plan Version needs to be identified and sent on an 834 Inbound file.
9001	Incoming Region does not match PRMMIS Region	Informational message	No action needed

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9002	Virtual region members not allowed for the carrier	Informational message	The Carriers who receive this error should validate that the member is actually valid for that date range within that Carrier.
9003	PMG/PCP information not required for Virtual Region Members	Informational message	No action needed.

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ADDENDUM 4

PRMMIS_835_Companion_ Guide_Payment_v1.8

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 0 0 0 0 2

NÚMERO DE CONTRATO

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 00002

NÚMERO DE CONTRATO

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DEPARTAMENTO DE SALUD

Puerto Rico Medicaid Management Information System – Phase III

835_Companion_Guide_Supplemental_Payments_v1.8

Technical Report Type 3 Implementation for 835

HIPAA Transaction Standard Companion Guide

Version 1.8

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The communications/connectivity component is included in the companion guide when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The transaction instruction component is included in the companion guide when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The transaction instruction component content is limited by ASC X12's copyrights and Fair Use statement.

This companion guide does not replace the HIPAA ANSI ASC X12N Implementation Guide. Nor does it contain any actions that would result in a Non-Compliant Transaction.

This companion guide is subject to change without prior notice. Trading Partners are responsible for periodically checking for companion guide updates on the Puerto Rico Department of Health (PRDoH) website.

Preface

This companion guide to the v5010 ASC X12N Technical Report Type 3 (TR3), and associated errata and addenda, adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with Puerto Rico Medicaid. Transmissions based on this companion guide, used in tandem with the TR3, also called 835 Health Care Claim Payment/Advice (835) ASC X12N (version 005010X221A1), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. This companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.





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Contents

1 Introduction 1
1.1 Purpose 2
1.2 Scope 2
1.3 Overview 3
1.4 References & Applicable Web Sites 4
1.5 Additional Information 5
1.5.1 National Provider Identifier 5
1.5.2 Acceptable Characters 5
1.5.3 Acknowledgements 5
1.5.4 File/System Specifications 5
2 Getting Started 7
2.1 Testing Overview 7
3 Connectivity With Puerto Rico Medicaid Program / Communications 8
3.1 Process Flows 8
3.2 Transmission Administrative Procedures 8
3.3 Re-transmission Procedure 8
4 Contact Information 9
4.1 Electronic Data Interchange Helpdesk 9
5 Control Segments / Envelopes 10
5.1 ISA - Interchange Control Header 10
5.2 IEA – Interchange Control Header 12
5.3 GS - Functional Group Header 12
5.4 GE - Functional Group Trailer 12
5.5 ST-SE 13
5.5.1 Transaction Set Header (ST) 14
5.5.2 Transaction Set Trailer (SE) 14
5.6 File Delimiters 14
6 Puerto Rico Medicaid Program-Specific Business Rules And Limitations 16
6.1 Trading Partner Identification Number 16
6.2 Testing 16
6.3 Terminology 16
6.4 Limits 16
6.5 Scheduled Maintenance 16
7 Notes on 835 Claim Payment/ Advice 17
7.1 835 Claim Payment/Advice 17
8 Acknowledgements And/Or Reports 18
8.1 Report Inventory 18

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9 Transaction-Specific Information 19
10 Disclosure Statement 32
11 Change Summary 34
11.1 Version 1.4 Revision Log 34
11.2 Version 1.7 Revision Log 34
11.3 Version 1.8 Revision Log 34

Figure

Figure 1: File Naming Convention for 835 Payment Remittance Used by PRMMIS 6
Figure 2: Retrieval of Puerto Rico Medicaid Program's 835 via Carrier's folder SFTP Site. 8

Tables

Table 1: Sample TR3 Table 1
Table 2: Explanation of File Name Elements in Figure 1 6
Table 3: ISA Interchange Control Header Fields 10
Table 4: IEA Interchange Control Trailer Fields 12
Table 5: GS Functional Group Header Fields 12
Table 6: GE Functional Group Trailer Fields 13
Table 7: ST Transaction Set Header Fields 14
Table 8: SE Transaction Set Trailder Fields 14
Table 9: 005010X221A1 – 835 Health Care Payment/Advice 19

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1 Introduction

This section describes how TR3, also called 835 ASC X12N (005010X221A1), which was adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), will be detailed with the use of a table. The table contains a Notes/Comments column for each segment that Puerto Rico Medicaid has additional information to provide over and above the information in the TR3. That information can do any of the following:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a subset of the implementation guide internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Puerto Rico Medicaid Program (PRMP).

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

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column for each segment that PRMP has additional information to provide, over and above the information in the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in Section 9: Transaction-Specific Information.

Table 1: Sample TR3 Table

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
193		2100C	NM1	Subscriber Name		This type of row exists to indicate that a new segment has begun. It is shaded at 10 percent and notes or comments about the segment itself go in this cell.
196		2100C	REF	Subscriber Additional Identification		
197		2100C	REF01	Reference Identification Qualifier	18 49 6P HJ N6	These are the only codes transmitted by Puerto Rico Medicaid.
				Plan Network Identification Number	N6	This type of row exists when a note for a particular code value is required. For example, this note may say that value "N6" is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218		2110C	EB	Subscriber Eligibility or Benefit Information		

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
231		2110C	EB12-1	Product/Service ID Qualifier	AD	This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 Purpose

This companion guide to the v5010 ASC X12N Technical Report Type 3 (TR3) Implementation Guide, and associated errata and addenda, adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with Puerto Rico Medicaid Program.

Transmissions based on this companion guide, used in tandem with the TR3, also called Health Care Claim Payment Advice (835) ASC X12N (version 005010X218), 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 835 ASC X12N TR3 adopted for use under HIPAA. This companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

1.2 Scope

PRMP developed the 5010 Companion Guides to supplement each 5010 Transaction Implementation Guide, based on Version 5, Release 1, with regards to Specific Codes and/or Values that PRMP will default on Outbound Transactions. PRMP Companion Guides will not create a Non-Compliant Transaction.

This companion guide will provide compliance for PRMP within the CAHQ CORE Payment Remittance (835) Infrastructure Rule for the X12 v5010 835 transaction.

This companion guide is intended to be used in conjunction with the ASC X12N/005010X218 Implementation Guide (IG). The IG provides standardized data requirements and content to all users of the American National Standards Institute (ANSI) ASC X12 Premium Payment Order/Remittance Advice (835) Transaction Set for the purpose of to transfer payment and remittance information.

It provides supplementation instructions not included in the (IG) that must be followed for implementation and conducting the transaction with PRMP. It does not change the requirements of the IG in any way.

Refer to the companion guide first if there is a question about how PRMP processes a HIPAA transaction.

For further information, contact PRMMIS-Internal-EDI-HD-Support@gainwelltechnologies.com. This document is intended as a resource to assist providers, clearinghouses, service bureaus, and all other trading partners (Managed Care Organizations – MCO and Platinos) with PRMP interChange in successfully conducting Electronic Data Interchange (EDI) of administrative health care transactions.

This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance. The information contained in this companion guide applies to Puerto Rico Medicaid. These programs use Puerto Rico Medicaid for processing.

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1.3 Overview

PRMP and all other covered entities are required by HIPAA to comply with the EDI standards for health care, as established by the Secretary of the federal Department of Health and Human Services (HHS). HIPAA requires the Secretary of the HHS to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. The Health Insurance Portability and Accountability Act of 1996 directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

The Health Insurance Portability and Accountability Act of 1996 serves to:

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

This guide is designed to help those responsible for testing and setting up the 835 Health Care Claim Payment/Advice transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting and identifies codes and data elements that do not apply to Puerto Rico Medicaid. This guide supplements (but does not contradict) requirements in the ASC X12N 835 (version 005010X221A1) implementation.

This information should be given to the trading partner's business area to ensure that the 835 Health Care Claim Payment/Advice transactions are interpreted correctly. This companion guide provides communications-related information a trading partner needs to obtain support, format the interchange control header (ISA), functional group header (GS) envelopes, and exchange test and production transactions with Puerto Rico Medicaid.

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist trading partners in implementing the electronic 835 Health Care Claim Payment/Advice transactions that meet Puerto Rico Medicaid processing standards by identifying pertinent structural and data-related requirements and recommendations

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1.4 References & Applicable Web Sites

For more information regarding the ASC X12 standards for EDI 835 (version 005010X221A1) and to purchase copies of the TR3 documents, consult the Washington Publishing Company Web site at http://www.wpc-edi.com/.

For information about EDI software and services, visit: http://www.1edisource.com/.

Additional information is available on the following Web sites:

- Accredited Standards Committee X12N develops and maintains X12 EDI and XML standards, standards interpretations and guidelines as they relate to all aspects of insurance and insurance-related business processes: http://www.x12.org/.
- Centers for Medicare and Medicaid Services (CMS) is the unit within the HHS that administers the Medicare and Medicaid programs. The CMS provides the Electronic Health Care Transactions and Code Sets Model Compliance Plan at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code- Sets/index.htm.
- Designated Standard Maintenance Organizations (DSMO) is a resource for information about the standard-setting organizations and transaction change request system: http://www.hipaa-dsmo.org/.
- Health Level Seven (HL7) is one of several ANSI-accredited Standards Development Organizations (SDOs) and is responsible for clinical and administrative data standards: www.hl7.org.
- Healthcare Information and Management Systems (HIMSS) is an organization exclusively focused on providing global leadership for the optimal use of IT and management systems for the betterment of health care: www.himss.org.
- National Committee on Vital and Health Statistics (NCVHS) was established by Congress to serve as an advisory body to the HHS on health data, statistics and national health information policy; for more information, refer to: www.ncvhs.hhs.gov.
- Office for Civil Rights (OCR) is the office within the federal HHS responsible for enforcing the Privacy Rule under HIPAA, which can be found at: www.hhs.gov/ocr/hipaa.
- The federal HHS is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA, which can be found at: www.aspe.hhs.gov/admnsimp.
- Washington Publishing Company (WPC) is a resource for HIPAA-required transaction implementation guides and code sets, which can be found at: www.wpc-edi.com/.
- The Workgroup for Electronic Data Interchange (WEDI) is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA: www.wedi.org.
- The registry for the NPI is the National Plan and Provider Enumeration System (NPPES), at: https://nppes.cms.hhs.gov/NPPES/Welcome.do.
- Implementation guides and non-medical code sets are at: store.x12.org/.
- The HIPAA statute, Final Rules, and related Notices of Proposed Rulemaking (NPRMS) are available at: https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/code-sets.
- The CMS online manuals system and Internet only manuals (IOM) system, including transmittals and program memoranda, can be found at: www.cms.hhs.gov/Manuals/.

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1.5 Additional Information

The ANSI is the coordinator for information on national and international standards. In 1979, ANSI chartered the ASC X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standard is recognized by the United States as the standard for North America. Electronic Data Interchange adoption has been proved to reduce the administrative burden on providers.

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

1.5.1 National Provider Identifier

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

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

PRMP has determined that all providers, except for non-emergency transportation, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. PRMP requires all health care providers to submit their NPI on electronic transactions.

1.5.2 Acceptable Characters

The HIPAA transactions must not contain any carriage returns, nor line feeds; the data must be received in one, continuous stream. PRMP accepts the extended character set. Uppercase characters are recommended.

1.5.3 Acknowledgements

PRMMIS will accept 999 Implementation Acknowledgement transactions from trading partners after they have downloaded their 835 Health Care Claim Payment/Advice transaction. If you return an acknowledgement file after downloading your 835 X12 we request that you name your file using the 835 X12 file name and extension.ACK.

Example:
Received X12:
201345_417181_######_@@@_CYCLEID_ERA835_20231101_1.X12

Acknowledgement file uploaded to Secure File Transfer Protocol (SFTP):
201345_417181_######_@@@_ CYCLEID _ERA835_20231101_1.ACK

– Trading Partner ID
@@@ – Trading Partner Short Name

1.5.4 File/System Specifications

EDI only accepts Windows/PC/DOS formatted files. Any file transmitted to EDI must be named in accordance with the standard file naming conventions, including a valid three-character file extension. The following standards will be used for the file deposited in the SFTP folder:

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Figure 1: File Naming Convention for 835 Payment Remittance Used by PRMMIS

201345_417181_######_@@@_CYCLEID_ERA835_20231101_1.X12

– Trading Partner ID
@@@ – Trading Partner Short Name

Table 2: Explanation of File Name Elements in Figure 1

Element	Description
SAKID	This is the unique ID assigned by PRMMIS to each file.
PARENT_SAKID	This is the unique ID assigned by PRMMIS to each file.
TPID	This is the "carrier's" PRMMIS ID.
ABRV_TP_NAME	Abbreviated trading partner's name
CYCLE_ID	012, 015
TS	ERA835
TDATE	YYYYMMDD
SEQ	#
EXTENSION	.X12

CYCLE_ID –012 supplemental payments cycle, 015 supplemental payments cycle

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2 Getting Started

2.1 Testing Overview

Test transactions (ISA15 value of "T") must be sent to our Testing (UAT) environment.

Production transactions (ISA15 value of "P") must be sent to our Production environment (PROD).

Reminder: Submitters are responsible for the preservation, privacy, and security of data in their possession. While using production data that contains Personal Health Information (PHI) to conduct testing, the data must be guarded and disposed of appropriately.





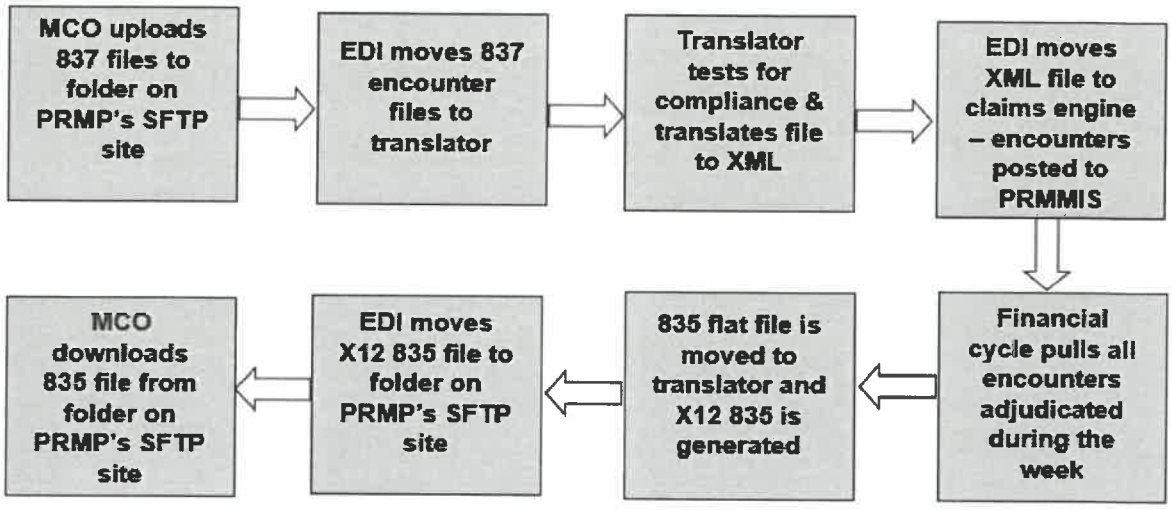
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3 Connectivity With Puerto Rico Medicaid Program / Communications

This section describes the process for sending the HIPAA 835 transactions, along with various security requirements and exceptions to handling procedures.

3.1 Process Flows

Figure 2: Retrieval of Puerto Rico Medicaid Program's 835 via Carrier's folder SFTP Site.



3.2 Transmission Administrative Procedures

PRMP is available only to authorized users. Submitters are required to be PRMP trading partners.

3.3 Re-transmission Procedure

In the event of an interrupted communications session, PRMMIS will re-initiate the file transfer.

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4 Contact Information

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

4.1 Electronic Data Interchange Helpdesk

If you have questions related to PRMP's 835 Health Care Claim Payment/Advice, contact the EDI Helpdesk by email at prmmis_edi_support@gainwelltechnologies.com or by phone at 1-833-209-8326.

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5 Control Segments / Envelopes

5.1 ISA - Interchange Control Header

This section describes PRMP's use of the ISA. It includes a description of expected sender and receiver codes, authorization information, and delimiters.

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

- Each trading partner is assigned a six-digit trading partner ID.
- All dates are in the CCYYMMDD format.
- All date/times are in the CCYYMMDDHHMM format.
- Payer ID can be found in all companion guides.
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Transactions transmitted are identified by an ISA and trailer segment (IEA) which form the envelope enclosing the transmission. The ISA marks the beginning of the transmission (batch) and provides sender and receiver identification.

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

The following table shows the fields that PRMP will be sending.

Note: PRMP sends files with one ISA/IEA loop per file.

Table 3: ISA Interchange Control Header Fields

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.3	**None**	**ISA**	**Interchange Control Header**		**The ISA is a fixed-length record with fixed-length elements.**
C.4		ISA01	Authorization Information Qualifier	00	00 = No authorization information present.
C.4		ISA02	Authorization Information		
C.4		ISA03	Security Information Qualifier	00	[10 spaces] Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier.
C.4		ISA04	Security Information		00 = No security information present.
C.4		ISA05	Interchange ID (Sender) Qualifier	30	[10 spaces] This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.4		ISA06	Interchange Sender ID	PRMMIS	30 = US Federal Tax Identification Number
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	ZZ = Mutually Defined
C.5		ISA08	Interchange Receiver ID		Trading Partner ID
C.5		ISA09	Interchange Date		Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified
C.5		ISA10	Interchange Time		Time of the interchange. The time format is HHMM.
C.5		ISA11	Repetition Separator		Type is not applicable; the repetition separator is a delimiter and not a data element; this field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure; this value must be different than the data element separator, component element separator, and the segment terminator.
C.5		ISA12	Interchange Control Version Number	00501	00501 – Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003
C.5		ISA13	Interchange Control Number		The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.
C.6		ISA14	Acknowledgement Requested	1	1 – Interchange Acknowledgment Requested (TA1)
C.6		ISA15	Usage Identifier	T & P	Code indicating whether the data enclosed is production or test.
			Production Data	T	File from PRMMIS test environment.
			Production Data	P	File from PRMMIS production environment.
C.6		ISA16	Component Element Separator	:	A colon ":" will be sent.

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5.2 IEA – Interchange Control Header

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

Table 4: IEA Interchange Control Trailer Fields

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.10	**None**	**IEA**	**Interchange Control Trailer**		
C.10		IEA01	Number of Included Functional Groups		Number of included Functional Groups
C.10		IEA02	Interchange Control Number.		Must be identical to the value in ISA13

5.3 GS - Functional Group Header

This section describes PRMP's use of the functional group control segments. It includes a description of expected application sender and receiver codes.

The following table shows the fields that PRMP will be sending.

Table 5: GS Functional Group Header Fields

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	**None**	**GS**	**Functional Group Header**		
C.7		GS01	Functional ID Code	HP	HP = Health Care Claim Payment/Advice (835)
C.7		GS02	Application Sender's Code	PRMMIS	PRMMIS = Application Sender's Code [6 characters left justified and 9 spaces]
C.7		GS03	Application Receiver's Code		Carrier's Trading Partner ID supplied by PRMP.
C.7		GS04	Date		The date format is CCYYMMDD.
C.8		GS05	Time		The time format is HHMM.
C.8		GS06	Group Control Number		Group Control Number – Must be identical to GE02.
C.8		GS07	Responsible Agency Code	X	X = Responsible Agency Code
C.8		GS08	Version/ Release/Industry Identifier Code	005010X218	005010X218 = Version/ Release/ Industry Identifier Code

5.4 GE - Functional Group Trailer

The following table shows the fields that Puerto Rico Medicaid will be sending.

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Table 6: GE Functional Group Trailer Fields

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.9	**None**	**GE**	**Functional Group Trailer**		
C.9		GE01	Number of Transaction Sets Included		Total number of transaction sets
C.9		GE02	Group Control Number		Must be identical to the value in GS06

5.5 ST-SE

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

PRMP recommends that trading partners follow the guidelines set forth in the TR3 — start the first ST02 in the first file with 000000001 and increment from there. The TR3 should be reviewed for how to create compliant transaction set control segments.

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5.5.1 Transaction Set Header (ST)

The TR3 should be reviewed for specific information.

Table 7: ST Transaction Set Header Fields

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
70	**None**	**ST**	**Transaction Set Header**		
70		ST01	Transaction Set Identifier Code	835	835 = Health Care Claim Payment/Advice (835)
70		ST02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA).
70		ST03	Implementation Guide Version Name	005010X218	00501018 = Version/ Release/ Industry Identifier Code This field contains the same value as GS08.

5.5.2 Transaction Set Trailer (SE)

The TR3 should be reviewed for specific information.

Table 8: SE Transaction Set Trailder Fields

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
496	**None**	**SE**	**Transaction Set Trailer**		
496		SE01	Transaction Segment Count		Total number of segments included in a transaction set including the ST and SE segments
496		SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical.

5.6 File Delimiters

PRMP uses the following delimiters in the 835 file:

- **Data Element**: Byte 4 in the ISA segment defines the data element separator to be used throughout the entire transaction. The data element delimiter is an asterisk (*).
- **Repetition Separator**: ISA11 defines the repetition separator to be used throughout the entire transaction. The repetition separator is a caret (^).
- **Component-Element**: ISA16 defines the component element delimiter to be used throughout the entire transaction. The component-element delimiter is a colon (:).
- **Data Segment**: Byte 106 of the ISA segment defines the segment terminator used throughout the entire transaction. The data segment delimiter is a tilde (~).

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These characters (* : ~ ^) cannot be present within the data content of the transaction elements.

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6 Puerto Rico Medicaid Program-Specific Business Rules And Limitations

6.1 Trading Partner Identification Number

The EDI team will create any needed Trading Partner Profiles during the PRMP's implementation of the PRMMIS.

6.2 Testing

Production Authorization Testing will be available for PRMMIS 835 files.

6.3 Terminology

The term "subscriber" will be used as a generic term throughout the companion guide.

6.4 Limits

There is no file size restriction on how many records will be reported in an 835.

6.5 Scheduled Maintenance

PRMMIS recycles the servers every night between 00:00 a.m. to 01:00 a.m. Atlantic Standard Time (AST).

PRMMIS schedules regular maintenance every Sunday from 00:00 a.m. to 04:00 a.m. AST.





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7 Notes on 835 Claim Payment/ Advice

7.1 835 Claim Payment/Advice

Puerto Rico Medicaid posts for download an 835 batch transaction upon release of a financial cycle. The financial cycle covers seven days.

Puerto Rico Medicaid generates electronic 835 transactions only for supplemental payment that have been paid based on claims/encounters.

The 835 files will be available for retrieval for thirty days. If an 835 file is needed after thirty days, contact the EDI Helpdesk via e-mail using PRMMIS-Internal-EDI-HD-Support@gainwelltechnologies.com.

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8 Acknowledgements And/Or Reports

8.1 Report Inventory

There are no acknowledgement reports at this time.

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9 Transaction-Specific Information

This section describes how ASC X12N implementation guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that PRMP has something additional, over and above, the information in the implementation guides. That information can:

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

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

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column for each segment that PRMP has additional information to provide, over and above the information in the TR3.

Table 9: 005010X221A1 – 835 Health Care Payment/Advice

TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
69			BPR	Financial Information		
70	1/1		BPR01	Financial Information	I H	
					I	I = Indicates to the payee that the remittance detail is moving separately from the payment. This also includes when the resulting payment would be zero.
					H	H = Indicates notification only, no payment.
71	1/10		BPR02	Total Actual Provider Payment Amount		The ACH system cannot support dollar amounts greater than 11 characters (including the decimal point). This provides an ACH limit of $99,999,999.99. for the 835. Dollar limits vary by the clearing system used, e.g. ACH vs. wire.
71	1/1		BPR03	Credit or Debit Flag Code	C	C = Credit This indicates a credit to the payee's account, and a debit to the Payer's account.

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
72	3/3		BPR04	Payment Method Code	ACH CHK NON	
				Non-Payment Data	NON	NON = This value will be used if the payment is zero
				Automated Clearing House	ACH	Automated Clearing House
				Check	CHK	
72	3/3		BPR05	Payment Format Code	CCP	Used when BPR04 is ACH.
72	2/2		BPR06	Depository Financial Institution (DFI) Identification Number Qualifier	01	Used when BPR04 is ACH.
73	3/12		BPR07	Sender DFI Identifier		Used when BPR04 in NON
74	1/3		BPR08	Account Number Qualifier	DA	Used when BPR04 is ACH.
74	1/35		BPR09	Sender Bank Account Number		Used when BPR04 is ACH.
74	10/10		BPR10	Payer Identifier		Used when BPR04 is ACH.
75	2/2		BPR12	Depository Financial Institution (DFI) Identification Number Qualifier		Used when BPR04 is ACH.
75	3/12		BPR13	Receiver or Provider Bank ID Number		Used when BPR04 is ACH.
76	1/3		BPR14	Account Number Qualifier		Used when BPR04 is ACH.
76	1/35		BPR15	Receiver or Provider Account Number		Used when BPR04 is ACH.
76	8/8		BPR16	Check Issue or EFT Effective Date		For check payment, this data element specifies the check issuance date. For payments other than check this data element specifies the date the originator (premium payer) intends to provide funds to the receiver (premium receiver) Date format will be CCYYMMDD

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
77			TRN	Reassociation Trace Number		The purpose of this segment is to uniquely identify this transaction set and to aid in reassociating payments and remittances that have been separated.
77	1/2		TRN01	Trace Type Code	3	3 = Financial Reassociation Trace Number The payment and remittance information have been separated and need to be reassociated by the receiver.
77	1/50		TRN02	Check or EFT Trace Number		This field is used to re-associate the payment with the remittance information.
78	10/10		TRN03	Payer Identification		Required when the receiver needs an originating company identification to reassociate a payment to a remittance.
100 079			CUR	Foreign Currency Information		This segment does not meet the situational requirements to be sent by PRMMIS.
82			REF	Receiver Identification		Note: Segment can repeat as needed.
82	2/3		REF01	Reference Identification Qualifier	EV	"EV" – Receiver Identification Number
82	1/50		REF02	Receiver Identifier		This field will contain the Trading Partner ID.
84			REF	Version Identification		This segment does not meet the situational requirements to be sent by PRMMIS.
85			DTM	Production Date		
85	3/3		DTM01	Date Time Qualifier	405	"405" – Production
86	8/8		DTM02	Production Date		Reports the end date for the adjudication production cycle for encounters included in this 835.
87		1000A	N1	Payer Identification		
87	2/3	1000A	N101	Entity Identifier Code	PR	"PR" – Payer

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
87	1/60	1000A	N102	Payer Name		This field will contain "PRMP" for Puerto Rico Medicaid Program.
89		1000A	N3	Payer Address		
89	1/55	1000A	N301	Payer Address Line		This field will contain the address of the payer.
90		1000A	N4	Payer City, State, ZIP Code		
90	2/30	1000A	N401	Payer City Name		This field will contain the city of the payer.
91	2/2	1000A	N402	Payer State Code		State of the payer.
91	3/15	1000A	N403	Postal Zone or ZIP Code		ZIP code of the payer.
92		1000A	REF	Additional Payer Identification		This segment does not meet the situational requirements to be sent by PRMMIS.
94		1000A	PER	Payer Business Contact		This segment does not meet the situational requirements to be sent by PRMMIS.
97		1000A	PER	Payer Technical Contact		This segment will contain EDI Helpdesk information as the Technical Contact.
97	2/2	1000A	PER01	Contact Function Code	BL	"BL" – Technical Department
98	1/60	1000A	PER02	Payer Technical Contact Name		PRMMIS EDI Helpdesk
98	2/2	1000A	PER03	Communication Number Qualifier	EM	"EM" – Electronic Email
98	1/256	1000A	PER04	Payer Contact Communication Number		Email address for EDI Helpdesk. PRMMIS-Internal-EDI-HD-Support@gainwelltechnologies.com
100		1000A	PER	Payer Web Site		This segment does not meet the situational requirements to be sent by PRMMIS.
102		1000B	N1	Payee Identification		
103	2/3	1000B	N101	Entity Identifier Code	PE	"PE" – Payee
103	1/60	1000B	N102	Payee Name		

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
103	½	1000B	N103	Identification Code Qualifier	FI XX	
					FI	Federal TIN
					XX	National Provider Identifier (NPI)
103	2/80	1000B	N104	Payee Identification Code		This field contains the billing provider's NPI when N103 contains the value "XX". This is the billing provider's Federal TIN when the N103 contains the value "FI".
104		1000B	N3	Payee Address		
105		1000B	N4	Payee City, State, ZIP Code		
107		1000B	REF	Payee Additional Identification		
109		1000B	RDM	Remittance Delivery Method		
111		2000	LX	Header Number		
111	1/6	2000	LX01	Assigned Number		
112		2000	TS3	Provider Summary Information		This segment does not meet the situational requirements to be sent by PRMMIS.
117		2000	TS2	Provider Supplemental Summary		This segment does not meet the situational requirements to be sent by PRMMIS.
123		2100	CLP	Claim Payment Information		
123	1/38	2100	CLP01	Patient Control Number		
124	1/2	2100	CLP02	Claim Status Code		
125	1/18	2100	CLP03	Total Claim Charge Amount		
125	1/18	2100	CLP04	Claim Payment Amount		
125	1/18	2100	CLP05	Patient Responsibility Amount		
126	½	2100	CLP06	Claim Filing Indicator Code		
127	1/50	2100	CLP07	Payer Claim Control Number		

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
127	1/2	2100	CLP08	Facility Type Code		
127	1/1	2100	CLP09	Claim Frequency Code		
128	1/4	2100	CLP11	Diagnosis Related Group (DRG) Code		
128	1/15	2100	CLP12	Diagnosis Related Group (DRG) Weight		
129		2100	CAS	Claim Adjustment		
131	1/2	2100	CAS01	Claim Adjustment Group Code		
131	1/5	2100	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	Adjustment Reason Code		
132	1/18	2100	CAS03 CAS05 CAS09 CAS12 CAS15 CAS18	Adjustment Amount		
137		2100	NM1	Patient Name		
137	2/3	2100	NM101	Identification Code Qualifier		
138	1/1	2100	NM102	Entity Type Qualifier		
138	1/60	2100	NM103	Patient Last Name		
138	1/35	2100	NM104	Patient First Name		
138	1/25	2100	NM105	Patient Middle Initial		
139	1/2	2100	NM108	Identification Code Qualifier		
139	2/80	2100	NM109	Patient Identifier		
140		2100	NM1	Insured Name		Puerto Rico Medicaid does not meet the situational rule to require this segment.
143		2100	NM1	Corrected Patient/Insured Name		
143	2/3	2100	NM101	Identification Code Qualifier		
144	1/1	2100	NM102	Entity Type Qualifier		
144	1/60	2100	NM103	Corrected Patient Last Name		

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
144	1/35	2100	NM104	Corrected Patient First Name		
144	1/25	2100	NM105	Corrected Patient Middle Initial		
144	1/10	2100	NM107	Corrected Patient Name Suffix		
145	1/2	2100	NM108	Identification Code Qualifier		
145	2/80	2100	NM109	Corrected Insured Identification Indicator		
146		2100	NM1	Service Provider Name		Puerto Rico Medicaid meets the situational rule to require this segment.
147	2/3	2100	NM101	Identification Code Qualifier		
147	1/1	2100	NM102	Entity Type Qualifier		
147	1/60	2100	NM103	Rendering Provider Last Name		
147	1/35	2100	NM104	Rendering Provider First Name		
148	1/25	2100	NM105	Rendering Provider Middle Initial		
148	1/2	2100	NM108	Identification Code Qualifier		
149	2/80	2100	NM109	Rendering Provider Identifier		
150		2100	NM1	Crossover Carrier Name		
153		2100	NM1	Corrected Priority Payer Name		
156		2100	NM1	Other Subscriber Name		
159		2100	MIA	Inpatient Adjudication Information		
160	1/15	2100	MIA01	Covered Days or Visits Count		
161	1/50	2100	MIA05	Claim Payment Remark Code		
164	1/50	2100	MIA20	Claim Payment Remark Code		
165	1/50	2100	MIA21	Claim Payment Remark Code		
165	1/50	2100	MIA22	Claim Payment Remark Code		

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
165	1/50	2100	MIA23	Claim Payment Remark Code		
166		2100	MOA	Outpatient Adjudication Information		Puerto Rico Medicaid meets the situational rule to require this segment.
167	1/50	2100	MOA03	Claim Payment Remark Code		
167	1/50	2100	MOA04	Claim Payment Remark Code		
167	1/50	2100	MOA05	Claim Payment Remark Code		
168	1/50	2100	MOA06	Claim Payment Remark Code		
168	1/50	2100	MOA07	Claim Payment Remark Code		
169		2100	REF	Other Claim Related Identification		
169	2/3	2100	REF01	Reference Identification Qualifier		
171		2100	REF	Rendering Provider Identification		
171	2/3	2100	REF01	Reference Identification Qualifier		
173		2100	DTM	Statement From or To Date		
174	3/3	2100	DTM01	Date Time Qualifier		
175			DTM	Coverage Expiration Date		
175	3/3	2100	DTM01	Date Time Qualifier		
172		2100	DTM02	Date		
177		2100	DTM	Claim Received Date		This segment does not meet the situational requirements to be sent by PRMMIS.
179		2100	PER	Claim Contact Information		This segment does not meet the situational requirements to be sent by PRMMIS.
182		2100	AMT	Amount Qualifier Code		This segment does not meet the situational requirements to be sent by PRMMIS.

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
184		2100	QTY	Claim Supplemental Information Quantity		This segment does not meet the situational requirements to be sent by PRMMIS.
		2100B	NM1	Individual Name		Loop can repeat as needed.
186		2110	SVC	Service Payment Information		
187	2/2	2110	SVC01-1	Product or Service ID Qualifier		
188	1/48	2110	SVC01-2	Adjudicated Procedure Code		
188	2/2	2110	SVC01-3	Procedure Modifier		
189	1/18	2110	SVC02	Line Item Charge Amount		
190	1/18	2110	SVC03	Line Item Provider Payment Amount		
190	1/48	2110	SVC04	National Uniform Billing Committee Revenue		
190	1/15	2110	SVC05	Units of Service Paid Count		
191	2/2	2110	SVC06-1	Product or Service ID Qualifier		
191	1/48	2110	SVC06-2	Procedure Code		
191	2/2	2110	SVC06-3	Procedure Modifier		
193	1/80	2110	SVC06-7	Procedure Code Description		
193	1/15	2110	SVC07	Original Units of Service Count		
194		2110	DTM	Service Date		Puerto Rico Medicaid meets the situational rule to require this segment.
195	3/3	2110	DTM01	Date Time Qualifier		
195	8/8	2110	DTM02	Service Date		
196		2110	CAS	Service Adjustment		
198	1/2	2110	CAS01	Claim Adjustment Group Code		
198 To 201	1/5	2100	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	Adjustment Reason Code		

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
199 To 201	1/18	2110	CAS03 CAS05 CAS09 CAS12 CAS15 CAS18	Adjustment Amount		
204		2110	REF	Service Identification		This segment does not meet the situational requirements to be sent by PRMMIS.
206		2110	REF	Line Item Control Number		
206	2/3	2110	REF01	Reference Identification Qualifier		
207		2110	REF	Rendering Provider Information		
207	2/3	2110	REF01	Reference Identification Qualifier		
209		2110	REF	Healthcare Policy Identification		This segment does not meet the situational requirements to be sent by PRMMIS.
211		2110	AMT	Service Supplemental Amount		
211	1/3	2110	AMT01	Amount Qualifier Code		
213		2110	QTY	Service Supplemental Quantity		This segment does not meet the situational requirements to be sent by PRMMIS.
215		2110	LQ	Health Care Remark Codes		Puerto Rico Medicaid meets the situational rule to require this segment.
215	1/3	2110	LQ01	Code List Qualifier Code		
216	1/30	2110	LQ02	Remark Code		
217		2110	PLB	Provider Adjustment		This segment does not meet the situational requirements to be sent by PRMMIS.
218	1/50	2110	PLB01	Provider Identifier		
218	8/8	2110	PLB02	Fiscal Period Date		

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
219	2/2	2110	PLB03-1 PLB05-1 PLB07-1 PLB09-1 PLB11-1 PLB13-1	Adjustment Reason Code	50 51 72 90 AH AM AP B2 B3 BD BN C5 CS CV CW DM E3 FB FC GO HM IP IR IS J1 L3 L6 LE LS OA OB PI PL RA RE SL TL WO WU	Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment.
				Late Charge	50	
				Interest Penalty Charge	51	
				Authorized Return	72	
				Early Payment Allowance	90	

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
				Origination Fee	AH	
				Applied to Borrower's Account	AM	
				Acceleration of Benefits	AP	
				Rebate	B2	
				Recovery Allowance	B3	
				Bad Debt Adjustment	BD	
				Bonus	BN	
				Temporary Allowance	C5	
				Adjustment	CS	
				Capital Passthru	CV	
				Certified Registered Nurse	CW	
				Anesthetist Passthru	DM	
				Direct Medical Education	E3	
				Passthru	FB	
				Withholding	FC	
				Forwarding Balance	GO	
				Fund Allocation	HM	
				Graduate Medical Education	IP	
				Passthru	IR	
				Hemophilia Clotting Factor	IS	
				Supplement	J1	
				Incentive Premium Payment	L3	
				Internal Revenue Service	L6	
				Withholding	LE	
				Interim Settlement	LS	Disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount.
				Nonreimbursable	J1	
				Penalty	L3	

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TR3 Page #	Min/Max	Loop ID	Reference	Name	Codes	Notes/Comments
				Interest Owed	L6	
				Levy	LE	
				Lump Sum	LS	
				Organ Acquisition Passthru	OA	
				Offset for Affiliated Providers	OB	
				Periodic Interim Payment	PI	
				Payment Final	PL	
				Retro-activity Adjustment	RA	
				Return on Equity	RE	
				Student Loan Repayment	SL	
				Third Party Liability	TL	
				Overpayment Recovery	WO	
				Unspecified Recovery	WU	
222	1/50	2110	PLB03-2 PLB05-2 PLB07-2 PLB09-2 PLB11-2 PLB13-2	Provider Adjustment Identifier		When the PLB is associated with a supplemental claim, the Carrier's Transaction Control Number (TCN) and the PRMMIS (Internal Control Number) ICN will appear in this field. A space will appear between the TCN and ICN. If the PLB is not associated with a supplemental claim, the field will contain 'N_A N_A'.
223	1/18	2110	PLB04 PLB06 PLB08 PLB10 PLB12 PLB14	Provider Adjustment Amount		This is the adjustment amount for the preceding adjustment reason.

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Appendix A.

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11 Change Summary

11.1 Version 1.4 Revision Log

Companion Guide: 835 HIPAA Transaction Standard

Name: Gainwell Date: 04-26-2024

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
Naming	5/6				Updated Naming Convention for 835s

11.2 Version 1.7 Revision Log

Companion Guide: 835 HIPAA Transaction Standard

Name: Gainwell Date: 05-08-2024

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2110	31	PLB03-2 PLB05-2 PLB07-2 PLB09-2 PLB11-2 PLB13-2	Provider Adjustment Identifier		Added Notes/Comments regarding adding the TCN and ICN to the PLB segment.

11.3 Version 1.8 Revision Log

Companion Guide: 835 HIPAA Transaction Standard

Name: Gainwell Date: 07-23-2024

- Added 015 Supplemental Payment cycle (refer to Table 2, page 6)

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ADDENDUM 5

PRMMIS_PHASE_I-837D_Companion_Guide_v7.1
PRMMIS_PHASE_I-837I_Companion_Guide_v7.2
PRMMIS_PHASE_I-837P_Companion_Guide_v7.1
PRMMIS_NCPDP_Post_Adjudication_Companion_Guide

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 00002

NÚMERO DE CONTRATO

GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3)
Implementation Guides Based on ASC X12 Version
005010X224A2 Dental Health Care Claim/Encounter (837D)

Companion Guide Version Number: 7.1

November 2021

Puerto Rico Medicaid Management Information System Services Project

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 00002

NÚMERO DE CONTRATO

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Preface

This companion guide to the v5010 ASC X12N Technical Report Type 3 (TR3) adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with the Puerto Rico Department of Health. Transmissions based on this companion guide, used in tandem with the TR3, also called the Health Care Dental Claim/Encounter ASC X12N version 005010X224A2 (837D), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. To access the HIPAA Implementation Guides, please contact the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).





Disclaimer: The information contained in this Companion Guide is subject to change.

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Table of Contents

1 INTRODUCTION 7

1.1 Scope 8
1.2 Overview 8
1.3 References 9
1.4 Additional Information 9
National Provider Identifier 9
Acceptable Characters 10
File/System Specifications 10

2 CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS 11

2.1 Process Flows 11
2.2 Transmission Administrative Procedures 11
2.3 Communication Protocol Specifications 11
Batch 11

3 CONTROL SEGMENTS / ENVELOPES 12

3.1 ISA-IEA 12
Interchange Control Header (ISA) 12
IEA – Interchange Control Header 13

3.2 GS-GE 13
Functional Group Header (GS) 13
Functional Group Trailer (GE) 14

3.3 ST-SE 14
TRANSACTION SET HEADER (ST) 14
TRANSACTION SET TRAILER (SE) 15

3.4 Control Segment Notes 15
3.5 File Delimiters 15
Element Separator 15
Repetition Separator 15
Component Separator 15
Segment Terminator 15

4 PUERTO RICO DEPARTMENT OF HEALTH-SPECIFIC BUSINESS RULES AND LIMITATIONS . 16

4.1 Trading Partner Identification Number 16
4.2 Testing 16

4.3 Terminology....16
4.4 Limits....16
4.5 Scheduled Maintenance....16
4.6 Procedures for Voiding Encounters....16

5 ACKNOWLEDGEMENTS AND/OR REPORTS....17

5.1 Acknowledgements....17
TA1 — Transaction Acknowledgement....17
999 — Functional Acknowledgement....17

6 TRANSACTION-SPECIFIC INFORMATION....18

6.1 005010X224A2 — 837D Health Care Claim/Encounter....18

A. APPENDIX A....30

A.1 Change History....30
A.2 Change History....30
A.3 Change History....31
A.4 Change History....33
A.5 Change History....39
A.6 Change History....41
A.7 Change History....43
A.8 Change History....43

1 INTRODUCTION

This section describes how TR3, also called 837D ASC X12N (version 005010X224A2), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that Puerto Rico Department of Health has information additional to the TR3. That information can:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guides' internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Puerto Rico Department of Health.

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

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column to provide additional information from Puerto Rico Department of Health for specific segments provided by the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in Section 6: TRANSACTION-SPECIFIC INFORMATION.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10 percent and notes or comments about the segment itself go in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Puerto Rico Department of Health.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value "N6" is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and how to specify that only one code value is applicable.

1.1 Scope

This companion guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 837D (referred to as Dental Claim/Encounter in the rest of this document) for the purpose of submitting 837D electronically. This companion guide is not intended to replace the TR3. The TR3s define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of this companion guide is to provide trading partners with a guide to communicate Puerto Rico Department of Health-specific information required to successfully exchange transactions electronically with Puerto Rico Department of Health. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

The information contained in this companion guide applies to Puerto Rico Department of Health for processing.

Puerto Rico Department of Health will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain Puerto Rico Department of Health-specific information, though processed, may be denied. For example, a compliant 837D Claim/Encounter created with an invalid Puerto Rico Department of Health member identification number will be processed by Puerto Rico Department of Health, but will be denied. For questions regarding appropriate billing procedures, as well as for policy and billing information, providers should refer to their policy-specific area of the Puerto Rico Department of Health.

Refer to this companion guide first if there is a question about how Puerto Rico Department of Health processes a HIPAA transaction. For further information, contact **their policy-specific** area of the Puerto Rico Department of Health or PRMMIS MCO EDI (prmmis_edi_support@dxc.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCOs) and clearinghouses with Puerto Rico Department of Health in successfully conducting EDI of administrative health care transactions. This document provides instructions for obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.2 Overview

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

The HIPAA requirements serve to:

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

This guide is designed to help those responsible for testing and setting up electronic Dental Claim/Encounter transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting, and identifies codes and data elements that do not apply to Puerto Rico Department of Health. This guide supplements (but does not contradict) requirements in the ASC X12N 837D (version 005010X224A2) Implementation Guide. This guide provides communications-related information that a trading partner needs to enroll as

a trading partner, obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with Puerto Rico Department of Health.

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist trading partners in implementing electronic 837D transactions that meet Puerto Rico Department of Health processing standards by identifying pertinent structural and data-related requirements and recommendations.

1.3 References

For more information regarding the ASC X12 Standards for Electronic Data Interchange 837D Health Care Claim/Encounter (version 005010X224A2) and to purchase copies of the TR3 documents, consult the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

The implementation guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The implementation guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that the provider's Information Technology (IT) staff or software vendor review this document in its entirety and follow the stated requirements to exchange HIPAA-compliant files with Puerto Rico Department of Health.

To obtain the Provider taxonomy code set, please contact the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

1.4 Additional Information

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

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

National Provider Identifier

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

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

All providers, except those that the Puerto Rico Department of Health determined to not identify as a healthcare provider such as non-emergency transportation, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. Puerto Rico Department of Health requires all health care providers to submit their NPI on electronic transactions.

Acceptable Characters

The HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. Puerto Rico Department of Health accepts the extended character set. Uppercase characters are recommended. Files should be less than 100 MB.

File/System Specifications

EDI only accepts Windows/PC/DOS formatted files. Any file transmitted to EDI must be named in accordance to standard file naming conventions, including a valid three-character file extension. The following standards should be used:

- To avoid accidently overwriting files, do not send multiple files with the same name on the same day.
- File Names should not be longer than 45 characters.
- File Names should not contain spaces or special characters.
- File Names should contain a file extension such as .dat or .txt.
- Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file.
- Zip files must contain the extension .zip (not case sensitive).

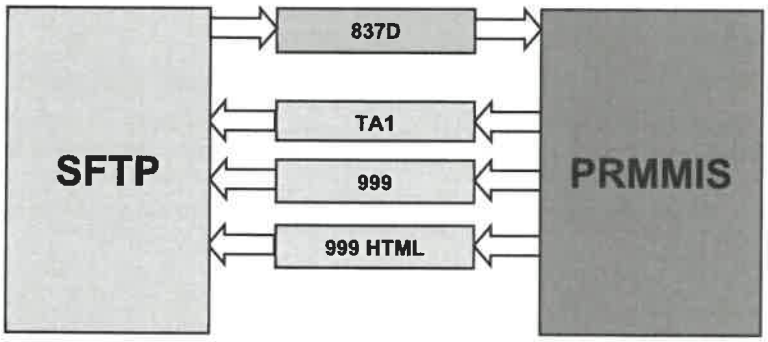
2 CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS

This section describes the process to interactively submit HIPAA 837D transactions, along with various submission methods, security requirements, and exception handling procedures.

2.1 Process Flows

This section contains process flow diagrams and appropriate text.
Each transaction is validated to ensure that the 837D complies with the 005010X224A2 TR3.

Transactions that fail this compliance check will generate a "Rejected" 999 file back to the sender with an error message indicating the compliance error. Transactions that pass this compliance check will generate an "Accepted" 999 file back to the sender with AK9*A to indicate that the file passed compliance. Transactions with multiple ST/SE loops that fail this compliance check in some of the ST/SE loops will generate a "Partial" 999 file back to the sender with an error message indicating the compliance error (all claims/encounters in the ST/SE envelopes that pass compliance will be processed). Claims/Encounters that pass compliance checks but fail to process (e.g., due to member not being found) will be denied. Claims/Encounters that pass compliance checks and have not failed to process (e.g., the member was found with enrollment within the date(s) of service) will be classified as "paid."



2.2 Transmission Administrative Procedures

This section provides Puerto Rico Department of Health's-specific transmission administrative procedures.

The trading partner must determine if the transmission being sent is Test or Production and is using the appropriate indicator (ISA15). For details about available Puerto Rico Department of Health access methods, refer to the Communication Protocol Specifications section.

Puerto Rico Department of Health is available only to authorized users. Submitters must be Puerto Rico Department of Health trading partners. A submitter is authenticated using a username and password assigned by the trading partner.

2.3 Communication Protocol Specifications

This section describes Puerto Rico Department of Health's communication protocol(s). The following communication methods are available to get a member's Eligibility and Benefits from Puerto Rico Department of Health:

Batch

Trading partners can submit all batch transactions to Puerto Rico Department of Health and download acknowledgements and response files. Access is free; however, the user must have his or her own internet connection to access the web application.

3 CONTROL SEGMENTS / ENVELOPES

3.1 ISA-IEA

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

Interchange Control Header (ISA)

To promote efficient, accurate electronic transaction processing, please note the following Puerto Rico Department of Health specifications:

- Each trading partner is assigned a Trading Partner ID.
- All dates are in the CCYYMMDD format. Except for ISA09.
- All dates/times are in the CCYYMMDDHHMM format.
- Payer IDs can be found in the companion guides.
- Batch responses are not returned until all inquiries are processed. Limiting the number of total inquiries per ISA-IEA will produce faster results.
- Each Payer ID must be in its own file.
- No more than 999 claims/encounters per Transaction Set (ST-SE).
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Transactions transmitted as a batch are identified by an ISA and trailer segment (IEA), which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The table below represents only those fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction — the TR3 should be reviewed for that information.

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

Note: Puerto Rico Department of Health accepts files with one ISA/IEA loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.3	None	ISA	Interchange Control Header		
C.4		ISA01	Authorization Information Qualifier	03	ENCOUNTER – "03" – Additional Data Identification
C.4		ISA02	Authorization Information		ENCOUNTER – MCO Medicaid ID + [space fill]
C.4		ISA03	Security Information Qualifier	00	00 = No Security Information Present
C.4		ISA04	Security Information		[space fill]
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	ZZ = Mutually defined
C.4		ISA06	Interchange Sender ID		Trading Partner ID supplied by Puerto Rico Department of Health, left-justified and space-filled.
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	ZZ = Mutually defined
C.5		ISA08	Interchange Receiver ID	PRMMIS	"PRMMIS" – left-justified and space-filled.
C.5		ISA09	Interchange Date		The date format is YYMMDD.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.5		ISA10	Interchange Time		The time format is HHMM.
C.5		ISA11	Repetition Separator	^	A Caret "^" is recommended.
C.5		ISA12	Interchange Control Version Number	00501	00501 = Control Version Number
C.5		ISA13	Interchange Control Number		The interchange control number assigned in ISA13 must be identical to the value in IEA02.
C.6		ISA14	Acknowledgement Requested	0	0 = No interchange acknowledgment requested (TA1)
C.6		ISA15	Usage Identifier	P, T	Code indicating whether the data enclosed is Production or Test.
			Production Data	P	Enter value "P" to indicate that the file contains Production data
			Test Data	T	Enter value "T" to indicate that the file contains Test data.
C.6		ISA16	Component Separator	:	A colon ":" is recommended.

IEA – Interchange Control Header

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.10	None	IEA	Interchange Control Trailer		
C.10		IEA01	Number of Included Functional Groups		Number of included Functional Groups
C.10		IEA02	Interchange Control Number		Must be identical to the value in ISA13

3.2 GS-GE

This section describes Puerto Rico Department of Health's use of the functional group control segments.

It includes a description of expected application sender and receiver codes.

Functional Group Header (GS)

In the table below are fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

Note: Puerto Rico Department of Health only accepts files with one GS/GE loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	None	GS	Functional Group Header		
C.7		GS01	Functional ID Code	HC	"HC" – Health Care Dental Claim/Encounter (837D)

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7		GS02	Application Sender's Code		'Trading Partner ID' supplied by Puerto Rico Department of Health.
C.7		GS03	Application Receiver's Code	PRMMIS	'PRMMIS' Puerto Rico Department of Health Sender ID.
C.7		GS04	Date		The date format is CCYYMMDD.
C.8		GS05	Time		The time format is HHMM.
C.8		GS06	Group Control Number		Group Control Number – Must be identical to GE02.
C.8		GS07	Responsible Agency Code	X	"X" – Responsible Agency Code
C.8		GS08	Version / Release / Industry Identifier Code	005010X224A2	Version / Release / Industry Identifier Code

Functional Group Trailer (GE)

In the table below are fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.9	None	GE	Functional Group Trailer		
C.9		GE01	Number of Transaction Sets Included		Total number of transaction sets
C.9		GE02	Group Control Number		Must be identical to the value in GS06

3.3 ST-SE

This section describes Puerto Rico Department of Health's use of transaction set control numbers.

Puerto Rico Department of Health recommends that trading partners follow the guidelines set forth in the TR3 — start the first ST02 in the first file with "000000001" and increment from there. The TR3 should be reviewed for how to create compliant transaction set control segments.

TRANSACTION SET HEADER (ST)

The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
70	None	ST	Transaction Set Header		
70		ST01	Transaction Set Identifier Code	837	837 Health Care Claim
70		ST02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA).
70		ST03	Implementation Guide Version Name	005010X224A2	This field contains the same value as GS08.

TRANSACTION SET TRAILER (SE)

The TR3 should be reviewed for specific information.

TR3 page #	Loop ID	Reference	Name	Codes	Notes/Comments
496	None	SE	TRANSACTION SET TRAILER		
496		SE01	Transaction Segment Count		Total number of transaction sets
496		SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical.

3.4 Control Segment Notes

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

3.5 File Delimiters

Puerto Rico Department of Health requests that you use the following delimiters on your file. If used as delimiters, these characters must not be submitted within the data content of the transaction sets. Contact PRMMIS MCO EDI (prmmis_edi_support@dxc.com) if there is a need to use a delimiter other than the following:

- Segment Terminator = ~
- Element Separator = *
- Component Separator = :
- Repetition Separator = ^

Element Separator

Byte 4 in the ISA segment defines the element separator to be used throughout the entire transaction. The recommended element separator is an asterisk (*).

Repetition Separator

ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a caret (^).

Component Separator

ISA16 defines the component separator to be used throughout the entire transaction. The recommended component separator is a colon (:).

Segment Terminator

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

4 PUERTO RICO DEPARTMENT OF HEALTH-SPECIFIC BUSINESS RULES AND LIMITATIONS

4.1 Trading Partner Identification Number

In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS, the EDI team will create any needed Trading Partner Profiles.

4.2 Testing

Module One of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.

4.3 Terminology

The term "subscriber" will be used as a generic term throughout the companion guide.

4.4 Limits

File Size is restricted to 5,000 transactions (claims/encounters) per file. One transaction set includes all data between and including a Transaction ST segment and Transaction SE segment.

4.5 Scheduled Maintenance

Puerto Rico Department of Health schedules regular maintenance every Sunday from 01:00 a.m. to 05:00 a.m. EST.

4.6 Procedures for Voiding Encounters

PRMMIS requires that the MCO's internal Transaction Control Number (TCN) be sent for every claim:

Loop 2330B – Other Payer Name
REF – Other Payer Claim Control Number
REF01 = F8 – Original Reference Number
REF02 = The TCN (in the MCO's system) of the claim being submitted

When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:

Loop: 2300 — CLAIM INFORMATION
REF – PAYER CLAIM CONTROL NUMBER
REF01 = F8 – Original Reference Number
REF02 = The TCN (in the MCO's system) of the encounter being voided

5 ACKNOWLEDGEMENTS AND/OR REPORTS

5.1 Acknowledgements

TA1 — Transaction Acknowledgement

Puerto Rico Department of Health will only respond with a TA1 when the batch X12 contains Envelope errors. If a TA1 is produced, then a 999 will be sent. The submitted 837D will need to be corrected and resubmitted.

999 — Functional Acknowledgement

This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a batch X12 file. Puerto Rico Department of Health will always respond with a 999 for a batch X12 file. If a "rejected" 999 is produced, then claims/encounters will not be sent to the claims engine for adjudication. The submitted 837D will need to be corrected and resubmitted.

6 TRANSACTION-SPECIFIC INFORMATION

This section describes how ASC X12N implementation guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Puerto Rico Department of Health has something additional, over and above, the information in the implementation guides. That information can do the following:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guides' internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Puerto Rico Department of Health.

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

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that Puerto Rico Department of Health has something additional, over and above, the information in the TR3s.

6.1 005010X224A2 — 837D Health Care Claim/Encounter

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
66	None	BHT	Beginning of Hierarchical Transaction		
66	None	BHT02	Transaction Set Purpose Code	00	"00" – Original
67	None	BHT06	Claim Identifier	CH, RP	CH = Claims — Chargeable RP = Encounters — Reporting
69	1000A	NM1	Submitter Name		
70	1000A	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
70	1000A	NM109	Submitter Identifier		Enter the same value as ISA06 'Trading Partner ID' supplied by Puerto Rico Department of Health.
71	1000A	PER	Submitter EDI Contact Information		This segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
71	1000A	PER01	Contact Function Code	IC	"IC" – Information Contact
71	1000A	PER02	Submitter Contact Name		This is required if it's different than the name contained in the Submitter Name (Loop 1000A, NM1 segment).
71	1000A	PER03	Communication Number Qualifier	EM, FX,TE	"EM" – Electronic Mail "FX" – Fax "TE" – Telephone
71	1000A	PER04	Communication Number		Email Address, Fax Number, or Telephone Number (including the area code)

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
74	2100A	NM1	Receiver Name		
75	1000B	NM103	Receiver Name	PUERTO RICO DEPARTMENT OF HEALTH	"PUERTO RICO DEPARTMENT OF HEALTH"
80	1000B	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
75	1000B	NM109	Receiver Primary Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
78	2000A	PRV	Billing Provider Specialty Information		ENCOUNTER – When required for NPI crosswalk, this loop should contain the Taxonomy Code for the Provider paid by the MCO (refer to 2010AA below).
78	2000A	PRV03	Reference Identification		Enter the taxonomy that was reported to Puerto Rico Department of Health for the service you are billing.
82	2010AA	NM1	Billing Provider Name		*Note:* Puerto Rico Department of Health only accepts the use of NPIs as identification for dental providers.
83	2010AA	NM102	Entity Type Qualifier	1, 2	Enter the "1" value to indicate that the biller is a person. Enter the "2" value to indicate that the biller is a non-person entity.
86	2010AA	N3	Billing Provider Address		Enter the address that is currently on file with Puerto Rico Department of Health. *Note:* Do not enter a P.O. Box in this segment. If a P.O. Box needs to be reported, use the Pay-To Address loop.
87	2010AA	N4	Geographic Location		Use the physical address as reported on the provider's Puerto Rico Department of Health certification.
88	2010AA	N403	Billing Provider Postal Zone or ZIP Code		Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department of Health. **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
96	2010AB	NM1	Pay-To Address Name		This loop will not be used by Puerto Rico Department of Health's PRMMIS.
101	2010AC	NM1	Pay-to Plan Name		This loop will only be used for subrogation.
114	2010BA	NM1	Subscriber Name		Enter information about the subscriber/member in this loop.
115	2010BA	NM102	Entity Type Qualifier	1	Enter the value "1" to indicate that the member is a person.
115	2010BA	NM103	Subscriber Last Name		Enter the member's last name.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
115	2010BA	NM104	Subscriber First Name		Enter the member's first name.
115	2010BA	NM108	Identification Code Qualifier	MI	Enter the value "MI" for member identification number.
116	2010BA	NM109	Subscriber Primary Identifier		PRMMIS will only use the last 11 digits of the Puerto Rico Department of Health's member identification number.
123	2010CA	REF	Property and Casualty Patient Identifier		This segment will not be used by Puerto Rico Department of Health.
124	2010BB	NM1	Payer Name		
125	2010BB	NM103	Payer Name	PUERTO RICO DEPARTMENT OF HEALTH	Enter the value "PUERTO RICO DEPARTMENT OF HEALTH".
125	2010BB	NM108	Identification Code Qualifier	PI	"PI" – Payer Identification
125	2010BB	NM109	Payer Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
125	2010BB	N4	Payer City, State, Zip Code		
125	2010BB	N401	City Name	SAN JUAN	
125	2010BB	N402	Payer State Code	PR	
126	2010BB	N403	Payer Postal Zone or ZIP Code	009220000	
123	2010CA	REF	Property and Casualty Patient Identifier		This segment will not be used by Puerto Rico Department of Health.
145	2300	CLM	Claim Information		*Note:* Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when only one encounter is found to be non-compliant, Puerto Rico Medicaid Program (PRMP) requires trading partners to enter Patient Control Number (PCN) and Transaction Control Number (TCN) in CLM01 separated by a dash.
146	2300	CLM01	Patient Control Number		ENCOUNTER – Trading partners should enter the encounter's Patient Control Number (PCN) and Transaction Control Number (TCN) separated by a dash – all characters will be returned in the 835's CLP01 field.
147	2300	CLM02	Total Claim Charge Amount		Enter the total billed amount for the entire claim/encounter.
147	2300	CLM05-3	Claim Frequency Code	1, 7, 8	The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use the claim frequency code to indicate whether the claim/encounter is being submitted for the first time or if it

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					is a replacement/void of a previously adjudicated and "paid" claim/encounter: "1" — Indicates that this is the first claim/encounter submitted to PRMMIS. "7" — Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" — Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. ENCOUNTER – Use "1" as a frequency code when resubmitting a denied claim. *Note:* The use of values "7" and "8" can result in the previously submitted claim/encounter being adjusted. Include the Internal Control Number (ICN) from the previously submitted claim/encounter in the original reference number segment in Loop 2300. The claim frequency code was switched to an external code source during the addenda process. See the NUBC Manual or Web site, www.nubc.org/. ENCOUNTER: Paper submissions/requests will not be supported for encounter processing. ENCOUNTER: MCOs are required to send their claim ID (TCN) for each encounter submitted as well as their claim ID (TCN) for an encounter being voided (refer to Section 4.6 – Procedures for Voiding Encounters).
148	2300	CLM19	Predetermination of Benefits Code		*Note:* Puerto Rico Department of Health does not support predetermination of benefits.
154	2300	DTP	Service Date		
154	2300	DTP01	Date / Time Qualifier	472	"472" – Service
154	2300	DTP02	Date Time Period Format Qualifier	D8, RD8	"D8" – Date expressed in format CCYYMMDD.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					"RD8" – Range of Dates expressed in format CCYYMMDD-CCYYMMDD (including dash).
154	2300	DTP03	Service Date		Service Date
166	2300	REF	Service Authorization Exception Code		*Note:* If all services were not the result of emergency care, submit multiple claims/encounters.
156	2300	DN1	Orthodontic Total Months of Treatment		
156	2300	DN101	Orthodontic Treatment Months Count		The estimated number of treatment months.
156	2300	DN102	Orthodontic Treatment Months Remaining Count		The number of treatment months remaining.
159	2300	PWK	Claim Supplemental Information		Puerto Rico Department of Health's PRMMIS does not use this segment for processing of the claim/encounter.
162	2300	CN1	Contract Information		ENCOUNTER – Required when the encounter claim was paid at the header level. This refers to the contract between the plan and the provider paid by the plan.
162	2300	CN101	Contract Type Code		ENCOUNTER – Required "05" – If provider's services were provided under a capitation agreement, Fee For Service (FFS) encounter claims should indicate the appropriate value as listed in the TR3.
162	2300	CN102	Contract Amount		ENCOUNTER – Required If CN101 = "05", then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
168	2300	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested). ENCOUNTER – MCOs are required to send their Claim ID (TCN) for an encounter being voided (refer to Section 4.6 – Procedures for Voiding Encounters).
168	2300	REF01	Reference Identification Qualifier	F8	"F8" – Original Reference Number

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
168	2300	REF02	Payer Claim Control Number		The ID (TCN), in the MCO's system, of the encounter being voided.
171	2300	REF	Prior Authorization		
172	2300	REF01	Reference Identification Qualifier	G1	"G1" – Prior Authorization Number
172	2300	REF02	Prior Authorization Number		Enter the 10-digit Prior Authorization Number. Enter this number only if the services rendered required and received prior authorization. This number must be entered with the qualifier "G1" (Prior Authorization Number).
190	2310A	NM1	Referring Provider Name		
191	2310A	NM101	Entity Identifier Code	DN, P3	"DN" – Referring Provider Use on the first iteration of this loop. Use if loop is used only once. "P3" – Primary Care Provider Use only if loop is used twice. Use only on second iteration of this loop.
192	2310A	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
192	2310A	NM109	Referring Provider Identifier		
193	2310A	PRV	Referring Provider Specialty Information		
193	2310A	PRV01	Provider Code	RF	"RF" – Referring
193	2310A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
193	2310A	PRV03	Provider Taxonomy Code		Referring Provider Taxonomy Code that is used for claims submitted with NPI.
194	2310A	REF	Referring Provider Secondary Identification		
194	2310A	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
196	2310B	NM1	Rendering Provider Name		*Note*: If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C N403.
197	2310B	NM101	Entity Identifier Code	82	"82" – Rendering Provider
198	2310B	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
198	2310B	NM109	Rendering Provider Identifier		

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
199	2310B	PRV	Rendering Provider Specialty Information		
199	2310B	PRV01	Provider Code	PE	"PE" – Performing
199	2310B	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
199	2310B	PRV03	Provider Taxonomy Code		Rendering Provider Taxonomy Code that is used for claims submitted with NPI.
200	2310B	REF	Rendering Provider Secondary Identification		
200	2310B	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
202	2310C	NM1	Service Facility Name		*Note:* Required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider). *Note:* If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C N403.
203	2310C	NM101	Entity Identifier Code	77	"77" – Service Location
203	2310C	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
204	2310C	NM109	Laboratory or Facility Primary Identifier		
205	2310C	N3	Service Facility Location Address		
205	2310C	N301	Laboratory or Facility Address Line		Service Facility Location Address Line
206	2310C	N4	Service Facility Location City, State, Zip Code		
206	2310C	N401	Laboratory or Facility City Name		Service Facility Location City
207	2310C	N402	Laboratory or Facility State or Province Code		Service Facility Location State
207	2310C	N403	Laboratory or Facility Postal Zone or ZIP Code		Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
221	2320	SBR	Other Subscriber Information		ENCOUNTER – Loop 2320 (Other Subscriber Information) is required on all encounter claims. *Note:* For encounter claims, the MCO should always be reported as one of the other payers. For example, when

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					there is Third Party Liability (TPL), the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
224	2320	SBR09	Claim Filing Indicator Code		ENCOUNTER – When the MCO is the payer the value should be "HM". *Note:* All valid values will be accepted for other payer loops.
225	2320	CAS	Claim Level Adjustments		
227	2320	CAS02	Adjustment Reason Code	A1	ENCOUNTER – "A1" – MCO denied claim
227	2320	CAS03	Adjustment Amount		
231	2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		
231	2320	AMT01	Amount Qualifier Code	D	"D" – Payer Amount Paid
231	2320	AMT02	Payer Paid Amount		Other Payer Amount Paid (TPL or MCO)
246	2330B	NM1	Other Payer Name		ENCOUNTER – Loop 2330B (Other Payer Name) is required on all encounter claims. *Note*: For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is Third Party Liability (TPL), the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
247	2330B	NM109	Other Payer Primary Identifier		This number must be identical to at least one occurrence of the 2430-SVD01 to identify the other payer. Puerto Rico Department of Health captures Third Party Payment Amount(s) from the service line(s) in 2430-SVD02. *Note*: The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail. ENCOUNTER – This value should be the MCO's assigned Trading Partner ID.
258	2330B	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal Claim ID be entered here for every encounter.
258	2330B	REF01	Reference Identification Qualifier	F8	Original Reference Number
258	2330B	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
281	2400	LX	Service Line Number		
281	2400	LX01	Assigned Number		Puerto Rico Department of Health accepts up to the HIPAA-allowed 50 detail lines per claim/encounter. The claim/encounter would need to be split to submit more than 50 detail lines.
282	2400	SV3	Dental Service		
282	2400	SV304-1	Oral Cavity Designation Code		Enter the appropriate Mouth Quadrant code for each procedure. Only the first value listed for each procedure is used to process the claim. Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both.
288	2400	TOO	Tooth Information		
288	2400	TOO01	Code List Qualifier Code	JP	"JP" – Universal National Tooth Designation System
288	2400	TOO02	Tooth Code		Enter the appropriate two-digit Tooth Number on the detail line for each procedure. Each line should contain only one Tooth Number (for permanent teeth) or Tooth Character (for primary teeth). Refer to the National Standards Tooth Numbering System for the appropriate Tooth Number or Tooth Letter for the procedure. Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both.
289	2400	TOO03-1	Tooth Surface Code		Enter the appropriate Tooth Surface code for each procedure. Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both.
290	2400	DTP	Service Date		
290	2400	DTP01	Date/ Time Qualifier	472	"472" – Service This DTP Segment is required if the Dates of Service are different than

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					those submitted within the 2300-DTP03, where DTP01 = 472.
290	2400	DTP02	Date Time Period Format Qualifier	D8	"D8" – Date expressed in format CCYYMMDD.
290	2400	DTP03	Service Date		
296	2400	CN1	Contract Information		ENCOUNTER – This information is required on all encounter claims paid at the line level. This refers to the contract between the plan and the provider paid by the plan.
296	2400	CN101	Contract Type Code		ENCOUNTER – Required "05" – If provider's services were provided under a capitation agreement, Fee For Service encounter claims should indicate the appropriate value as listed in the TR3.
296	2400	CN102	Contract Amount		ENCOUNTER – Required If CN101 = "05", then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (SVD02 in 2430 loop) and CN102 contains the amount that the health plan paid the provider for this detail.
316	2420A	NM1	Rendering Provider Name		*Note*: This is required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is different than the Billing/Pay-To Provider (2010AA\AB).
318	2420A	NM108	Identification Code Qualifier	XX	XX = Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers
318	2420A	NM109	Rendering Provider Identifier		National Provider Identifier (NPI)
319	2420A	PRV	Rendering Provider Specialty Information		Used for claims submitted with NPI.
319	2420A	PRV01	Provider Code	PE	"PE" – Performing
319	2420A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
319	2420A	PRV03	Provider Taxonomy Code		Rendering Provider Taxonomy Code
320	2420A	REF	Rendering Provider Secondary Identification		
320	2420A	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number Non-healthcare providers must send this REF segment where REF01 = G2.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
333	2420D	NM1	Service Facility Name		*Note*: This is required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider).
334	2420D	NM101	Entity Identifier Code	77	"77" – Service Location
334	2420D	NM102	Entity Type Qualifier	2	"2" – Non-Person Entity
334	2420D	NM102	Laboratory or Facility Name		
334	2420D	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
334	2420D	NM109	Laboratory or Facility Primary Identifier		
336	2420D	N3	Service Facility Location Address		
336	2420D	N301	Laboratory or Facility Address Line		
337	2420D	N4	Service Facility Location City, State, Zip Code		
337	2420D	N401	Laboratory or Facility City Name		
338	2420D	N402	Laboratory or Facility State or Province Code		
338	2420D	N403	Laboratory or Facility Postal Zone or ZIP Code		Must be nine digits **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
339	2420D	REF	Service Facility Location Secondary Identification		
339	2420D	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note*: The "G2" qualifier should only be used for non-healthcare providers.
340	2420D	REF02	Service Facility Location Secondary Identifier		
341	2430	SVD	Line Adjudication Information		ENCOUNTER – Loop 2430 is required on all encounter claims. *Note*: Other payer payment amounts are required to be entered at the detail level.
341	2430	SVD01	Other Payer Primary Identifier		This should match one occurrence of the 2330B – NM109 identifying Other Payer.
342	2430	SVD02	Service Line Paid Amount		Enter the Third Party Payment Amount or amount health plan paid to provider at the detail level only. This is also used for crossover detail paid amount.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					ENCOUNTER – If CN101 = "05", SVD02 should be zero. If CN101 = "09", then SVD02 should be the detail other payer paid amount or amount health plan paid to provider.
345	2430	CAS	Line Adjustment		
346	2430	CAS02	Adjustment Reason Code	A1	ENCOUNTER – "A1" – MCO denied claim
346	2430	CAS03	Adjustment Amount		
490	2430	DTP	Line Check or Remittance Date		ENCOUNTER – Claim will be denied if all the dates at the detail level are not the same date.

A. APPENDIX A

A.1 Change History

Version 1.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					Initial submission

A.2 Change History

Version 2.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	16		Specific business rules and limitations		Added new text for PRMMIS procedure for Voiding encounters
2300	23	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested).
2300	23	REF02	Payer Claim Control Number		The ID, in the MCO's system, of the encounter being voided
2330B	29	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal claim ID be entered here for every encounter.
2330B	29	REF01	Reference Identification Qualifier	F8	Original Reference Number
2330B	29	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted

A.3 Change History

Version 3.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	7		Introduction		Change Section 10 to Section 6.
2300	20	CLM02	Total Claim Charge Amount		Remove Note: *"Note:* Puerto Rico Department of Health interChange will process claims/encounters submitted with a negative billed amount as if the provider submitted a zero billed amount."
2300	22	PWK06	Attachment Control Number		Remove text: Please see page 16, "Hard Copy Attachments."
2300	23	CN101	Contract Type Code	05,09	Replace text with: ENCOUNTER - Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	23	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	23	CN103	Contract Percentage		Remove row.
2300	24	HI	Health Care Diagnosis Code		Remove segment.
2310A	25	REF01	Reference Identification Qualifier	0B, G2G2	Modify text: "0B" – State License Number "G2" – Provider Commercial Number *Note:* This is not required for nursing homes.

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					Note: The "G2" qualifier must be used for non-healthcare providers.
2310B	25	REF01	Reference Identification Qualifier	0B, G2G2	Modify text: "0B" – State License Number "G2" – Provider Commercial Number *Note:* This is not required for nursing homes. *Note:* The "G2" qualifier must be used for non-healthcare providers.
2310C	25	NM1	Service Facility Name		Remove text: NOTE: If a zip code is required in the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C.
2330B	27	NM1	Other Payer Name		Remove text: NOTE: If a zip code is required in the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C.
2420D	30	REF04-1	Reference Identification Qualifier		Remove row.

A.4 Change History

Version 3.1 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 09-09-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
Section 1.1	8		Scope		Modify text: For further information, contact **their policy-specific** area of the Puerto Rico Department of Health or PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCO) and clearinghouses
Section 1.2	8		Overview		Remove text: This information should be given to the provider's business area to ensure that Claim/Encounters are interpreted correctly.
Section 1.4	9		National Provider Identifier		Modify text in third paragraph: All providers, except those that the Puerto Rico Department of Health determined as not a healthcare provider such as non-emergency transportation
Section 1.4	9		File/System Specifications		Remove text: The recommended extension is .txt or .dat. EDI does not allow zipped files. Files will be submitted to EDI via STFP. Add text: The following standards should be used: To avoid accidently overwriting files, do not send multiple files with the same name on the same day. File Names should not be longer than 45 characters

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					File Names should not contain spaces or special characters File Names should contain a file extension such as .dat or .txt Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file Zip files must contain the extension .zip (not case sensitive)
Section 1.4	9		Negative Dollar Amounts		New Paragraph: Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
Section 2.1	11		Process Flow		Modify text: classified as "paid".
N/A	12	ISA01	Authorization Information Qualifier		Remove text: "00" – No Authorization Information Present.
N/A	12	ISA02	Authorization Information		Remove text: Claim - [space fill]
N/A	13	ISA14	Acknowledgement Requested	0	Remove code 1 & comment.
Section 4.1	16		Trading Partner Identification Number		Modify test: In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS the EDI team will create any needed Trading Partner Profiles.
Section 4.2	16		Testing		Modify Text: Module one of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.
Section 4.4	16		Limits		Modify text: File Size is restricted to 5,000 transactions (claims/encounters) per file
Section 4.6	16		Procedures for Voiding Encounters		Modify text: When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010AB	19	NM1	Pay-To Address Name		Modify text: This loop will not be used by Puerto Rico Department of Health's PRMMIS.
2010BA	20	NM109	Subscriber Primary Identifier		Change text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. Remove Text: *Note:* Do not enter any other numbers or letters. Use the Puerto Rico Department of Health card or the EVS to obtain the correct identification number.
2300	20	CLM01	Patient Control Number		Modify Note/Comment: *Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length. Encounters: MCO should send the original PCN from the provider's original claim.
2300	21	CLM05-3	Claim Frequency Code		Modify Note/Comment: "1" — Indicates that this is the first claim/encounter submitted to the PRMMIS. "7" — Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" — Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. Encounter: Paper submissions/requests will not be supported for encounter processing. Remove Note/Comment:

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					Electronic adjustments are subject to the same requirements as paper adjustments and therefore may result in a letter to the provider if the requirements are not met. Do not use adjustment values if reconsideration of the original payment is needed. All requests for reconsideration should be submitted on paper with supporting documentation. Add Note/Comment: Encounter: MCOs are required to send their claim ID (TCN) for each encounter submitted as well as their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
2300	22	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" -- If provider's services were provided under a capitation agreement. "09" - FFS
2300	22	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	22	PWK	Claim Supplemental Information		Modify Note/Comment: Puerto Rico Department of Health PRMMIS does not use this field for processing of the claim/encounter
2300	22	PWK01 thru PWK05			Delete rows.

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	23	REF	Payer Claim Control Number		Add Note/Comment: Encounter: MCOs are required to send their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
2300	25	REF02	Payer Claim Control Number		Add Note/Comment: The ID (TCN), in the MCO's system, of the encounter being voided.
2300	25	REF	Claim Identifier for Transmission Intermediaries		Remove Segment
2310A	25	REF01	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2310B	24	REF01	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2320	25	CAS02	Adjustment Reason Code	A1	Remove text: All external code source values from code source 139 are allowed.
2320	25	CAS05 thru CAS17	Adjustment Reason Code		Delete rows.
2400	26	LX01	Assigned Number		Add text: Puerto Rico Department of Health accepts up to the HIPAA allowed 50 detail lines per claim/encounter. The claim/encounter would need to be split to submit more than 50 detail lines.
2430	28	SVD	Line Adjudication Information		Change name of segment and remove (name loop) from Notes/Comments
2430	28	SVD01	Other Payer Primary Identifier		Remove number from Notes/Comments
2430	28	SVD02	Service Line Paid Amount		Modify text: Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the detail level only. This is also used for crossover detail paid amount. ENCOUNTER - If CN101 = 05, SVD02 should be zero. If CN101 = 09, then SVD02 should be the detail other

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					payer paid amount OR amount health plan paid to provider.
2430	29	CAS02	Adjustment Reason Code	A1	Remove text: All external code source values from code source 139 are allowed.
2430	29	CAS05 thru CAS18	Adjustment Reason Code & Adjustment Amount		Delete rows.
N/A	34		Section 7 – Appendix A		Remove Section 7

A.5 Change History

Version 4.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 10-24-17

Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	10	Section 1.4	Additional Information		Remove text: **Negative Dollar Amounts** Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
2010BA	20	NM109	Subscriber Primary Identifier		Add text: ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID.
2320	24	SBR09	Claim Filing Indicator Code	16, CI,HM, MA, MB	Modify text: "16" – HMO Medicare Risk (required for Medicare Part C claims) "CI" – Commercial Insurance "HM" – Managed Care Organization "MA" – Medicare Part A "MB" – Medicare Part B
2330B	25	NM109	Other Payer Primary Identifier		Add text: ENCOUNTER – This value should be the MCO's assigned trading partner ID.
2300	25	DTP	Claim Check or Remittance Date		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.
2330B	25	DTP	Claim Check or Remittance Date		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.
2400	27	CN1	Contract Information		Add text: ENCOUNTER - This information is required on all encounter claims. This refers to the contract between the plan and the provider paid by the plan.

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2400	27	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" -- If provider's services were provided under a capitation agreement. "09" - FFS
2400	27	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.

A.6 Change History

Version 5.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-17-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	22	CN1	Contract Information		Modify the text: ENCOUNTER – Required:when the encounter claim was paid at the header level This refers to the contract between the plan and the provider paid by the plan.
2300	22	CN101	Contract Type Code	~~05, 09~~	Modify the text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. And no other value applies. "09" – FFS
2300	22	CN102	Contract Amount		Modify the text: If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered.
2300	23	NTE	Claim Notes		Remove Segment
2300	23	NTE01	Note Reference Code	ADD	Remove line
2300	23	NTE02	Claim Note Text		Remove line
2320	25	SBR09	Claim Filing Indicator Code	~~16, CI, HM, MA, MB~~	Modify the text: ~~"16" – HMO Medicare Risk (required for Medicare Part C claims).~~ ~~"CI" – Commercial Insurance~~ ~~"HM" – Managed Care Organization~~ ~~"MA" – Medicare Part A~~ ~~"MB" – Medicare Part B~~ ENCOUNTER: When the MCO is the payer the value should be "HM" *NOTE:* All valid values will be accepted for other payer loops.
2330B	25	DTP	Claim Check or Remittance Date		Remove Segment

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2330B	25	DTP01	Date / Time Qualifier	573	Remove Line: "573" – Other Payer or MCO Claim Adjudication Date
2330B	25	DTP02	Date Time Period Format Qualifier	D8	Remove Line: "D8" – Date Expressed in Format CCYYMMDD
2330B	25	DTP03	Adjudication or Payment Date		Remove Line: TPL or MCO Adjudication Date (CCYYMMDD)
2400	27	CN1	Contract Information		Modify text: ENCOUNTER - This information is required on all encounter claims paid at the line level. This refers to the contract between the plan and the provider paid by the plan.
2400	27	CN101	Contract Type Code	~~05, 09~~	Modify the text: ENCOUNTER "05" – If provider's services were provided under a capitation agreement. FFS encounter claims should indicate the appropriate value as listed in the TR3.
2400	27	CN102	Contract Amount		Modify the text: ENCOUNTER If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider..

A.7 Change History

Version 6.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 03-01-19
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010BA	20	NM109	Subscriber Primary Identifier		Old text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID. New text: PRMMIS will only use the last 11 digits of the Puerto Rico Department of Health's member identification number.
2300	20	CLM	Claim Information		Add text: NOTE: Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when one encounter is found to be non-compliant, the recommendation is to enter TCN in CLM02.
2430	28	DTP	Line Check or Remittance Date		Add new segment: ENCOUNTER – Claim will be denied if all the dates at the detail level are not the same date.

A.8 Change History

Version 7.0 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 05-05-20
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	20	CLM	Claim Information		New text *Note:* Because duplicate CLM01 values within ST/SE

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					loop will cause all encounters to be rejected, even when only one encounter is found to be non-compliant, PRMP requires trading partners to enter PCN and TCN in CLM01 separated by a dash.
2300	20	CLM01	Patient Control Number		New text ENCOUNTER: Trading partners should enter encounter's PCN and TCN separated by a dash – all characters will be returned in the 835's CLP01 field.

A.9 Change History

Version 7.1 Revision Log
Companion Document: 837D Health Care Dental Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-10-21
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010AA	19	N403	Billing Provider Postal Zone or ZIP Code		New text Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department of Health. **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
2310C	24	N403	Laboratory or Facility Postal Zone or ZIP Code		New text: Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
2420D	28	N403	Laboratory or Facility Postal Zone or ZIP Code		Must be nine digits **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**

GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3) Implementation Guides Based on ASC X12 Version 005010X223A2 Institutional Health Care Claim/Encounter (837I)

Companion Guide Version Number: 7.2

November 2021

Puerto Rico Medicaid Management Information System Services Project

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 00002

NÚMERO DE CONTRATO

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Preface

This companion guide to the v5010 ASC X12N Technical Report Type 3 (TR3) adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with the Puerto Rico Department of Health. Transmissions based on this companion guide, used in tandem with the TR3, also called the Health Care Institutional Claim/Encounter ASC X12N version 005010X223A2 (837I), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. To access the HIPAA Implementation Guides, please contact the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).





Disclaimer: The information contained in this Companion Guide is subject to change.

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Table of Contents

1 INTRODUCTION 7

1.1 Scope 8

1.2 Overview 8

1.3 References 9

1.4 Additional Information 9

National Provider Identifier 9

Acceptable Characters 10

File/System Specifications 10

2 CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS 11

2.1 Process Flows 11

2.2 Transmission Administrative Procedures 11

2.3 Communication Protocol Specifications 11

Batch 11

3 CONTROL SEGMENTS / ENVELOPES 12

3.1 ISA-IEA 12

Interchange Control Header (ISA) 12

IEA – Interchange Control Header 13

3.2 GS-GE 13

Functional Group Header (GS) 13

Functional Group Trailer (GE) 14

3.3 ST-SE 14

TRANSACTION SET HEADER (ST) 14

TRANSACTION SET TRAILER (SE) 15

3.4 Control Segment Notes 15

3.5 File Delimiters 15

Element Separator 15

Repetition Separator 15

Component Separator 15

Segment Terminator 15

4 PUERTO RICO DEPARTMENT OF HEALTH-SPECIFIC BUSINESS RULES AND LIMITATIONS . 16

4.1 Trading Partner Identification Number 16

4.2 Testing 16

4.3 Terminology 16

4.4 Limits 16

4.5 Scheduled Maintenance 16

4.6 Procedures for Voiding Encounters 16

5 ACKNOWLEDGEMENTS AND/OR REPORTS 17

5.1 Acknowledgements 17

TA1 — Transaction Acknowledgement 17

999 — Functional Acknowledgement 17

6 TRANSACTION-SPECIFIC INFORMATION 18

6.1 005010X223A2 — 837I Health Care Claim/Encounter 18

A. APPENDIX A 30

A.1 Change History 30

A.2 Change History 31

A.3 Change Summary 32

A.4 Change Summary 34

A.5 Change History 42

A.6 Change History 43

A.7 Change History 45

A.8 Change History 46

1 INTRODUCTION

This section describes how TR3, also called 837I ASC X12N (version 005010X223A2), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that Puerto Rico Department of Health has information additional to the TR3. That information can:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guides' internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Puerto Rico Department of Health.

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

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column to provide additional information from Puerto Rico Department of Health for specific segments provided by the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in Section 6: TRANSACTION-SPECIFIC INFORMATION.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10 percent and notes or comments about the segment itself go in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Puerto Rico Department of Health.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value "N6" is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and how to specify that only one code value is applicable.

1.1 Scope

This companion guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 837I (referred to as Institutional Claim/Encounter in the rest of this document) for the purpose of submitting 837I electronically. This companion guide is not intended to replace the TR3. The TR3s define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of this companion guide is to provide trading partners with a guide to communicate Puerto Rico Department of Health-specific information required to successfully exchange transactions electronically with Puerto Rico Department of Health. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

The information contained in this companion guide applies to Puerto Rico Department of Health for processing.

Puerto Rico Department of Health will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain Puerto Rico Department of Health-specific information, though processed, may be denied. For example, a compliant 837I Claim/Encounter created with an invalid Puerto Rico Department of Health member identification number will be processed by Puerto Rico Department of Health, but will be denied. For questions regarding appropriate billing procedures, as well as for policy and billing information, providers should refer to their policy-specific area of the Puerto Rico Department of Health.

Refer to this companion guide first if there is a question about how Puerto Rico Department of Health processes a HIPAA transaction. For further information, contact their policy-specific area of the Puerto Rico Department of Health or PRMMIS MCO EDI (prmmis_edi_support@gainwelltechnologies.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCOs) and clearinghouses with Puerto Rico Department of Health in successfully conducting EDI of administrative health care transactions. This document provides instructions for obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.2 Overview

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

The HIPAA requirements serve to:

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

This guide is designed to help those responsible for testing and setting up electronic Institutional Claim/Encounter transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting, and identifies codes and data elements that do not apply to Puerto Rico Department of Health. This guide supplements (but does not contradict) requirements in the ASC X12N 837I (version 005010X223A2) Implementation Guide. This guide provides communications-related information that a trading partner needs to enroll as

a trading partner, obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with Puerto Rico Department of Health.

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist trading partners in implementing electronic 837I transactions that meet Puerto Rico Department of Health processing standards by identifying pertinent structural and data-related requirements and recommendations.

1.3 References

For more information regarding the ASC X12 Standards for Electronic Data Interchange 837I Health Care Claim/Encounter (version 005010X223A2) and to purchase copies of the TR3 documents, consult the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

The implementation guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The implementation guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that the provider's Information Technology (IT) staff or software vendor review this document in its entirety and follow the stated requirements to exchange HIPAA-compliant files with Puerto Rico Department of Health.

To obtain the Provider taxonomy code set, please contact the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

1.4 Additional Information

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

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

National Provider Identifier

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

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

All providers, except those that the Puerto Rico Department of Health determined to not identify as a healthcare provider such as non-emergency transportation, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. Puerto Rico Department of Health requires all health care providers to submit their NPI on electronic transactions.

Acceptable Characters

The HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. Puerto Rico Department of Health accepts the extended character set. Uppercase characters are recommended. Files should be less than 100 MB.

File/System Specifications

EDI only accepts Windows/PC/DOS formatted files. Any file transmitted to EDI must be named in accordance to standard file naming conventions, including a valid three-character file extension. The following standards should be used:

- To avoid accidently overwriting files, do not send multiple files with the same name on the same day.
- File Names should not be longer than 45 characters.
- File Names should not contain spaces or special characters.
- File Names should contain a file extension such as .dat or .txt.
- Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file.
- Zip files must contain the extension .zip (not case sensitive).

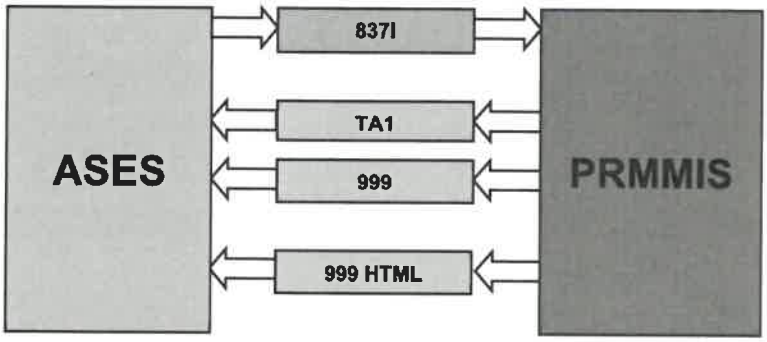
2 CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS

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

2.1 Process Flows

This section contains process flow diagrams and appropriate text.
Each transaction is validated to ensure that the 837I complies with the 005010X223A2 TR3.

Transactions that fail this compliance check will generate a "Rejected" 999 file back to the sender with an error message indicating the compliance error. Transactions that pass this compliance check will generate an "Accepted" 999 file back to the sender with AK9*A to indicate that the file passed compliance. Transactions with multiple ST/SE loops that fail this compliance check in some of the ST/SE loops will generate a "Partial" 999 file back to the sender with an error message indicating the compliance error (all claims/encounters in the ST/SE envelopes that pass compliance will be processed). Claims/Encounters that pass compliance checks but fail to process (e.g., due to member not being found) will be denied. Claims/Encounters that pass compliance checks and have not failed to process (e.g., the member was found with enrollment within the date(s) of service) will be classified as "paid."



2.2 Transmission Administrative Procedures

This section provides Puerto Rico Department of Health's-specific transmission administrative procedures.

The trading partner must determine if the transmission being sent is Test or Production and is using the appropriate indicator (ISA15). For details about available Puerto Rico Department of Health access methods, refer to the Communication Protocol Specifications section.

Puerto Rico Department of Health is available only to authorized users. Submitters must be Puerto Rico Department of Health trading partners. A submitter is authenticated using a username and password assigned by the trading partner.

2.3 Communication Protocol Specifications

This section describes Puerto Rico Department of Health's communication protocol(s).
The following communication methods are available to get a member's Eligibility and Benefits from Puerto Rico Department of Health:

Batch

Trading partners can submit all batch transactions to Puerto Rico Department of Health and download acknowledgements and response files. Access is free; however, the user must have his or her own internet connection to access the web application.

3 CONTROL SEGMENTS / ENVELOPES

3.1 ISA-IEA

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

Interchange Control Header (ISA)

To promote efficient, accurate electronic transaction processing, please note the following Puerto Rico Department of Health specifications:

- Each trading partner is assigned a Trading Partner ID.
- All dates are in the CCYYMMDD format. Except for ISA09.
- All dates/times are in the CCYYMMDDHHMM format.
- Payer IDs can be found in the companion guides.
- Batch responses are not returned until all inquiries are processed. Limiting the number of total inquiries per ISA-IEA will produce faster results.
- Each Payer ID must be in its own file.
- No more than 999 claims/encounters per Transaction Set (ST-SE).
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Transactions transmitted as a batch are identified by an ISA and trailer segment (IEA), which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The table below represents only those fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction — the TR3 should be reviewed for that information.

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

Note: Puerto Rico Department of Health accepts files with one ISA/IEA loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.3	None	ISA	Interchange Control Header		
C.4		ISA01	Authorization Information Qualifier	03	ENCOUNTER – "03" – Additional Data Identification
C.4		ISA02	Authorization Information		ENCOUNTER – MCO Medicaid ID + [space fill]
C.4		ISA03	Security Information Qualifier	00	00 = No Security Information Present
C.4		ISA04	Security Information		[space fill]
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	ZZ = Mutually defined
C.4		ISA06	Interchange Sender ID		Trading Partner ID supplied by Puerto Rico Department of Health, left-justified and space-filled.
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	ZZ = Mutually defined
C.5		ISA08	Interchange Receiver ID	PRMMIS	"PRMMIS" – left-justified and space-filled.
C.5		ISA09	Interchange Date		The date format is YYMMDD.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.5		ISA10	Interchange Time		The time format is HHMM.
C.5		ISA11	Repetition Separator	^	A Caret "^" is recommended.
C.5		ISA12	Interchange Control Version Number	00501	00501 = Control Version Number
C.5		ISA13	Interchange Control Number		The interchange control number assigned in ISA13 must be identical to the value in IEA02.
C.6		ISA14	Acknowledgement Requested	0	0 = No interchange acknowledgment requested (TA1)
C.6		ISA15	Usage Identifier	P, T	Code indicating whether the data enclosed is Production or Test.
			Production Data	P	Enter value "P" to indicate that the file contains Production data.
			Test Data	T	Enter value "T" to indicate that the file contains Test data.
C.6		ISA16	Component Separator	:	A colon ":" is recommended.

IEA – Interchange Control Header

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.10	None	IEA	Interchange Control Trailer		
C.10		IEA01	Number of Included Functional Groups		Number of included Functional Groups
C.10		IEA02	Interchange Control Number		Must be identical to the value in ISA13

3.2 GS-GE

This section describes Puerto Rico Department of Health's use of the functional group control segments.

It includes a description of expected application sender and receiver codes.

Functional Group Header (GS)

In the table below are fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

Note: Puerto Rico Department of Health only accepts files with one GS/GE loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	None	GS	Functional Group Header		
C.7		GS01	Functional ID Code	HC	"HC" – Health Care Institutional Claim/Encounter (837I)

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7		GS02	Application Sender's Code		'Trading Partner ID' supplied by Puerto Rico Department of Health.
C.7		GS03	Application Receiver's Code	PRMMIS	'PRMMIS' Puerto Rico Department of Health Sender ID.
C.7		GS04	Date		The date format is CCYYMMDD.
C.8		GS05	Time		The time format is HHMM.
C.8		GS06	Group Control Number		Group Control Number – Must be identical to GE02.
C.8		GS07	Responsible Agency Code	X	"X" – Responsible Agency Code
C.8		GS08	Version / Release / Industry Identifier Code	005010X223A2	Version / Release / Industry Identifier Code

Functional Group Trailer (GE)

In the table below are fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.9	None	GE	Functional Group Trailer		
C.9		GE01	Number of Transaction Sets Included		Total number of transaction sets
C.9		GE02	Group Control Number		Must be identical to the value in GS06

3.3 ST-SE

This section describes Puerto Rico Department of Health's use of transaction set control numbers.

Puerto Rico Department of Health recommends that trading partners follow the guidelines set forth in the TR3 — start the first ST02 in the first file with "000000001" and increment from there. The TR3 should be reviewed for how to create compliant transaction set control segments.

TRANSACTION SET HEADER (ST)

The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
70	None	ST	Transaction Set Header		
70		ST01	Transaction Set Identifier Code	837	837 Health Care Claim
70		ST02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA).
70		ST03	Implementation Guide Version Name	005010X223A2	This field contains the same value as GS08.

TRANSACTION SET TRAILER (SE)

The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
496	None	SE	TRANSACTION SET TRAILER		
496		SE01	Transaction Segment Count		Total number of transaction sets
496		SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical.

3.4 Control Segment Notes

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

3.5 File Delimiters

Puerto Rico Department of Health requests that you use the following delimiters on your file. If used as delimiters, these characters must not be submitted within the data content of the transaction sets. Contact PRMMIS MCO EDI (prmmis_edi_support@gainwelltechnologies.com) if there is a need to use a delimiter other than the following:

- Segment Terminator = ~
- Element Separator = *
- Component Separator = :
- Repetition Separator = ^

Element Separator

Byte 4 in the ISA segment defines the element separator to be used throughout the entire transaction. The recommended element separator is an asterisk (*).

Repetition Separator

ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a caret (^).

Component Separator

ISA16 defines the component separator to be used throughout the entire transaction. The recommended component separator is a colon (:).

Segment Terminator

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

4 PUERTO RICO DEPARTMENT OF HEALTH-SPECIFIC BUSINESS RULES AND LIMITATIONS

4.1 Trading Partner Identification Number

In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS, the EDI team will create any needed Trading Partner Profiles.

4.2 Testing

Module One of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.

4.3 Terminology

The term "subscriber" will be used as a generic term throughout the companion guide.

4.4 Limits

File Size is restricted to 5,000 transactions (claims/encounters) per file. One transaction set includes all data between and including a Transaction ST segment and Transaction SE segment.

4.5 Scheduled Maintenance

Puerto Rico Department of Health schedules regular maintenance every Sunday from 01:00 a.m. to 05:00 a.m. EST.

4.6 Procedures for Voiding Encounters

PRMMIS requires that the MCO's internal Transaction Control Number (TCN) be sent for every claim:

Loop 2330B – Other Payer Name
REF – Other Payer Claim Control Number
REF01 = F8 – Original Reference Number
REF02 = The TCN (in the MCO's system) of the claim being submitted

When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:

Loop: 2300 — CLAIM INFORMATION
REF – PAYER CLAIM CONTROL NUMBER
REF01 = F8 – Original Reference Number
REF02 = The TCN (in the MCO's system) of the encounter being voided

5 ACKNOWLEDGEMENTS AND/OR REPORTS

5.1 Acknowledgements

TA1 — Transaction Acknowledgement

Puerto Rico Department of Health will only respond with a TA1 when the batch X12 contains Envelope errors. If a TA1 is produced, then a 999 will be sent. The submitted 837I will need to be corrected and resubmitted.

999 — Functional Acknowledgement

This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a batch X12 file. Puerto Rico Department of Health will always respond with a 999 for a batch X12 file. If a "rejected" 999 is produced, then claims/encounters will not be sent to the claims engine for adjudication. The submitted 837I will need to be corrected and resubmitted.





6 TRANSACTION-SPECIFIC INFORMATION

This section describes how ASC X12N implementation guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Puerto Rico Department of Health has something additional, over and above, the information in the implementation guides. That information can do the following:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guides' internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Puerto Rico Department of Health.

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

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that Puerto Rico Department of Health has something additional, over and above, the information in the TR3s.

6.1 005010X223A2 — 837I Health Care Claim/Encounter

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
66	None	BHT	Beginning of Hierarchical Transaction		
66	None	BHT02	Transaction Set Purpose Code	00	"00" – Original
67	None	BHT06	Claim Identifier	CH, RP	CH = Claims — Chargeable RP = Encounters — Reporting
69	1000A	NM1	Submitter Name		
70	1000A	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
70	1000A	NM109	Submitter Identifier		Enter the same value as ISA06 'Trading Partner ID' supplied by Puerto Rico Department of Health.
71	1000A	PER	Submitter EDI Contact Information		This segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
71	1000A	PER01	Contact Function Code	IC	"IC" – Information Contact
71	1000A	PER02	Submitter Contact Name		This is required if it's different than the name contained in the Submitter Name (Loop 1000A, NM1 segment).
71	1000A	PER03	Communication Number Qualifier	EM, FX, TE	"EM" – Electronic Mail "FX" – Fax "TE" – Telephone
71	1000A	PER04	Communication Number		Email Address, Fax Number, or Telephone Number (including the area code)

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
74	2100A	NM1	Receiver Name		
75	1000B	NM103	Receiver Name	PUERTO RICO DEPARTMENT OF HEALTH	"PUERTO RICO DEPARTMENT OF HEALTH"
75	1000B	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
75	1000B	NM109	Receiver Primary Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
80	2000A	PRV	Billing Provider Specialty Information		*Note:* Taxonomy codes are only required if the National Provider Identifier (NPI) has multiple certifications and the taxonomy is necessary to determine the appropriate one.
80	2000A	PRV01	Provider Code	BI	"BI" – Billing
80	2000A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
80	2000A	PRV03	Provider Taxonomy Code		Enter the taxonomy that was reported to Puerto Rico Department of Health for the service you are billing.
84	2010AA	NM1	Billing Provider Name		ENCOUNTER – This loop should contain the NPI information for the Provider paid by the MCO. *Note:* For MCO Plan ID submission information, refer to ISA01 and ISA02.
85	2010AA	NM102	Entity Identifier Code	85	"85" – Billing Provider
86	2010AA	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
86	2010AA	NM109	Billing Provider Identifier		HIPAA National Provider Identifier
87	2010AA	N3	Billing Provider Address		Enter the address that is currently on file with Puerto Rico Department of Health. *Note:* Do not enter a P.O. Box in this segment. If a P.O. Box needs to be reported, use the Pay-To Address loop.
88	2010AA	N4	Geographic Location		Use the physical address as reported on the provider's Puerto Rico Department of Health certification.
88	2010AA	N403	Billing Provider Postal Zone or ZIP Code		Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department of Health. **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
90	2010AA	REF	Billing Provider Tax Identification		
90	2010AA	REF01	Reference Identification Qualifier	EI	"EI" – Employer ID Number (EIN)
90	2010AA	REF02	Billing Provider Tax Identification Number		Valid nine-digit Employer ID number
94	2010AB	NM1	Pay-To Address Name		This loop will not be used by Puerto Rico Department of Health's PRMMIS.
107	2000B	HL	Subscriber Hierarchical Level		*Note:* For Puerto Rico Department of Health, the insured and the patient are always the same person. Use this HL segment to identify the recipient and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop may not process correctly.
108	2000B	HL03	Hierarchical Level Code	22	"22" – Subscriber
108	2000B	HL04	Hierarchical Child Code	0	"0" – No Subordinate HL Segment in this Hierarchical Structure.
109	2000B	SBR	Subscriber Information		
110	2000B	SBR09	Claim Filing Indicator Code	MC	"MC" = Medicaid
112	2010BA	NM1	Subscriber Name		Enter information about the subscriber/member in this loop.
113	2010BA	NM102	Entity Type Qualifier	1	Enter the value "1" to indicate that the member is a person.
113	2010BA	NM103	Subscriber Last Name		Enter the member's last name.
113	2010BA	NM104	Subscriber First Name		Enter the member's first name.
113	2010BA	NM108	Identification Code Qualifier	MI	"MI" – Member identification number.
114	2010BA	NM109	Subscriber Primary Identifier		PRMMIS will only use the last 11 digits of the Puerto Rico Department of Health's member identification number.
116	2010BA	N4	Subscriber City, State, Zip Code		
116	2010BA	N401	Subscriber City Name		Subscriber City
116	2010BA	N402	Subscriber State Code		Subscriber State
117	2010BA	N403	Subscriber Postal Zone or ZIP Code		Subscriber Zip Code

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
121	2010CA	REF	Property and Casualty Patient Identifier		This segment will not be used by Puerto Rico Department of Health.
122	2010BB	NM1	Payer Name		
122	2010BB	NM103	Payer Name	PUERTO RICO DEPARTMENT OF HEALTH	Enter "PUERTO RICO DEPARTMENT OF HEALTH"
123	2010BB	NM108	Identification Code Qualifier	PI	"PI" – Payer Identification
123	2010BB	NM109	Payer Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
125	2010BB	N4	Payer City, State, Zip Code		
125	2010BB	N401	City Name	SAN JUAN	
125	2010BB	N402	Payer State Code	PR	
126	2010BB	N403	Payer Postal Zone or ZIP Code	009220000	
129	2010BB	REF	Billing Provider Secondary Identification		
129	2010BB	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Code *Note:* The "G2" qualifier must be used for non-healthcare providers.
130	2010BB	REF02	Billing Provider Secondary Identifier		Puerto Rico Department of Health Provider ID
143	2300	CLM	Claim Information		*Note:* Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when only one encounter is found to be non-compliant, PRMP requires trading partners to enter Patient Control Number (PCN) and Transaction Control Number (TCN) in CLM01 separated by a dash.
144	2300	CLM01	Patient Control Number		ENCOUNTER: Trading partners should enter the encounter's Patient Control Number (PCN) and Transaction Control Number (TCN) separated by a dash – all characters will be returned in the 835's CLP01 field.
145	2300	CLM02	Total Claim Charge Amount		Enter the total billed amount for the entire claim/encounter.
147	2300	CLM05-1	Facility Type Code		Value received is the first two positions of the Type of Bill (TOB).
147	2300	CLM05-2	Facility Code Qualifier	A	"A" – Uniform Billing Claim Form Bill Type

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
147	2300	CLM05-3	Claim Frequency Code	1, 3, 7, 8	The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use the claim frequency code to indicate whether the claim/encounter is being submitted for the first time or if it is a replacement/void of a previously adjudicated and "paid" claim/encounter: "1" — Indicates that this is the first claim/encounter submitted to PRMMIS. "3" — Hospice Only "7" — Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" — Void (Credit only). Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. ENCOUNTER – Use "1" as a frequency code when resubmitting a denied claim. *Note:* The use of values "7" and "8" can result in the previously submitted claim/encounter being adjusted. Include the Internal Control Number (ICN) from the previously submitted claim/encounter in the original reference number segment in Loop 2300. The claim frequency code was switched to an external code source during the addenda process. See the NUBC Manual or Web site, www.nubc.org/. ENCOUNTER: Paper submissions/requests will not be supported for encounter processing. ENCOUNTER: MCOs are required to send their Claim ID (TCN) for each encounter submitted as well as their Claim ID (TCN) for an encounter being voided (refer to Section 4.6 – Procedures for Voiding Encounters).
149	2300	DTP	Discharge Hour		

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
149	2300	DTP01	Date / Time Qualifier	096	"096" – Discharge
149	2300	DTP02	Date Time Period Format Qualifier	TM	"TM" – Time (HHMM)
149	2300	DTP03	Discharge Time		Bill the Discharge Hour on all claims involving final services rendered. When a Discharge Hour is submitted, the Discharge Date is populated with the Statement Last Date of Service. This field only applies for nursing home patients discharged prior to the end of the month.
150	2300	DTP	Statement Dates		
150	2300	DTP01	Date / Time Qualifier	434	"434" – Statement
150	2300	DTP02	Date Time Period Format Qualifier	RD8	"RD8" – Range of Dates expressed in format: CCYYMMDD-CCYYMMDD.
153	2300	CL1	Institutional Claim Code		
153	2300	CL103	Patient Status Code		*Note:* Nursing home claims/encounters are not a covered program for the Puerto Rico Department of Health.
154	2300	PWK	Claim Supplemental Information		Puerto Rico Department of Health's PRMMIS does not use this segment for processing of the claim/encounter.
158	2300	CN1	Contract Information		ENCOUNTER – This refers to the contract between the plan and the provider paid by the plan.
158	2300	CN101	Contract Type Code		ENCOUNTER – Required "05" – If provider's services were provided under a capitation agreement, Fee For Service (FFS) encounter claims should indicate the appropriate value as listed in the TR3.
158	2300	CN102	Contract Amount		ENCOUNTER – Required If CN101 = "05", then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount that the health plan paid the provider.
163	2300	REF	Referral Number		

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
163	2300	REF01	Reference Identification Qualifier	9F	"9F" – Referral Number
163	2300	REF02	Referral Number		
164	2300	REF	Prior Authorization		
164	2300	REF01	Reference Identification Qualifier	G1	"G1" – Prior Authorization Number
164	2300	REF02	Prior Authorization Number		Enter the 10-digit Prior Authorization Number. Enter this number only if the services rendered required and received prior authorization. This number must be entered with the qualifier "G1" (Prior Authorization Number).
166	2300	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested).
166	2300	REF01	Reference Identification Qualifier	F8	"F8" – Original Reference Number
166	2300	REF02	Payer Claim Control Number		The ID (TCN), in the MCO's system, of the encounter being voided.
258	2300	HI	Occurrence Information		For those HI Segments (Page 184 through Page 304) within the 837I Implementation Guide that can repeat multiple times and allow up to 12 occurrences of information within each segment are captured and stored within the MMIS.
258	2300	HI01-1	Code List Qualifier Code	BH	"BH" – Occurrence
269	2300	HI12-1	Code List Qualifier Code	BH	"BH" – Occurrence
319	2310A	NM1	Attending Provider Name		This is required for Inpatient Services.
319	2310A	NM101	Entity Identifier Code	71	"71" – Attending Provider
321	2310A	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
321	2310A	NM109	Attending Provider Primary Identifier		HIPAA National Provider Identifier
322	2310A	PRV	Attending Provider Specialty Information		
322	2310A	PRV01	Provider Code	AT	"AT" – Attending
322	2310A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
322	2310A	PRV03	Provider Taxonomy Code		Rendering Provider Taxonomy Code that is used for claims submitted with NPI.
324	2310A	REF	Attending Provider Secondary Identification		
324	2310A	REF01	Reference Identification Qualifier	0B, G2	"0B" – State License Number "G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
336	2310D	NM1	Rendering Provider Name		*Note:* This is required when the Rendering Provider is different than the Attending Provider reported in Loop ID-2310A of this claim.
337	2310D	NM101	Entity Identifier Code	82	"82" – Rendering Provider
338	2310D	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
338	2310D	NM109	Rendering Provider Identifier		HIPAA National Provider Identifier
339	2310D	REF	Rendering Provider Secondary Identification		
339	2310D	REF01	Reference Identification Qualifier	0B, G2	"0B" – State License Number "G2" – Provider Commercial Number *Note:* The "G2" qualifier should only be used for non-healthcare providers.
341	2310E	NM1	Service Facility Name		*Note:* This is required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider).
342	2310E	NM101	Entity Identifier Code	77	"77" – Service Location
342	2310E	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
342	2310E	NM109	Laboratory or Facility Primary Identifier		HIPAA National Provider Identifier
344	2310E	N3	Service Facility Location Address		
344	2310E	N301	Laboratory or Facility Address Line		Service Facility Location Address Line
345	2310E	N4	Service Facility Location City, State, Zip Code		
345	2310E	N401	Laboratory or Facility City Name		Service Facility Location City
346	2310E	N402	Laboratory or Facility State or Province Code		Service Facility Location State

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
346	2310E	N403	Laboratory or Facility Postal Zone or ZIP Code		Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
339	2310E	REF	Rendering Provider Secondary Identification		
339	2310E	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note:* The "G2" qualifier should only be used for non-healthcare providers.
349	2310F	NM1	Referring Provider Name		*Note:* This is required on an outpatient claim when the Referring Provider is different than the Attending Provider.
350	2310F	NM101	Entity Identifier Code	DN	"DN" – Referring Provider
351	2310F	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
351	2310F	NM109	Referring Provider Identifier		HIPAA National Provider Identifier
352	2310F	REF	Referring Provider Secondary Identification		
352	2310F	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier should only be used for non-healthcare providers.
354	2320	SBR	Other Subscriber Information		ENCOUNTER – Loop 2320 (Other Subscriber Information) is required on all encounter claims. *Note:* For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is Third Party Liability (TPL), the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
355	2320	SBR01	Payer Responsibility Sequence Number Code		Enter the appropriate standard code. The X12N 837I does not support the use of the Financial Class Code that is currently billed on Hospital claims. Claim Filing Indicators and the Payer Responsibility Sequence, which indicates the relationship each payer has to Medicaid and other payers on each claim, replaces the data supplied by the Financial Class Code.
356	2320	SBR09	Claim Filing Indicator Code		ENCOUNTER – When the MCO is the payer, the value should be "HM". *Note:* All valid values will be accepted for other payer loops.
358	2320	CAS	Claim Level Adjustments		

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
360	2320	CAS02	Adjustment Reason Code	A1	ENCOUNTER – "A1" – MCO Denied Claim
360	2320	CAS03	Adjustment Amount		
364	2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		
364	2320	AMT01	Amount Qualifier Code	D	"D" – Payer Amount Paid
364	2320	AMT02	Payer Paid Amount		Other Payer Amount Paid (Third Party Liability or Managed Care Organization)
364	2320	AMT	Remaining Patient Liability		
364	2320	AMT01	Amount Qualifier Code	EAF	"EAF" – Amount Owed
364	2320	AMT02	Remaining Patient Liability		
384	2330B	NM1	Other Payer Name		ENCOUNTER – Loop 2330B (Other Payer Name) is required on all encounter claims. *Note:* For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is Third Party Liability (TPL), the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
385	2330B	NM108	Identification Code Qualifier	PI, XV	"PI" – Payer Identification "XV" – Centers for Medicare and Medicaid Services Plan ID
385	2330B	NM109	Other Payer Primary Identifier		This number must be identical to at least one occurrence of the 2430-SVD01 to identify the other payer. Puerto Rico Department of Health captures third party payment amount(s) from the service line(s) in 2430-SVD02. *Note:* The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail. ENCOUNTER – This value should be the MCO's assigned Trading Partner ID.
258	2330B	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal Claim ID be entered here for every encounter.
258	2330B	REF01	Reference Identification Qualifier	F8	"F8" – Original Reference Number
258	2330B	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
423	2400	LX	Service Line Number		
423	2400	LX01	Assigned Number		Puerto Rico Department of Health accepts up to the HIPAA-allowed 999 detail lines per claim.
424	2400	SV2	Institutional Service Line		
424	2400	SV201	Service Line Revenue Code		*Note:* Nursing homes are not a covered service under the Puerto Rico Medicaid program.
425	2400	SV202-1	Product/Service ID Qualifier	HC	"HC" – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
428	2400	SV205	Service Unit Count		Enter the number of days spent in hospital or at home. Puerto Rico Department of Health processes only the whole number when units are entered with decimals. Example: Units entered on the transaction, 3.75, are processed as 3 units.
459	2410	LIN	Drug Identification		
451	2410	LIN02	Service ID Qualifier	N4	"N4" – National Drug Code
451	2410	LIN03	Drug Identification		Enter National Drug Code in 5-4-2 format.
451	2410	CTP	Drug Quantity		
452	2410	CTP04	National Drug Unit Count		National Drug Unit Count
452	2410	CTP05-1	Code Qualifier	UN	"UN" – Unit
476	2430	SVD	Line Adjudication Information		ENCOUNTER – Loop 2430 required on all encounter claims. *Note:* Other payer payment amounts are required to be entered at the detail level.
476	2430	SVD01	Other Payer Primary Identifier		This should match one occurrence of the 2330B-NM109 identifying Other Payer.
477	2430	SVD02	Service Line Paid Amount		Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the line-item level only.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					This is also used for crossover detail paid amount. ENCOUNTER – If CN101 = "05", SVD02 should be zero. If CN101 = "09", then SVD02 should be the detail other payer paid amount OR amount health plan paid to provider.
481	2430	CAS	Line Adjustment		
482	2430	CAS02	Adjustment Reason Code	A1	ENCOUNTER – "A1" – MCO Denied line item
482	2430	CAS03	Adjustment Amount		

A. APPENDIX A

A.1 Change History

Version 1.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					Initial Submission

A.2 Change History

Version 2.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	17		Specific business rules and limitations		Added new text for PRMMIS procedure for Voiding encounters
2300	27	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested).
2300	27	REF02	Payer Claim Control Number		The ID, in the MCO's system, of the encounter being voided
2330B	34	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal claim ID be entered here for every encounter.
2330B	34	REF01	Reference Identification Qualifier	F8	Original Reference Number
2330B	29	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted

A.3 Change Summary

Version 3.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	7		Introduction		Change Section 10 to Section 6
2000B	21	SBR09	Claim Filing Indicator Code		Update text: See Comment on 2000B-SBR03
2300	22	CLM02	Total Claim Charge Amount		Remove Note – negative amount will fail compliance
2300	24	CL103	Patient Status Code		Changed the title of Section 9 to Nursing Home Termination Codes to Patient Status Codes Crosswalk.
2300	25	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	25	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	25	CN104	Contract Code		REMOVED THIS ROW
2310A	27	REF01	Reference Identification Qualifier	0B, G2	Modify text: "0B" – State License Number "G2" – Provider Commercial Number *Note:* This is not required for nursing homes.

					Note: The "G2" qualifier must be used for non-healthcare providers.
2310A	27	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* This is not required for nursing homes. *Note:* The "G2" qualifier must be used for non-healthcare providers.
2310D	27	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* This is not required for nursing homes. *Note:* The "G2" qualifier must be used for non-healthcare providers.
2320	30	CAS03	Adjustment Amount		Remove Comment.
2320	30	CAS06	Adjustment Amount		Remove Comment.
2320	30	CAS09	Adjustment Amount		Remove Comment.
2320	30	CAS12	Adjustment Amount		Remove Comment.
2320	30	CAS15	Adjustment Amount		Remove Comment.
2320	31	CAS18	Adjustment Amount		Remove Comment.
2320	34	CAS03	Adjustment Amount		Remove Comment.
2320	34	CAS06	Adjustment Amount		Remove Comment.
2320	34	CAS09	Adjustment Amount		Remove Comment.
2320	34	CAS12	Adjustment Amount		Remove Comment.
2320	35	CAS15	Adjustment Amount		Remove Comment.
2320	35	CAS18	Adjustment Amount		Remove Comment.

A.4 Change Summary

Version 3.1 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 09-09-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
Section 1.1	7		Scope		Modify text: For further information, contact their policy-specific area of the Puerto Rico Department of Health or PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCO) and clearinghouses with Puerto Rico Department of Health in successfully conducting EDI of administrative health care transactions.
Section 1.2	7		Overview		Remove text: This information should be given to the provider's business area to ensure that Claim/Encounters are interpreted correctly.
Section 1.4	9		National Provider NPI		Modify text: All providers, except those that the Puerto Rico Department of Health determined as not a healthcare provider such as non-emergency transportation,
Section 1.4	10		File/System Specifications		Remove text: The recommended extension is .txt or .dat. EDI does not allow zipped files. Files will be submitted to EDI via STFP. Add text: The following standards should be used: To avoid accidently overwriting files, do not send

					multiple files with the same name on the same day. File Names should not be longer than 45 characters File Names should not contain spaces or special characters File Names should contain a file extension such as .dat or .txt Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file Zip files must contain the extension .zip (not case sensitive)
Section 1.4	10		Negative Dollar Amounts		New Paragraph: Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
Section 2.1	11		Process Flows		Modify text: classified as "paid".
N/A	12	ISA01	Authorization Information Qualifier		Remove text: "00" – No Authorization Information Present.
N/A	12	ISA02	Authorization Information		Remove text: Claim - [space fill]
N/A	13	ISA14	Acknowledgement Requested	0	Remove code 1 & comment.
Section 4.1	16		Trading Partner Identification Number		Modify text: In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS the EDI team will create any needed Trading Partner Profiles.
Section 4.2	16		Testing		Module One of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.
Section 4.4	16		Limits		Modify text: File Size is restricted to 5,000 transactions (claims/encounters) per file.
Section 4.6	16		Procedures for Voiding Encounters		Modify text:

					When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:
2010AB	20	NM1	Pay-To Address Name		Modify text: This loop will not be used by Puerto Rico Department of Health's PRMMIS.
2000B	20	SBR01	Payer Responsibility Sequence Number Code		The X12N 837I does not support the use of the Financial Class Code that is currently billed on Hospital claims. Claim Filing Indicators and the Payer Responsibility Sequence, which indicates the relationship each payer has to Medicaid and other payers on each claim replaces the data supplied by the Financial Class Code. Remove Text: See Section 7 - Appendix A for a crosswalk of Financial Class Codes to the Claim Filing Indicator/Payer Responsibility Sequence.
2000B	21	SBR09	Claim Filing Indicator Code		Update text: See Comment on 2000B-SBR03
2010BA	20	NM109	Subscriber Primary Identifier		Change text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. Remove Text: *Note:* Do not enter any other numbers or letters. Use the Puerto Rico Department of Health card or the EVS to obtain the correct identification number.
2300	21	CLM01	Patient Control Number		Modify text: *Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length. Remove text:

					Note: Value received is returned on the 835 Remittance Advice. Add text: ENCOUNTERS: MCO should send the original PCN from the provider's original claim.
2300	21	CLM05-3	Claim Frequency Code		Modify text: "1" — Indicates that this is the first claim/encounter submitted to PRMMIS. "3" — Hospice Only "7" — Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" — Void (Credit only). Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. Remove text: Electronic adjustments are subject to the same requirements as paper adjustments and therefore may result in a letter to the provider if the requirements are not met. Do not use adjustment values if reconsideration of the original payment is needed. All requests for reconsideration should be submitted on paper with supporting documentation. Modify text: ENCOUNTER: Paper submissions/requests will not be supported for encounter processing. Add text: ENCOUNTER: MCOs are required to send their claim

					ID (TCN) for each encounter submitted as well as their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
2300	25	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	25	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	23	PWK	Claim Supplemental Information		Modify text: *Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length.
2300	23	PWK01 thru PWK05			Remove rows.
2300	23				Modify text: Puerto Rico Department of Health's PRMMIS does not use this field for processing of the claim/encounter
2300	23	CL103	Patient Status Code		Remove text: The X12N 837I does not support the use of the Nursing Home Termination Codes currently billed on Nursing Home claims. Remove Text: The Termination Code is derived from the Patient Status Code. Remove Text: See Section 9 - Nursing Home Termination Codes to

					Patient Status Codes Crosswalk. Add text: *Note:* Nursing home claims/encounters are not a covered program for the Puerto Rico Department of Health.
2300	24	REF	Payer Claim Control Number		Add Note/Comment: ENCOUNTER: MCOs are required to send their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
2300	24	REF02	Payer Claim Control Number		Modify Note/Comment: The ID (TCN), in the MCO's system, of the encounter being voided.
2300	25	REF02	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2300	25	REF	Claim Identifier for Transmission Intermediaries		Remove Segment
2300	25	REF02	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2300	26	HI01-1	Code List Qualifier Code	BH	Modify Notes/Comments: "BH" – Occurrence Remove Text: See Appendix B for a list of current Puerto Rico-specific Occurrence Codes to replacement codes and their description.
2300	26	HI12-1	Code List Qualifier Code	BH	Modify Notes/Comments: "BH" – Occurrence Remove Text: See Appendix B for a list of current Puerto Rico-specific Occurrence Codes to replacement codes and their description.
2310F	26	REF02	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2320	27	SBR01	Payer Responsibility Sequence Number Code		Modify Notes/Comments: The X12N 837I does not support the use of the Financial Class Code that is currently billed on Hospital claims. Claim Filing

					Indicators and the Payer Responsibility Sequence, which indicates the relationship each payer has to Medicaid and other payers on each claim replaces the data supplied by the Financial Class Code. Remove Text: See Section 7 - Appendix A for a crosswalk of Financial Class Codes to the Claim Filing Indicator/Payer Responsibility Sequence.
2320	27	CAS02	Adjustment Reason Code	A1	Remove text: For Inpatient: "1" - Deductible "2" - Coinsurance Other external code source values from code source 139 are allowed.
2320	27 thru 28	CAS05 thru CAS18	Adjustment Reason Code & Adjustment Amount		Delete rows.
2400	29	SV201	Service Line Revenue Code		Remove text: Nursing home submitters must enter a revenue code. Enter Revenue Code "0101" and the per diem amount if no home days or hospital days need to be reported. Enter Revenue Code "0185" for days spent in hospital or Service Line Revenue Code "0182" for days spent at home. (Nursing Home only) Add text: *Note:* Nursing homes are not a covered service under the Puerto Rico Medicaid program.
2430	30	SVD	Line Adjudication Information		Remove (name loop) from Notes/Comments
2430	30	SVD01	Other Payer Primary Identifier		Remove number from Notes/Comments
2430	30	SVD02	Service Line Paid Amount		Modify text: Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the line item level only.

					This is also used for crossover detail paid amount. ENCOUNTER - If CN101 = 05, SVD02 should be zero. If CN101 = 09, then SVD02 should be the detail other payer paid amount OR amount health plan paid to provider.
2430	31	CAS02	Adjustment Reason Code	A1	Remove text: For Inpatient: "1" - Deductible "2" - Coinsurance Other external code source values from code source 139 are allowed.
2430	31 thru 32	CAS05 thru CAS18	Adjustment Reason Code & Adjustment Amount		Delete rows.
N/A	36		Section 7 – Appendix A		Remove Section 7
N/A	36		Section 8 – Appendix B		Remove Section 8
N/A	36		Section 9 – Appendix C		Remove Section 9
N/A	37		Section 10 – Appendix D		Remove Section 10

A.5 Change History

Version 4.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 10-24-17

Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	10	Section 1.4	Additional Information		Remove text: Negative Dollar Amounts Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
2010BA	20	NM109	Subscriber Primary Identifier		Add text: ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID.
2320	26	SBR09	Claim Filing Indicator Code	16 CI, HM MA, MB	Modify text: "16" – HMO Medicare Risk (required for Medicare Part C claims) "CI" – Commercial Insurance "HM" – Managed Care Organization "MA" – Medicare Part A "MB" – Medicare Part B
2330B	27	NM109	Other Payer Primary Identifier		Add text: ENCOUNTER – This value should be the MCO's assigned trading partner ID.
2330B	27	DTP	Claim Check or Remittance Date		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.

A.6 Change History

Version 5.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-17-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	23	CN1	Contract Information		Modify the text: ENCOUNTER – This refers to the contract between the plan and the provider paid by the plan.
2300	23	CN101	Contract Type Code	~~05, 09~~	Modify the text: ENCOUNTER - Required "05" – If provider's services were provided under a capitation agreement FFS encounter claims should indicate the appropriate value as listed in the TR3.
2300	22	CN102	Contract Amount		Modify the text: If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered.
2300	24	K3	File Information		Remove Segment
2300	24	K301	Fixed Format Information		Remove Line: MCO Receipt Date – Format: CCYYMMDD.
2320	26	SBR09	Claim Filing Indicator Code	~~16, CI, HM, MA, MB~~	Modify the text: ~~"16" – HMO Medicare Risk (required for Medicare Part C claims).~~ ~~"CI" – Commercial Insurance~~ ~~"HM" – Managed Care Organization~~ ~~"MA" – Medicare Part A~~ ~~"MB" – Medicare Part B~~ ENCOUNTER: When the MCO is the payer the value should be "HM" *NOTE:* All valid values will be accepted for other payer loops.
2330B	27	DTP	Claim Check or Remittance Date		Remove Segment
2330B	27	DTP01	Date / Time Qualifier	573	Remove Line: "573" – Other Payer or MCO Claim Adjudication Date

2330B	27	DTP02	Date Time Period Format Qualifier	D8	Remove Line: "D8" – Date Expressed in Format CCYYMMDD
2330B	27	DTP03	Adjudication or Payment Date		Remove Line: TPL or MCO Adjudication Date (CCYYMMDD)

A.7 Change History

Version 6.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 04-01-19
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010BA	20	NM109	Subscriber Primary Identifier		Old text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID. New text: PRMMIS will only use the last 11 digits of the Puerto Rico Department of Health's member identification number.
2300	21	CLM	Claim Information		New text: NOTE: Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when one encounter is found to be non-compliant, the recommendation is to enter TCN in CLM02.

A.8 Change History

Version 7.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 05-05-20
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	21	CLM	Claim Information		New text *Note:* Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when only one encounter is found to be non-compliant, PRMP requires trading partners to enter PCN and TCN in CLM01 separated by a dash.
2300	21	CLM01	Patient Control Number		New text ENCOUNTER: Trading partners should enter encounter's PCN and TCN separated by a dash – all characters will be returned in the 835's CLP01 field.

A.9 Change History

Version 7.1 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-10-21
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010AA	19	N403	Billing Provider Postal Zone or ZIP Code		Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department of Health. **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
2310E	26	N403	Laboratory or Facility Postal Zone or ZIP Code		Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**

A.10 Change History

Version 7.2 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-22-21
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2000B	20	SBR01	Payer Responsibility Sequence Number Code		Remove row
2000B	20	SBR09	Claim Filing Indicator Code	MC	Remove text: See Comment on 2000B-SBR01. Add text: "MC" = Medicaid

GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

HIPAA Transaction
Standard Companion Guide

Refers to the Technical Report Type 3 (TR3) Implementation Guides Based on ASC X12 Version 005010X222A1 Professional Health Care Claim/Encounter (837P)

Companion Guide Version Number: 7.1

November 2021

Puerto Rico Medicaid Management Information System Services Project

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 00002

NÚMERO DE CONTRATO

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The communications/connectivity component is included in the companion guide when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The transaction instruction component is included in the companion guide when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The transaction instruction component content is limited by ASC X12's copyrights and Fair Use statement.





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Preface

This companion guide to the v5010 ASC X12N Technical Report Type 3 (TR3) adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with the Puerto Rico Department of Health. Transmissions based on this companion guide, used in tandem with the TR3, also called the Health Care Professional Claim/Encounter ASC X12N version 005010X222A1 (837P), are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. To access the HIPAA Implementation Guides, please contact the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).





Disclaimer: The information contained in this Companion Guide is subject to change.

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Table of Contents

1 INTRODUCTION 7

1.1 Scope 8

1.2 Overview 8

1.3 References 9

1.4 Additional Information 9

National Provider Identifier 9

Acceptable Characters 10

File/System Specifications 10

2 CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS 11

2.1 Process Flows 11

2.2 Transmission Administrative Procedures 11

2.3 Communication Protocol Specifications 11

Batch 11

3 CONTROL SEGMENTS / ENVELOPES 12

3.1 ISA-IEA 12

Interchange Control Header (ISA) 12

IEA – Interchange Control Header 13

3.2 GS-GE 13

Functional Group Header (GS) 13

Functional Group Trailer (GE) 14

3.3 ST-SE 14

TRANSACTION SET HEADER (ST) 14

TRANSACTION SET TRAILER (SE) 15

3.4 Control Segment Notes 15

3.5 File Delimiters 15

Element Separator 15

Repetition Separator 15

Component Separator 15

Segment Terminator 15

4 PUERTO RICO DEPARTMENT OF HEALTH-SPECIFIC BUSINESS RULES AND LIMITATIONS 16

4.1 Trading Partner Identification Number 16

4.2 Testing 16

4.3 Terminology 16

4.4 Limits 16

4.5 Scheduled Maintenance 16

4.6 Procedures for Voiding Encounters 16

5 ACKNOWLEDGEMENTS AND/OR REPORTS 17

5.1 Acknowledgements 17

TA1 — Transaction Acknowledgement 17

999 — Functional Acknowledgement 17

6 TRANSACTION-SPECIFIC INFORMATION 18

6.1 005010X222A1 — 837P Health Care Claim/Encounter 18

A. APPENDIX A 34

A.1 Change Summary 34

A.2 Change Summary 35

A.3 Change Summary 35

A.4 Change Summary 38

A.5 Change History 44

A.6 Change History 46

A.7 Change History 48

A.8 Change History 49

1 INTRODUCTION

This section describes how TR3, also called 837P ASC X12N (version 005010X222A1), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that Puerto Rico Department of Health has information additional to the TR3. That information can:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guides' internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with Puerto Rico Department of Health.

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

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column to provide additional information from Puerto Rico Department of Health for specific segments provided by the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in Section 6: TRANSACTION-SPECIFIC INFORMATION.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10 percent and notes or comments about the segment itself go in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by Puerto Rico Department of Health.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value "N6" is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 Scope

This companion guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 837P (referred to as Professional Claim/Encounter in the rest of this document) for the purpose of submitting 837P electronically. This companion guide is not intended to replace the TR3. The TR3s define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of this companion guide is to provide trading partners with a guide to communicate Puerto Rico Department of Health-specific information required to successfully exchange transactions electronically with Puerto Rico Department of Health. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

The information contained in this companion guide applies to Puerto Rico Department of Health for processing.

Puerto Rico Department of Health will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain Puerto Rico Department of Health-specific information, though processed, may be denied. For example, a compliant 837P Claim/Encounter created with an invalid Puerto Rico Department of Health member identification number will be processed by Puerto Rico Department of Health, but will be denied. For questions regarding appropriate billing procedures, as well as for policy and billing information, providers should refer to their policy-specific area of the Puerto Rico Department of Health.

Refer to this companion guide first if there is a question about how Puerto Rico Department of Health processes a HIPAA transaction. For further information, contact **their policy-specific** area of the Puerto Rico Department of Health or PRMMIS MCO EDI (prmmis_edi_support@gainwelltechnologies.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCOs) and clearinghouses with Puerto Rico Department of Health in successfully conducting EDI of administrative health care transactions. This document provides instructions for obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.2 Overview

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

The HIPAA requirements serve to:

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

This guide is designed to help those responsible for testing and setting up electronic Professional Claim/Encounter transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting, and identifies codes and data elements that do not apply to Puerto Rico Department of Health. This guide supplements (but does not contradict) requirements in the ASC X12N 837P (version 005010X222A1) Implementation Guide. This guide provides communications-related information that a trading partner needs to enroll as

a trading partner, obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with Puerto Rico Department of Health.

This companion guide must be used in conjunction with the TR3 instructions. The companion guide is intended to assist trading partners in implementing electronic 837P transactions that meet Puerto Rico Department of Health processing standards by identifying pertinent structural and data-related requirements and recommendations.

1.3 References

For more information regarding the ASC X12 Standards for Electronic Data Interchange 837P Health Care Claim/Encounter (version 005010X222A1) and to purchase copies of the TR3 documents, consult the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

The implementation guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The implementation guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that the provider's Information Technology (IT) staff or software vendor review this document in its entirety and follow the stated requirements to exchange HIPAA-compliant files with Puerto Rico Department of Health.

To obtain the Provider taxonomy code set, please contact the Washington Publishing Company by phone (425-562-2245) or email (admin@wpc-edi.com).

1.4 Additional Information

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

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

National Provider Identifier

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

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

All providers, except those that the Puerto Rico Department of Health determined to not identify as a healthcare provider such as non-emergency transportation, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. Puerto Rico Department of Health requires all health care providers to submit their NPI on electronic transactions.

Acceptable Characters

The HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. Puerto Rico Department of Health accepts the extended character set. Uppercase characters are recommended. Files should be less than 100 MB.

File/System Specifications

EDI only accepts Windows/PC/DOS formatted files. Any file transmitted to EDI must be named in accordance to standard file naming conventions, including a valid three-character file extension. The following standards should be used:

- To avoid accidently overwriting files, do not send multiple files with the same name on the same day.
- File Names should not be longer than 45 characters.
- File Names should not contain spaces or special characters.
- File Names should contain a file extension such as .dat or .txt.
- Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file.
- Zip files must contain the extension .zip (not case sensitive).

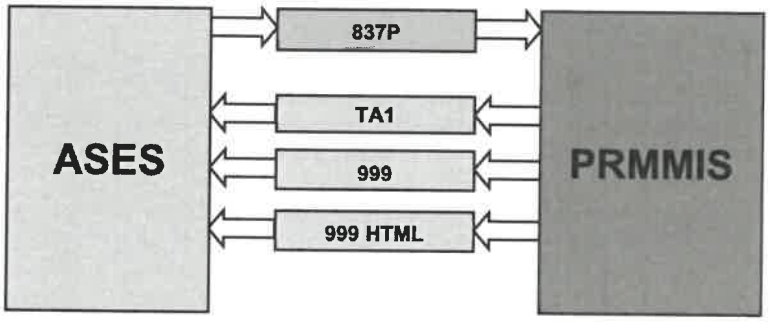
2 CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS

This section describes the process to interactively submit HIPAA 837P transactions, along with various submission methods, security requirements, and exception handling procedures.

2.1 Process Flows

This section contains process flow diagrams and appropriate text.
Each transaction is validated to ensure that the 837P complies with the 005010X222A1 TR3.

Transactions that fail this compliance check will generate a "Rejected" 999 file back to the sender with an error message indicating the compliance error. Transactions that pass this compliance check will generate an "Accepted" 999 file back to the sender with AK9*A to indicate that the file passed compliance. Transactions with multiple ST/SE loops that fail this compliance check in some of the ST/SE loops will generate a "Partial" 999 file back to the sender with an error message indicating the compliance error (all claims/encounters in the ST/SE envelopes that pass compliance will be processed). Claims/Encounters that pass compliance checks but fail to process (e.g., due to member not being found) will be denied. Claims/Encounters that pass compliance checks and have not failed to process (e.g., the member was found with enrollment within the date(s) of service) will be classified as "paid."



2.2 Transmission Administrative Procedures

This section provides Puerto Rico Department of Health's-specific transmission administrative procedures.

The trading partner must determine if the transmission being sent is Test or Production and is using the appropriate indicator (ISA15). For details about available Puerto Rico Department of Health access methods, refer to the Communication Protocol Specifications section.

Puerto Rico Department of Health is available only to authorized users. Submitters must be Puerto Rico Department of Health trading partners. A submitter is authenticated using a username and password assigned by the trading partner.

2.3 Communication Protocol Specifications

This section describes Puerto Rico Department of Health's communication protocol(s).
The following communication methods are available to get a member's Eligibility and Benefits from Puerto Rico Department of Health:

Batch

Trading partners can submit all batch transactions to Puerto Rico Department of Health and download acknowledgements and response files. Access is free; however, the user must have his or her own internet connection to access the web application.

3 CONTROL SEGMENTS / ENVELOPES

3.1 ISA-IEA

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

Interchange Control Header (ISA)

To promote efficient, accurate electronic transaction processing, please note the following Puerto Rico Department of Health specifications:

- Each trading partner is assigned a Trading Partner ID.
- All dates are in the CCYYMMDD format. Except for ISA09.
- All dates/times are in the CCYYMMDDHHMM format.
- Payer IDs can be found in the companion guides.
- Batch responses are not returned until all inquiries are processed. Limiting the number of total inquiries per ISA-IEA will produce faster results.
- Each Payer ID must be in its own file.
- No more than 999 claims/encounters per Transaction Set (ST-SE).
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Transactions transmitted as a batch are identified by an ISA and trailer segment (IEA), which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification. The table below represents only those fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction — the TR3 should be reviewed for that information.

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

Note: Puerto Rico Department of Health accepts files with one ISA/IEA loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.3	None	ISA	Interchange Control Header		
C.4		ISA01	Authorization Information Qualifier	03	ENCOUNTER – "03" – Additional Data Identification
C.4		ISA02	Authorization Information		ENCOUNTER – MCO Medicaid ID + [space fill]
C.4		ISA03	Security Information Qualifier	00	00 = No Security Information Present
C.4		ISA04	Security Information		[space fill]
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	ZZ = Mutually defined
C.4		ISA06	Interchange Sender ID		Trading Partner ID supplied by Puerto Rico Department of Health, left-justified and space-filled.
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	ZZ = Mutually defined
C.5		ISA08	Interchange Receiver ID	PRMMIS	"PRMMIS" – left-justified and space-filled.
C.5		ISA09	Interchange Date		The date format is YYMMDD.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.5		ISA10	Interchange Time		The time format is HHMM.
C.5		ISA11	Repetition Separator	^	A Caret "^" is recommended.
C.5		ISA12	Interchange Control Version Number	00501	00501 = Control Version Number
C.5		ISA13	Interchange Control Number		The interchange control number assigned in ISA13 must be identical to the value in IEA02.
C.6		ISA14	Acknowledgement Requested	0	0 = No interchange acknowledgment requested (TA1)
C.6		ISA15	Usage Identifier	P, T	Code indicating whether the data enclosed is Production or Test.
			Production Data	P	Enter value "P" to indicate that the file contains Production data.
			Test Data	T	Enter value "T" to indicate that the file contains Test data.
C.6		ISA16	Component Separator	:	A colon ":" is recommended.

IEA – Interchange Control Header

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.10	None	IEA	Interchange Control Trailer		
C.10		IEA01	Number of Included Functional Groups		Number of included Functional Groups
C.10		IEA02	Interchange Control Number		Must be identical to the value in ISA13

3.2 GS-GE

This section describes Puerto Rico Department of Health's use of the functional group control segments.

It includes a description of expected application sender and receiver codes.

Functional Group Header (GS)

In the table below are fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

Note: Puerto Rico Department of Health only accepts files with one GS/GE loop per file.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7	None	GS	Functional Group Header		
C.7		GS01	Functional ID Code	HC	"HC" – Health Care Professional Claim/Encounter (837P)

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.7		GS02	Application Sender's Code		'Trading Partner ID' supplied by Puerto Rico Department of Health.
C.7		GS03	Application Receiver's Code	PRMMIS	'PRMMIS' Puerto Rico Department of Health Sender ID.
C.7		GS04	Date		The date format is CCYYMMDD.
C.8		GS05	Time		The time format is HHMM.
C.8		GS06	Group Control Number		Group Control Number – Must be identical to GE02.
C.8		GS07	Responsible Agency Code	X	"X" – Responsible Agency Code
C.8		GS08	Version / Release / Industry Identifier Code	005010X222A1	Version / Release / Industry Identifier Code

Functional Group Trailer (GE)

In the table below are fields in which Puerto Rico Department of Health requires a specific value or has additional guidance on what the value should be. The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.9	None	GE	Functional Group Trailer		
C.9		GE01	Number of Transaction Sets Included		Total number of transaction sets
C.9		GE02	Group Control Number		Must be identical to the value in GS06

3.3 ST-SE

This section describes Puerto Rico Department of Health's use of transaction set control numbers.

Puerto Rico Department of Health recommends that trading partners follow the guidelines set forth in the TR3 — start the first ST02 in the first file with "000000001" and increment from there. The TR3 should be reviewed for how to create compliant transaction set control segments.

TRANSACTION SET HEADER (ST)

The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
70	None	ST	Transaction Set Header		
70		ST01	Transaction Set Identifier Code	837	837 Health Care Claim
70		ST02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA).
70		ST03	Implementation Guide Version Name	005010X222A1	This field contains the same value as GS08.

TRANSACTION SET TRAILER (SE)

The TR3 should be reviewed for specific information.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
496	None	SE	TRANSACTION SET TRAILER		
496		SE01	Transaction Segment Count		Total number of transaction sets
496		SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical.

3.4 Control Segment Notes

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

3.5 File Delimiters

Puerto Rico Department of Health requests that you use the following delimiters on your file. If used as delimiters, these characters must not be submitted within the data content of the transaction sets. Contact PRMMIS MCO EDI (prmmis_edi_support@gainwelltechnologies.com) if there is a need to use a delimiter other than the following:

- Segment Terminator = ~
- Element Separator = *
- Component Separator = :
- Repetition Separator = ^

Element Separator

Byte 4 in the ISA segment defines the element separator to be used throughout the entire transaction. The recommended element separator is an asterisk (*).

Repetition Separator

ISA11 defines the repetition separator to be used throughout the entire transaction. The recommended repetition separator is a caret (^).

Component Separator

ISA16 defines the component separator to be used throughout the entire transaction. The recommended component separator is a colon (:).

Segment Terminator

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

4 PUERTO RICO DEPARTMENT OF HEALTH-SPECIFIC BUSINESS RULES AND LIMITATIONS

4.1 Trading Partner Identification Number

In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS, the EDI team will create any needed Trading Partner Profiles.

4.2 Testing

Module One of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.

4.3 Terminology

The term "subscriber" will be used as a generic term throughout the companion guide.

4.4 Limits

File Size is restricted to 5,000 transactions (claims/encounters) per file. One transaction set includes all data between and including a Transaction ST segment and Transaction SE segment.

4.5 Scheduled Maintenance

Puerto Rico Department of Health schedules regular maintenance every Sunday from 01:00 a.m. to 05:00 a.m. EST.

4.6 Procedures for Voiding Encounters

PRMMIS requires that the MCO's internal Transaction Control Number (TCN) be sent for every claim:

Loop 2330B – Other Payer Name
REF – Other Payer Claim Control Number
REF01 = F8 – Original Reference Number
REF02 = The TCN (in the MCO's system) of the claim being submitted

When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:

Loop: 2300 — CLAIM INFORMATION
REF – PAYER CLAIM CONTROL NUMBER
REF01 = F8 – Original Reference Number
REF02 = The TCN (in the MCO's system) of the encounter being voided

5 ACKNOWLEDGEMENTS AND/OR REPORTS

5.1 Acknowledgements

TA1 — Transaction Acknowledgement

Puerto Rico Department of Health will only respond with a TA1 when the batch X12 contains Envelope errors. If a TA1 is produced, then a 999 will not be sent. The submitted 837P will need to be corrected and resubmitted.

999 — Functional Acknowledgement

This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a batch X12 file. Puerto Rico Department of Health will always respond with a 999 for a batch X12 file. If a "rejected" 999 is produced then claims/encounters will not be sent to the claims engine for adjudication. The submitted 837P will need to be corrected and resubmitted.

6 TRANSACTION-SPECIFIC INFORMATION

This section describes how ASC X12N implementation guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Puerto Rico Department of Health has something additional, over and above, the information in the implementation guides. That information can do the following:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guides' internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Puerto Rico Department of Health.

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

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that Puerto Rico Department of Health has something additional, over and above, the information in the TR3s.

6.1 005010X222A1 — 837P Health Care Claim/Encounter

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
71	None	BHT	Beginning of Hierarchical Transaction		
71	None	BHT02	Transaction Set Purpose Code	00	"00" – Original
71	None	BHT06	Claim Identifier	CH, RP	CH = Claims — Chargeable. RP = Encounters — Reporting.
74	1000A	NM1	Submitter Name		
75	1000A	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
75	1000A	NM109	Submitter Identifier		Enter the same value as ISA06 'Trading Partner ID' supplied by Puerto Rico Department of Health.
76	1000A	PER	Submitter EDI Contact Information		This segment identifies the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.
77	1000A	PER01	Contact Function Code	IC	"IC" – Information Contact
77	1000A	PER02	Submitter Contact Name		This is required if it's different than the name contained in the Submitter Name (Loop 1000A, NM1 segment).
77	1000A	PER03	Communication Number Qualifier	EM, FX, TE	"EM" – Electronic Mail "FX" – Fax "TE" – Telephone
77	1000A	PER04	Communication Number		Email Address, Fax Number, or Telephone Number (including the area code)

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
79	1000B	NM1	Receiver Name		
80	1000B	NM103	Receiver Name	PUERTO RICO DEPARTMENT OF HEALTH	"PUERTO RICO DEPARTMENT OF HEALTH"
80	1000B	NM108	Identification Code Qualifier	46	"46" – Electronic Transmitter Identification Number (ETIN)
80	1000B	NM109	Receiver Primary Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
83	2000A	PRV	Billing Provider Specialty Information		ENCOUNTER – When required for NPI crosswalk, this loop should contain the Taxonomy Code for the Provider paid by the MCO (refer to 2010AA below).
83	2000A	PRV01	Provider Code	BI	"BI" – Billing
83	2000A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code *Note:* Taxonomy codes are only required if the National Provider Identifier (NPI) has multiple certifications and the taxonomy is necessary to determine the appropriate one.
83	2000A	PRV03	Provider Taxonomy Code		Enter the taxonomy that was reported to Puerto Rico Department of Health for the service you are billing. *Note:* The provider is required to use the appropriate taxonomy code that is associated to the provider type and specialty currently on file with Puerto Rico Department of Health.
88	2010AA	NM1	Billing Provider Name		ENCOUNTER – This loop should contain the NPI information for the Provider paid by the MCO. *Note:* For MCO Plan ID submission information, refer to ISA01 and ISA02.
88	2010AA	NM102	Entity Identifier Code	85	"85" – Billing Provider
89	2010AA	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
89	2010AA	NM109	Billing Provider Identifier		HIPAA National Provider Identifier
91	2010AA	N3	Billing Provider Address		Enter the address that is currently on file with Puerto Rico Department Of Health. *Note:* Do not enter a P.O. Box in this segment. If a P.O. Box needs to be reported, use the Pay-To Address loop.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
92	2010AA	N4	Geographic Location		Use the physical address as reported on the provider's Puerto Rico Department of Health certification.
93	2010AA	N403	Billing Provider Postal Zone or ZIP Code		Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department Of Health. **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
94	2010AA	REF	Billing Provider Tax Identification		
94	2010AA	REF01	Reference Identification Qualifier	EI	"EI" – Employer ID Number (EIN)
94	2010AA	REF02	Billing Provider Tax Identification Number		Valid nine-digit Employer ID number
101	2010AB	NM1	Pay-To Address Name		*Note:* This loop will not be used by Puerto Rico Department of Health's PRMMIS.
114	2000B	HL	Subscriber Hierarchical Level		*Note:* For Puerto Rico Department of Health, the insured and the patient are always the same person. Use this HL segment to identify the recipient and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop may not process correctly.
115	2000B	HL03	Hierarchical Level Code	22	"22" – Subscriber
115	2000B	HL04	Hierarchical Child Code	0	"0" – No Subordinate HL Segment in this Hierarchical Structure.
116	2000B	SBR	Subscriber Information		
116	2000B	SBR01	Payer Responsibility Sequence Number Code		Refer to the 837 Professional Implementation Guide for valid values (page 296).
118	2000B	SBR09	Claim Filing Indicator Code	MC	"MC" – Medicaid
121	2010BA	NM1	Subscriber Name		Enter information about the subscriber/member in this loop.
122	2010BA	NM102	Entity Type Qualifier	1	Enter the value "1" to indicate that the member is a person.
122	2010BA	NM103	Subscriber Last Name		Enter the member's last name.
122	2010BA	NM104	Subscriber First Name		Enter the member's first name.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
122	2010BA	NM108	Identification Code Qualifier	MI	MI = Member Identification number.
123	2010BA	NM109	Subscriber Primary Identifier		PRMMIS will only use the last 11 digits of the Puerto Rico Department of Health's member identification number.
125	2010BA	N4	Subscriber City, State, Zip Code		
125	2010BA	N401	Subscriber City Name		Subscriber City
125	2010BA	N402	Subscriber State Code		Subscriber State
126	2010BA	N403	Subscriber Postal Zone or ZIP Code		Subscriber Zip Code
130	2010CA	REF	Property and Casualty Patient Identifier		This segment will not be used by Puerto Rico Department Of Health.
133	2010BB	NM1	Payer Name		
134	2010BB	NM103	Payer Name	PUERTO RICO DEPARTMENT OF HEALTH	Enter "PUERTO RICO DEPARTMENT OF HEALTH"
134	2010BB	NM108	Identification Code Qualifier	PI	"PI" – Payer Identification
134	2010BB	NM109	Payer Identifier	PRMMIS	"PRMMIS" – Puerto Rico Department of Health's Payer ID
136	2010BB	N4	Payer City, State, Zip Code		
136	2010BB	N401	City Name	SAN JUAN	
137	2010BB	N402	Payer State Code	PR	
137	2010BB	N403	Payer Postal Zone or ZIP Code	00922	
140	2010BB	REF	Billing Provider Secondary Identification		*Note:* Non-healthcare (Atypical) providers are required to submit this segment.
140	2010BB	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Code *Note:* This qualifier may only be used by non-healthcare providers who do not possess an NPI ID (i.e., Med waivers).
141	2010BB	REF02	Billing Provider Secondary Identifier		Puerto Rico Department of Health Provider ID
157	2300	CLM	Claim Information		*Note:* Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when only one encounter is found to be non-compliant, Puerto Rico Medicaid Program (PRMP) requires trading

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					partners to enter Patient Control Number (PCN) and Transaction Control Number (TCN) in CLM01 separated by a dash.
158	2300	CLM01	Patient Control Number		ENCOUNTER: Trading partners should enter the encounter's Patient Control Number (PCN) and Transaction Control Number (TCN) separated by a dash – all characters will be returned in the 835's CLP01 field.
159	2300	CLM02	Total Claim Charge Amount		Enter the total billed amount for the entire claim/encounter.
159	2300	CLM05-1	Facility Type Code		Value received is the first two positions of the Type of Bill (TOB). Enter the two-digit Place of Service Code at the claim header. Enter Place of Service code "99" for public transportation claims.
159	2300	CLM05-2	Facility Code Qualifier	B	"B" – Place of Service Codes for Professional or Dental Services
159	2300	CLM05-3	Claim Frequency Code	1, 7, 8	The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use the claim frequency code to indicate whether the claim/encounter is being submitted for the first time or if it is a replacement/void of a previously adjudicated and "paid" claim/encounter: "1" – Original Claim/encounter submitted to PRMMIS. "7" – Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" – Void (Credit only). Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety. ENCOUNTER – Use "1" as a Frequency code when resubmitting a denied claim. *Note:* The use of values "7" and "8" can result in the previously submitted claim/encounter being adjusted. Include the Internal Control Number (ICN) from the previously submitted claim/encounter in the original

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					reference number segment in Loop 2300. The claim frequency code was switched to an external code source during the addenda process. See the NUBC Manual or Web site, www.nubc.org/. ENCOUNTER: Paper submissions/requests will not be supported for encounter processing. ENCOUNTER: MCOs are required to send their Claim ID (TCN) for each encounter submitted as well as their Claim ID (TCN) for an encounter being voided (refer to Section 4.6 – Procedures for Voiding Encounters).
161	2300	CLM11-1	Related Causes Code	AA, EM, OA	"AA" – Auto Accident "EM" – Employment "OA" – Other Accident If the services being rendered are the result of an injury or accident, enter one of the standard two-character injury codes listed above in each Data Element if they apply. Otherwise, this field may be left blank.
161	2300	CLM11-2	Related Causes Code	AA, EM, OA	"AA" – Auto Accident "EM" – Employment "OA" – Other Accident If the services being rendered are the result of an injury or accident, enter one of the standard two-character injury codes listed above in each Data Element, if they apply. Otherwise, this field may be left blank.
182	2300	PWK	Claim Supplemental Information		Puerto Rico Department of Health's PRMMIS does not use this segment for processing of the claim/encounter.
186	2300	CN1	Contract Information		ENCOUNTER – This is required when the encounter claim was paid at the header level. This refers to the contract between the plan and the provider paid by the plan.
186	2300	CN101	Contract Type Code		ENCOUNTER – Required "05" – If provider's services were provided under a capitation agreement, Fee For Service (FFS) encounter claims should indicate the appropriate value as listed in the TR3.
186	2300	CN102	Contract Amount		ENCOUNTER – Required If CN101 = "05", then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					Note: The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 Loop) and CN102 contains the total monetary amount the health plan paid the provider.
193	2300	REF	Referral Number		
193	2300	REF01	Reference Identification Qualifier	9F	"9F" – Referral Number
193	2300	REF02	Referral Number		
194	2300	REF	Prior Authorization		
194	2300	REF01	Reference Identification Qualifier	G1	"G1" – Prior Authorization Number
195	2300	REF02	Prior Authorization Number		Enter the 10-digit Prior Authorization Number. Enter this number only if the services rendered required and received prior authorization. This number must be entered with the qualifier "G1" (Prior Authorization Number).
196	2300	REF	Payer Claim Control Number		Include this segment when requesting an electronic adjustment/void (a value of "7" or "8" in CLM05-3 indicates that an adjustment/void is being requested). ENCOUNTER – MCOs are required to send their Claim ID (TCN) for an encounter being voided (refer to Section 4.6 – Procedures for Voiding Encounters).
196	2300	REF01	Reference Identification Qualifier	F8	"F8" – Original Reference Number
196	2300	REF02	Payer Claim Control Number		The ID (TCN), in the MCO's system, of the encounter being voided.
211	2300	CR1	Ambulance Transport Information		
212	2300	CR104	Ambulance Transport Reason Code		Enter the Ambulance Transport Reason Code. *Note:* Refer to the 837 Professional Implementation Guide for the valid code values.
212	2300	CR105	Unit or Basis for Measurement Code	DH	"DH" – Miles
213	2300	CR106	Transport Distance		Puerto Rico Department of Health processes only the whole number when units are entered with decimals. Example: Units entered on the transaction, 3.75, are processed as 3 units.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
213	2300	CR109	Round Trip Purpose Description		Description/clarification of the Purpose of the ambulatory trip. *Note:* Only used on round-trip ambulatory claims.
214	2300	CR2	Spinal Manipulation Service Information		
215	2300	CR208	Patient Condition Code		Enter the corresponding Condition Code. *Note:* Refer to the 837 Professional Implementation Guide for the valid code values.
216	2300	CRC	EPSDT Referral		
216	2300	CRC01	Code Category	07, ZZ	"07" – Ambulance Certification "ZZ" – Mutually Defined Enter this for Child Health Check-Up Screening Referral Information.
217	2300	CRC02	Certification Condition Indicator	Y, N	"Y" – Yes "N" – No For Child Health Check-Up screenings, enter a "Y" if the patient is referred to another provider as a result of the screening. Enter "N" if no referral is made. If "N" is entered here, enter "NU".
217	2300	CRC03	Condition Code	AV, NU, S2, ST	Enter one of the following valid values. For Child Health Check-Up Exam Result: "AV" – Patient Refused Referral "NU" – Not Used (Patient Not Referred) "S2" – Under Treatment "ST" – New Services Requested
257	2310A	NM1	Referring Provider Name		
258	2310A	NM101	Entity Identifier Code	DN	"DN" – Referring Provider
258	2310A	NM102	Entity Type Qualifier	1	"1" – Person
259	2310A	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
259	2310A	NM109	Referring Provider Identifier		
260	2310A	REF	Referring Provider Secondary Identification		
260	2310A	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
262	2310B	NM1	Rendering Provider Name		*Note:* This is required when the Rendering Provider is different than

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					the Billing Provider reported in Loop 2010AA. *Note:* If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop (2310C – N403).
263	2310B	NM101	Entity Identifier Code	82	"82" – Rendering Provider
264	2310B	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
264	2310B	NM109	Rendering Provider Identifier		
265	2310B	PRV	Rendering Provider Specialty Information		
265	2310B	PRV01	Provider Code	PE	"PE" – Performing
265	2310B	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
265	2310B	PRV03	Provider Taxonomy Code		Rendering Provider Taxonomy Code that is used for claims submitted with NPI.
267	2310B	REF	Rendering Provider Secondary Identification		
267	2310B	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* The "G2" qualifier must be used for non-healthcare providers. This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.
269	2310C	NM1	Service Facility Name		*Note:* If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop (2310C – N403).
270	2310C	NM101	Entity Identifier Code	77	"77" – Service Location
270	2310A	NM102	Entity Type Qualifier	2	"2" – Non-Person Entity
270	2310A	NM103	Laboratory or Facility Name		
271	2310C	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
271	2310C	NM109	Laboratory or Facility Primary Identifier		
272	2310C	N3	Service Facility Location Address		

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
272	2310C	N301	Laboratory or Facility Address Line		
273	2310C	N4	Service Facility Location City, State, Zip Code		
273	2310C	N401	Laboratory or Facility City Name		
273	2310C	N402	Laboratory or Facility State or Province Code		
273	2310C	N403	Laboratory or Facility Postal Zone or ZIP Code		Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
275	2310C	REF	Service Facility Location Secondary Information		
275	2310C	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
276	2310C	REF02	Laboratory or Facility Secondary Identifier		
285	2310E	NM1	Ambulance Pick-Up Location		*Note:* For Ambulatory claims only.
285	2310E	NM101	Entity Identifier Code	PW	"PW" – Pickup Address
286	2310E	NM102	Identification Code Qualifier	2	"2" – Non-Person Entity
287	2310E	N3	Ambulance Pick-Up Location Address		
287	2310E	N301	Ambulance Pick-up Address Line		*Note:* If the ambulance pickup location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, 'crossroad of State Road 34 and 45' or 'Exit near Mile marker 265 on Interstate').
288	2310E	N4	Ambulance Pick-Up Location City, State, Zip Code		
288	2310E	N401	Ambulance Pick-up City Name		
289	2310E	N402	Ambulance Pick-up State or Province Code		
289	2310E	N403	Ambulance Pick-up Postal Zone or ZIP Code		
290	2310F	NM1	Ambulance Drop-Off Location		*Note:* For Ambulatory Claims Only
290	2310F	NM101	Entity Identifier Code	45	"45" – Drop-Off Location
291	2310F	NM102	Identification Code Qualifier	2	"2" – Non-Person Entity

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
292	2310F	N3	Ambulance Drop-Off Location Address		
292	2310F	N301	Ambulance Drop-off Address Line		*Note:* If the ambulance pickup location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, 'crossroad of State Road 34 and 45' or 'Exit near Mile marker 265 on Interstate').
293	2310F	N4	Ambulance Drop-Off Location City, State and Zip Code		
293	2310F	N401	Ambulance Drop-off City Name		
294	2310F	N402	Ambulance Drop-off State or Province Code		
294	2310F	N403	Ambulance Drop-off Postal Zone or ZIP Code		
295	2320	SBR	Other Subscriber Information		ENCOUNTER – Loop 2320 (Other Subscriber Information) is required on all encounter claims. *Note:* For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is Third Party Liability (TPL), the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.
298	2320	SBR09	Claim Filing Indicator Code		ENCOUNTER – When the MCO is the payer, the value should be "HM". *Note:* All valid values will be accepted for other payer loops.
299	2320	CAS	Claim Level Adjustments		
301	2320	CAS02	Adjustment Reason Code	A1	ENCOUNTER – "A1" – MCO denied claim
305	2320	AMT	Coordination of Benefits (COB) Payer Paid Amount		
305	2320	AMT01	Amount Qualifier Code	D	"D" – Payer Amount Paid
305	2320	AMT02	Payer Paid Amount		Other Payer Amount Paid (Third Party Liability or Managed Care Organization)
320	2330B	NM1	Other Payer Name		ENCOUNTER – Loop 2330B (Other Payer Name) is required on all encounter claims. *Note:* For encounter claims, the MCO should always be reported as one of the other payers. For example, when there is Third Party Liability (TPL), the TPL is primary and the MCO is secondary. When there is no TPL, the MCO is primary.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
321	2330B	NM109	Other Payer Primary Identifier		This number must be identical to at least one occurrence of the 2430-SVD01 to identify the other payer. Puerto Rico Department of Health captures Third Party Payment Amount(s) from the service line(s) in 2430-SVD02. *Note:* The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail. ENCOUNTER – This value should be the MCO's assigned Trading Partner ID.
258	2330B	REF	Other Payer Claim Control Number		PRMMIS requires the MCO's internal Claim ID be entered here for every encounter.
258	2330B	REF01	Reference Identification Qualifier	F8	"F8" – Original Reference Number
258	2330B	REF02	Other Payer's Claim Control Number		The ID, in the MCO's system, of the encounter being submitted.
350	2400	LX	Service Line Number		
350	2400	LX01	Assigned Number		
351	2400	SV1	Professional Service		
351	2400	SV101	Service Line Revenue Code		*Note:* Nursing homes are not a covered service under the Puerto Rico Medicaid program.
352	2400	SV101-1	Product/Service ID Qualifier	HC	"HC" – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
353	2400	SV101-2	Procedure Code		Enter the procedure code for this Service line. For Child Health Check-up (CHCUP) claims, enter the screening procedure code on the first service line. Enter procedure code "99998" for Public Transportation Claims.
355	2400	SV104	Service Unit Count		
357	2400	SV109	Emergency Indicator	Y	"Y" – Yes Enter 'Y' if the services are known to be an emergency.
357	2400	SV111	EPSDT Indicator	Y	"Y" – Yes Enter 'Y' when the recipient was referred for services as the result of a Child Health Check-up screening.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
357	2400	SV112	Family Planning Indicator	Y	"Y" – Yes Enter 'Y' if the services relate to pregnancy or if the services were for Family Planning.
373	2400	CRC	Ambulance Certification		
374	2400	CRC03	Condition Code		Enter the Patient Condition Code. Use this Loop and Segment if Condition Code is different by detail line, otherwise use CRC03 in the 2300 Loop if the Condition Code applies to entire claim. Used only for Ambulance claims.
375	2400	CRC07	Condition Code		Enter the Patient Condition Code. Use this Loop and Segment if the Condition Code is different by detail line, otherwise use CRC03 in the 2300 Loop if the Condition Code applies to entire claim. Used only for Ambulance claims.
395	2400	CN1	Contract Information		ENCOUNTER – This information is required on all encounter claims paid at the line level. This refers to the contract between the plan and the provider paid by the plan.
395	2400	CN101	Contract Type Code		ENCOUNTER – Required "05" – If provider's services were provided under a capitation agreement, Fee For Service encounter claims should indicate the appropriate value as listed in the TR3.
395	2400	CN102	Contract Amount		ENCOUNTER – Required If CN101 = "05", then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (SVD02 in 2430 loop) and CN102 contains the amount that the health plan paid the provider for this detail.
423	2410	LIN	Drug Identification		
425	2410	LIN02	Product or Service ID Qualifier	N4	"N4" – National Drug Code
425	2410	LIN03	National Drug Code		Enter National Drug Code in 5-4-2 format.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
426	2410	CTP	Drug Quantity		
426	2410	CTP04	National Drug Unit Count		
427	2410	CTP05-1	Code Qualifier	UN	"UN" – Unit
430	2420A	NM1	Rendering Provider Name		*Note:* This is required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering Provider information is different than the Billing Provider (2010 AA). *Note:* If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop (2310C – N403).
432	2420A	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
432	2420A	NM109	Rendering Provider Identifier		
433	2420A	PRV	Rendering Provider Specialty Information		
433	2420A	PRV01	Provider Code	PE	"PE" – Performing
433	2420A	PRV02	Reference Identification Qualifier	PXC	"PXC" – Health Care Provider Taxonomy Code
433	2420A	PRV03	Provider Taxonomy Code		Detail Level Rendering Provider Taxonomy Code
434	2420A	REF	Rendering Provider Secondary Identification		
434	2420A	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* Non-healthcare providers must send this REF segment where REF01 = G2.
435	2420A	REF02	Rendering Provider Secondary Identifier		Enter Puerto Rico Medicaid Provider ID.
441	2420C	NM1	Service Facility Name		*Note:* If a zip code is required for the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop (2310C – N403).
442	2420C	NM101	Entity Identifier Code	77	"77" – Service Location
442	2420C	NM102	Entity Type Qualifier	2	"2" – Non-Person Entity
442	2420C	NM103	Laboratory or Facility Name		

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
442	2420C	NM108	Identification Code Qualifier	XX	XX = Centers for Medicare and Medicaid Services National Provider Identifier
442	2420C	NM109	Laboratory or Facility Primary Identifier		
444	2420C	N3	Service Facility Location Address		
444	2420C	N301	Laboratory or Facility Address Line		
445	2420C	N4	Service Facility Location City, State, Zip Code		
445	2420C	N401	Laboratory or Facility City Name		
446	2420C	N402	Laboratory or Facility State or Province Code		
446	2420C	N403	Laboratory or Facility Postal Zone or ZIP Code		Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
447	2420C	REF	Service Facility Location Secondary Information		
447	2420C	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
448	2420C	REF02	Laboratory or Facility Secondary Identifier		
480	2430	SVD	Line Adjudication Information		ENCOUNTER – Loop 2430 is required on all encounter claims. *Note:* Other payer payment amounts are required to be entered at the detail level.
480	2430	SVD01	Other Payer Primary Identifier		This should match one occurrence of the 2330B-NM109 Identifying Other Payer.
480	2430	SVD02	Service Line Paid Amount		Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the detail level only. This is also used for crossover detail paid amount. ENCOUNTER – If CN101 = "05", SVD02 should be zero. If CN101 = "09", then SVD02 should be the detail other payer paid amount or amount health plan paid to provider.
484	2430	CAS	Line Adjustment		

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
486	2430	CAS02	Adjustment Reason Code	A1	ENCOUNTER – "A1" – MCO Denied detail
486	2430	CAS03	Adjustment Amount		

A. APPENDIX A

A.1 Change Summary

Version 1.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
					Initial Submission

A.2 Change Summary

Version 2.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2310B	24	NM1	Rendering Provider Name		*Note:* Required when the Rendering Provider is different than the Attending Provider reported in Loop ID-2310A of this claim. *Note:* If a zip code is required in the Rendering Provider's NPI crosswalk, then it must be entered in the facility loop; 2310C. **Changed to:** *Note:* Required when the Rendering Provider is different than the Billing Provider reported in Loop 2010AA.

A.3 Change Summary

Version 3.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
N/A	3		Introduction		The following is just an example of the type of information that would be spelled out or elaborated on in Section 6: TRANSACTION-SPECIFIC INFORMATION.
2300	19	CLM02	Total Claim Charge Amount		Remove Note – negative amount will fail compliance
2300	21	CN101	Contract Type Code		Modify test: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	21	CN102	Contract Amount		Change text to: ENCOUNTER - Required

					If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	22	REF02	Value Added Network Trace Number		Modify text: Enter the 13-digit ICN or 17-digit TCN assigned to the original claim submission. (ICN/TCN to be credited/voided).
2310A	23	REF01	Reference Identification Qualifier	0B, G2	*Note:* The "G2" qualifier must be used for non-healthcare providers.
2310B	24	REF01	Reference Identification Qualifier	G2	"G2" – Provider Commercial Number *Note:* This is not required for nursing homes. *Note:* The "G2" qualifier must be used for non-healthcare providers. This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.
2310C	25	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note:* The "G2" qualifier must be used for non-healthcare providers.
2400	28	SV101-1	Product/Service ID Qualifier	HC	Element changed from SV102-1 to SV101-1.
2400	28	SV101-2	Procedure Code		Element changed from SV102-2 to SV101-2.
2400	29	CRC	Ambulance Certification		Loop corrected from 2410 to 2400
2400	29	CRC03	Condition Code		Loop corrected from 2410 to 2400
2400	29	CRC07	Condition Code		Loop corrected from 2410 to 2400

2420C	31	REF01	Reference Identification Qualifier	G2, LU	"G2" – Provider Commercial Number "LU" – Location Number *Note:* The "G2" qualifier must be used for non-healthcare providers.

A.4 Change Summary

Version 3.1 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 09-09-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
Section 1.1	8		Scope		Modify text: For further information, contact their policy-specific area of the Puerto Rico Department of Health or PRMMIS MCO EDI (PRMMISMCOEDI@hpe.com). This guide is intended as a resource to assist trading partners (Managed Care Organizations – MCO) and clearinghouses
Section 1.2	8		Overview		Remove text: This information should be given to the provider's business area to ensure that Claim/Encounters are interpreted correctly.
Section 1.4	9		National Provider Identifier		Modify text: All providers, except those that the Puerto Rico Department of Health determined as not a healthcare provider such as non-emergency transportation,
Section 1.4	10		File/System Specifications		Remove text: The recommended extension is .txt or .dat. EDI does not allow zipped files. Files will be submitted to EDI via STFP. Add text: The following standards should be used: To avoid accidently overwriting files, do not send multiple files with the same name on the same day. File Names should not be longer than 45 characters

					File Names should not contain spaces or special characters File Names should contain a file extension such as .dat or .txt Zip or compressed files are allowed, but a zip or compressed file should contain only one X12 file Zip files must contain the extension .zip (not case sensitive)
Section 1.4	10		Negative Dollar Amounts		New Paragraph: Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
Section 2.1	11		Process Flows		Modify text: classified as "paid".
N/A	12	ISA01	Authorization Information Qualifier		Remove text: Claim - [space fill]
N/A	12	ISA02	Authorization Information		Remove text: "00" – No Authorization Information Present.
N/A	14	ISA14	Acknowledgement Requested	0	Remove code 1 & comment.
Section 4.1	16		Trading Partner Identification		Modify text: In Module One of the Puerto Rico Department of Health's implementation of the PRMMIS the EDI team will create any needed Trading Partner Profiles
Section 4.2	16		Testing		Modify text: Module one of the Puerto Rico Department of Health's implementation of the PRMMIS will not require any Production Authorization Testing.
Section 4.4	16		Limits		Modify text: File Size is restricted to 5,000 transactions (claims/encounters) per file. One transaction set includes all data between and including the Transaction ST segment and Transaction SE segment.
Section 4.6	16		Procedures for voiding encounters		Modify text:

					When voiding a claim/encounter, the MCO should send their internal Transaction ID of the claim being voided in:
1000B	18	NM1	Receiver Name		Correct the Loop number.
2010AB	20	NM1	Pay-to-Address		Modify text: *Note:* This loop will not be used by Puerto Rico Department of Health's PRMMIS.
2010BA	22	NM109	Subscriber Primary Identifier		Change text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. Remove Text: *Note:* Do not enter any other numbers or letters. Use the Puerto Rico Department of Health card or the EVS to obtain the correct identification number.
2300	23	CLM01	Patient Control Number		Modify text: *Note:* Puerto Rico Department of Health's PRMMIS will process patient control numbers up to 20 characters in length. Remove text: *Note:* Value received is returned on the 835 Remittance Advice. Add text: ENCOUNTERS: MCO should send the original PCN from the provider's original claim.
2300	23	CLM05-1	Facility Type Code		Remove text: *Note:* See the Medicaid Provider Reimbursement Handbook for a list of all of the valid values.
2300	23	CLM05-3	Claim Frequency Code		Remove text: Valid values are as follows: Modify text: The third digit of the type of bill, as defined by the National Uniform Billing Committee (NUBC), is the frequency code. Use the claim frequency code to indicate whether the claim/encounter is being submitted for the first time or if it is a replacement/void of

					a previously adjudicated and "paid" claim/encounter: "1" – Original claim/encounter submitted to PRMMIS. "7" – Indicates that this claim/encounter is replacing a previously submitted and adjudicated claim/encounter. Puerto Rico Department of Health's PRMMIS will void the previously submitted claim/encounter and completely replace it with this corrected claim/encounter. "8" – Void (Credit only). Indicates that Puerto Rico Department of Health's PRMMIS should recoup the previously submitted claim/encounter in its entirety.
2300		CN1			
2300	21	CN101	Contract Type Code		Modify test: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement. "09" – FFS
2300	21	CN102	Contract Amount		Change text to: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.
2300	23	PWK	Claim Supplemental Information		Remove text: ENCOUNTER - Attachments are not permitted for Encounter Claims Modify text: Puerto Rico Department of Health's PRMMIS does not use this segment for processing of the claim/encounter.

2300	23	PWK01 thru PWK05			Delete rows.
2300	24	REF02	Referral Number		Remove text: Enter DS Waiver Coordinator Number with the REF01 = '9F'
2300	25	REF	Payer Claim Control Number		Add Note/Comment: ENCOUNTER: MCOs are required to send their claim ID (TCN) for an encounter being voided (see 4.6 - Procedures for Voiding Encounters).
2300	25	REF02	Payer Claim Control Number		Modify Note/Comment: The ID (TCN), in the MCO's system, of the encounter being voided.
2300	25	REF	Claim Identifier for Transmission Intermediaries		Remove Segment
2300	26	REF01	Reference Identification Qualifier		Remove code and text: "0B" – State License Number
2310B	26	REF01	Reference Identification Qualifier		Remove text: *Note:* This is not required for nursing homes.
2320	28	CAS02	Adjustment Reason Code	A1	Remove text: All values from code source 139 are allowed.
2320	28 thru 29	CAS05 thru CAS18	Adjustment Reason Code & Adjustment Amount		Delete rows.
2400	29	LX01	Assigned Number		Add text: Puerto Rico Department of Health accepts up to the HIPAA allowed 50 detail lines per claim/encounter. The claim/encounter would need to be split to submit more than 50 detail lines.
2400	30	SV101	Service Line Revenue Code		Remove text: Nursing home submitters must enter a revenue code. Enter Revenue Code "0101" and the per diem amount if no home days or hospital days need to be reported. Enter Revenue Code "0185" for days spent in hospital or Service Line Revenue Code "0182" for days spent at home. (Nursing Home only) Add text: *Note:* Nursing homes are not a covered service under the

					Puerto Rico Medicaid program.
2430	33	SVD	Line Adjudication Information		Remove (name loop) from Notes/Comments
2430	34	SVD01	Other Payer Primary Identifier		Remove number from Notes/Comments
2430	34	SVD02	Service Line Paid Amount		Modify text: Enter the Third Party Payment Amount (TPL) or amount health plan paid to provider at the detail level only. This is also used for crossover detail paid amount. ENCOUNTER - If CN101 = 05, SVD02 should be zero. If CN101 = 09, then SVD02 should be the detail other payer paid amount OR amount health plan paid to provider.
2430	33	CAS02	Adjustment Reason Code		Remove code & text: "1" = Medicare Deductible Amount "2" = Medicare Coinsurance Amount "66" = Medicare Blood Deductible. Remove text: Other external code source values from code source 139 are allowed.
2430	33	CAS03	Adjustment Amount		Remove codes & text: "1" = Medicare Deductible Amount "2" = Medicare Coinsurance Amount "66" enter the Medicare Blood Deductible. ENCOUNTER: "A1" - MCO Denied detail Other external code source values from code source 139 are allowed.
2430	28 thru 29	CAS05 thru CAS18	Adjustment Reason Code & Adjustment Amount		Delete rows.

A.5 Change History

Version 4.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 10-24-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	23	CN1	Contract Information		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.
N/A	10	Section 1.4	Additional Information		Remove text: **Negative Dollar Amounts** Please note that a negative dollar amount in the CAS, CN1, SV1, SV2, SV3 or SVD segments will pass HIPAA compliance, PRMMIS will not process the negative amount during adjudication.
2010BA	20	NM109	Subscriber Primary Identifier		Add text: ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID.
2320	28	SBR09	Claim Filing Indicator Code	16, CI, HM, MA, MB	Modify text: "16" – HMO Medicare Risk (required for Medicare Part C claims) "CI" – Commercial Insurance "HM" – Managed Care Organization "MA" – Medicare Part A "MB" – Medicare Part B
2330B	28	NM109	Other Payer Primary Identifier		Add text: ENCOUNTER – This value should be the MCO's assigned trading partner ID.
2330B	28	DTP	Claim Check or Remittance Date		Add text: ENCOUNTER – PRMMIS requires the Other Payer's Remittance Date be at the header and not at the detail.
2400	30	CN1	Contract Information		Add text: ENCOUNTER - This information is required on all encounter claims. This refers to the contract between the plan and the provider paid by the plan.

2400	30	CN101	Contract Type Code		Modify text: ENCOUNTER- Required "05" -- If provider's services were provided under a capitation agreement. "09" - FFS
2400	30	CN102	Contract Amount		Modified text and note: ENCOUNTER - Required If CN101 = 05, then amount is zero. If CN101 = 09, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider.

A.6 Change History

Version 5.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-16-17
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	23	CN1	Contract Information		Modify the text: ENCOUNTER – Required:when the encounter claim was paid at the header level This refers to the contract between the plan and the provider paid by the plan.
2300	23	CN101	Contract Type Code	~~05, 09~~	Modify the text: ENCOUNTER- Required "05" – If provider's services were provided under a capitation agreement FFS encounter claims should indicate the appropriate value as listed in the TR3.
2300	22	CN102	Contract Amount		Modify the text: If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered.
2300	24	K3	File Information		Remove Segment
2300	24	K301	Fixed Format Information		Remove Line: MCO Receipt Date – Format: CCYYMMDD.
2320	28	SBR09	Claim Filing Indicator Code	~~16, CI, HM, MA, MB~~	Modify the text: ~~"16" – HMO Medicare Risk (required for Medicare Part C claims).~~ ~~"CI" – Commercial Insurance~~ ~~"HM" – Managed Care Organization~~ ~~"MA" – Medicare Part A~~ ~~"MB" – Medicare Part B~~ ENCOUNTER: When the MCO is the payer the value should be "HM" *NOTE:* All valid values will be accepted for other payer loops.
2330B	29	DTP	Claim Check or Remittance Date		Remove Segment

2330B	29	DTP01	Date / Time Qualifier	573	Remove Line: "573" – Other Payer or MCO Claim Adjudication Date
2330B	29	DTP02	Date Time Period Format Qualifier	D8	Remove Line: "D8" – Date Expressed in Format CCYYMMDD
2330B	29	DTP03	Adjudication or Payment Date		Remove Line: TPL or MCO Adjudication Date (CCYYMMDD)
2400	30	CN1	Contract Information		Modify text: ENCOUNTER - This information is required on all encounter claims paid at the line level. This refers to the contract between the plan and the provider paid by the plan.
2400	30	CN101	Contract Type Code	~~05, 09~~	Modify the text: ENCOUNTER "05" – If provider's services were provided under a capitation agreement. FFS encounter claims should indicate the appropriate value as listed in the TR3.
2400	30	CN102	Contract Amount		Modify the text: ENCOUNTER If CN101 = 05, then amount is zero. For all other values of CN101, then the amount paid to the provider for services rendered. *Note:* The Other Payer Amount Paid (the sum of SVD02 elements in the 2430 loop) and CN102 contains the total monetary amount the health plan paid the provider..

A.7 Change History

Version 6.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 04-01-19
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010BA	20	NM109	Subscriber Primary Identifier		Old text: PRMMIS will only use the last 10 digits of the Puerto Rico Department of Health's member identification number. ENCOUNTER: Add 008 to the beginning of the 10 digit Member ID. New text: PRMMIS will only use the last 11 digits of the Puerto Rico Department of Health's member identification number.
2300	21	CLM	Claim Information		Add new text: NOTE: Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when one encounter is found to be non-compliant, the recommendation is to enter TCN in CLM02.

A.8 Change History

Version 7.0 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 05-05-20
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2300	21	CLM	Claim Information		New text *Note:* Because duplicate CLM01 values within ST/SE loop will cause all encounters to be rejected, even when only one encounter is found to be non-compliant, PRMP requires trading partners to enter PCN and TCN in CLM01 separated by a dash.
2300	21	CLM01	Patient Control Number		New text ENCOUNTER: Trading partners should enter encounter's PCN and TCN separated by a dash – all characters will be returned in the 835's CLP01 field.

A.9 Change History

Version 7.1 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: Wil Joslyn Designation: EDI BA Date: 11-10-21
Approved by:
Name: _____ Designation: _____ Date: _____

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
2010AA	20	N403	Billing Provider Postal Zone or ZIP Code		New text: Enter the ZIP+4 code that will correspond to the physical address on file with Puerto Rico Department Of Health. **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
2310C	27	N403	Laboratory or Facility Postal Zone or ZIP Code		New text: Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**
2420C	32	N403	Laboratory or Facility Postal Zone or ZIP Code		New text: Service Facility Location nine-digit Zip Code **NOTE: The full nine digit ZIP code must be provided. When there is no Zip+4, use extension 9998.**

ADMINISTRACIÓN DE SEGUROS DE SALUD

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NÚMERO DE CONTRATO

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GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

Puerto Rico Medicaid Management Information System Fiscal Agent Services

PRMMIS_NCPDP_Post_Adjudication_Companion_Guide

Puerto Rico Medicaid Program Post Adjudication Companion Guide

HIPAA Transaction Standard Companion Guide

Refers to the NCPDP Post Adjudication Standard V4.2

Companion Guide

Version 4.Ø – November 2Ø2Ø

Disclosure Statement

This template is based on the CORE v5Ø1Ø Master Companion Guide Template and adapted from the CAQH/WEDI Best Practices Companion Guide Template originally published January 1, 2ØØ3.

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Preface

This Companion Guide to the NCPDP Post Adjudication 4.2 Implementation Guide clarifies and specifies the data content when exchanging electronically with Puerto Rico Medicaid Program. Transmissions based on this Companion Guide, used in tandem with the Post Adjudication 4.2 Implementation Guides, are compliant with NCPDP. This Companion Guide is intended to convey information that is within the framework of the Post Adjudication 4.2 Implementation Guides. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

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Contents

1 Introduction 1
1.1 Scope 2
2 NCPDP Post Adjudication Transaction Standard Version 4.2 File Information 3
2.1 Record Delimiter 3
2.2 Over Punch Sign Requirements 3
2.3 Additional NCPDP Post Adjudication Transaction Standard Version 4.2 File Information 4
3 Naming Convention Rules for NCPDP V4.2 Post Adjudication File: 6
4 Transaction Specific Information 7
4.1 POST ADJUDICATION HISTORY HEADER RECORD 7
4.2 POST ADJUDICATION HISTORY DETAIL RECORD 9
4.2.1 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD1 68
4.2.2 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD2 94
4.3 POST ADJUDICATION HISTORY TRAILER RECORD 95
Appendix A: Discussion of MAO COB/TPL Reporting When: 96
MAO Only Paid 96
MAO Paid & Wraparound Picked Up Copay 106
Wraparound Paid (Medicaid Only) 115
Commercial Insurance as Primary and MAO as Secondary 124
Appendix B: Change Summary 135

Tables

Table 1 – Example NCPDP Post Adjudication 4.2 Implementation Guides Table 2
Table 2 – Over Punch Sign Requirements 3
Table 3 – Post Adjudication History Header Record 7
Table 4 – Post Adjudication History Detail Record 9
Table 5 – Post Adjudication History Compound Detail Record1 68
Table 6 – Post Adjudication History Compound Detail Record2 94
Table 7 – Post Adjudication History Trailer Record 95
Table 8 – MAO Only Paid 96
Table 9 – MAO Paid & Wraparound Picked Up Copay 106
Table 10 – Wraparound Paid (Medicaid Only) 115
Table 11 – Commercial Insurance as Primary and MAO as Secondary 124

1 Introduction

NCPDP – NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS

The Health Insurance Portability and Accountability Act (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 issuers. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

The National Council for Prescription Drug Programs (NCPDP) is a non-profit organization formed in 1976. It is dedicated to the development and dissemination of voluntary consensus standards that are necessary to transfer information that is used to administer the prescription drug benefit program.

Refer to the NCPDP Post Adjudication Version 4.2 documents (NCPDP Post Adjudication Standard Implementation Guide (IG), Data Dictionary, and External Code List) for more detailed information on field values and segments.

The following information is intended to serve only as a Companion Guide to the aforementioned NCPDP Post Adjudication Standard Version 4.2 documents. The use of this Companion Guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This Companion Guide supplements, but does not contradict, any requirements in the NCPDP Post Adjudication Standard Version 4.2 Implementation Guide and related documents.

To request a copy of the NCPDP Standard Formats or for more information contact the National Council for Prescription Drug Programs, Inc. at www.ncpdp.org. The contact information is as follows:

National Council for Prescription Drug Programs
924Ø East Raintree Drive Scottsdale, AZ 8526Ø
Phone: (48Ø) 477-1ØØØ
Fax (48Ø) 767-1Ø42

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This section describes how the NCPDP Post Adjudication (4.2) Implementation Guides (IGs) will be detailed with the use of a table. The table contains a row for each element/field of the NCPDP Post Adjudication V4.2 records.

Each row will indicate whether the element/field is required or is not required by PRMMIS.

The following table is an example:

Table 1 – Example NCPDP Post Adjudication 4.2 Implementation Guides Table

SHADED Rows represent "sections" in the NCPDP Post Adjudication Implementation Guide.
NON-SHADED Rows represent "data elements" in the NCPDP Post Adjudication Implementation Guide.

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	PA – Post Adjudication History Header Record	M	P	A	2	1	2	Required
6Ø1-Ø9	TOTAL RECORD COUNT	Total number of records being submitted, including header and trailer.		M	P	N	1Ø	3	12	Required
895	TOTAL NET AMOUNT DUE	Summarization of Net Amount Due (281).		M	P	D	12	13	24	Required

1.1 Scope

This Companion Guide is to be used in addition to the NCPDP Post Adjudication 4.2 Implementation Guide, Data Dictionary, and External Code List.

This Companion Guide contains supplemental information for creating transactions for PRMP while ensuring compliance with the associated Post Adjudication 4.2 Implementation Guide.

The Transaction Instruction component of this Companion Guide must be used in conjunction with an associated NCPDP Post Adjudication 4.2 Implementation Guide, Data Dictionary, and External Code List.

The instructions in this Companion Guide are not intended to be stand-alone requirements documents. This Companion Guide conforms to all the requirements of any associated NCPDP Post Adjudication 4.2 Implementation Guide, Data Dictionary, and External Code List, and is in conformance with NCPDP's Fair Use and Copyright statements.

2 NCPDP Post Adjudication Transaction Standard Version 4.2 File Information

The batch specifications contained in this document include the header, detail, compound, and trailer segments. Batch files should contain one header record, one trailer record, and a maximum of 2ØØ,ØØØ transaction details.

- Post Adjudication History Header (Occurs 1)
- Post Adjudication History Detail (Occurs 1 to 2ØØ,ØØØ)
- Post Adjudication History Compound Detail 1 (Occurs 1 as Applicable with Detail Record)
- Post Adjudication History Compound Detail 2 (Occurs 1 as Applicable with Detail Record)
- Post Adjudication History Trailer (Occurs 1)

Note: All ingredients in a Compound detail should be consecutive and contiguous to each other; gaps or holes in the sequence are not accepted. Also, only send a Compound Detail 2 record if and only if Compound Detail 1 has all 8 ingredients already set up, and more ingredients or components are required.

Batch files should have a creation date in the batch header that is valid and less than 3Ø days old from the submission date of the file, or the file will be rejected. Values in the header and trailer will be edited to verify that they contain appropriate values.

2.1 Record Delimiter

The V4.2 Post Adjudication V4.2 record is 3,7ØØ characters followed by a Carriage return only – UNIX-based system (record length n+1).

2.2 Over Punch Sign Requirements

Table 2 – Over Punch Sign Requirements

Positive Signed		Negative Signed	
Numeric	**Graphic**	**Numeric**	**Graphic**
Ø	{	Ø	}
1	A	1	J
2	B	2	K
3	C	3	L
4	D	4	M
5	E	5	N

Positive Signed		Negative Signed	
Numeric	**Graphic**	**Numeric**	**Graphic**
6	F	6	O
7	G	7	P
8	H	8	Q
9	I	9	R

Examples:

1. 1Ø{ is 1ØØ
2. 45A is 451

Decimal points are usually implied, not explicit in the text. Using numbers with two decimal digits: 1ØØØØ{ is 1ØØ.ØØ.

2.3 Additional NCPDP Post Adjudication Transaction Standard Version 4.2 File Information

The following definitions are given to ensure consistency of interpretation:

- **Field** – The Post Adjudication Transaction Standard Version 4.2 field number
- **Field Name** – The Post Adjudication Transaction Standard Version 4.2 field name
- **Description** – A short description of field
- **Values** – Required or default value(s) for each field
- **Usage** – Field designation – indicates whether a field is mandatory, situational, or not used. Mandatory fields are made mandatory by the NCPCP Post Adjudication Transaction Standard Version 4.2 and/or required by the processor. If a field is situational and data does not exist for the field, the field MUST be populated with the appropriate padding (default value). If a field is not required, note that PRMMIS will not process any data submitted.
    - M – Mandatory field
    - S – Situational field
    - N/U – Not used (PRMMIS will not use information sent in this field)
- **Source** – Data source
    - C – Submitted Claim or the Processor's response to the Submitted Claim
    - P – Processor/Payer

- **Format** – Field format values
  - A – Alpha Numeric – upper case when alpha, always left justified, space filled, printable characters and **default values of spaces**
    - Example: X(14) represents "1234ABC44bbbbb"
  - N – Unsigned Numeric – always right justified, zero filled and **default values of zeros**
    - Example: 9(7)v999 represents "9999999999"
  - D – Signed Numeric – sign is internal and trailing (see Section **Over Punch Sign Requirements**), zero always positive, always right justified, zero filled dollar-cents amount with 2 positions to the right of the implied decimal point, all other positions to the left of the implied decimal point and **default values of positive zeros**
    - Example: "D" fields of length 8 represent $$$$$$cc
- **Size** – The field length
- **Start** – The starting position of the field in the record
- **End** – The ending position of the field in the record
- **PRMP Comment** – Notes/comments about specific fields

3 Naming Convention Rules for NCPDP V4.2 Post Adjudication File:

Position 1 – 4 = 4 byte abbreviation of PBM/MAO's name
Position 5 – 6 = sequence number of file (each file limited to 2ØØ,ØØØ claims)
Position 7 = underscore
Position 8 – 2Ø = Always use PRM_ClaimData
Position 21 = underscore
Position 22 – 29 = Date file was created (YYYYMMDD format)
Position 3Ø – 33 = use .dat or .zip

Example #1:
Submission Date: 11/Ø1/2Ø19
Total Number of Claims: 3ØØ,ØØØ

ABRV01_ PRM_ClaimData_20191101.dat [First 2ØØ,ØØØ claims]
ABRV02_ PRM_ClaimData_20191101.dat [Last 1ØØ,ØØØ claims]

Example #2:
Submission Date: 11/15/2Ø19
Total No of Claims: 5ØØ,ØØØ

ABRV01_ PRM_ClaimData_20191115.dat [First 2ØØ,ØØØ claims]
ABRV02_ PRM_ClaimData_20191115.dat [Second 2ØØ,ØØØ claims]
ABRV03_ PRM_ClaimData_20191115.dat [Last 1ØØ,ØØØ claims]

4 Transaction Specific Information

This section describes how the NCPDP Post Adjudication 4.2 Implementation Guide (IG), Data Dictionary, and the External Code List will be used. The tables contain a row for each data element that PRMP has something additional, over and above, the information in the IGs in addition to any other information tied directly to a data element pertinent to trading electronically with PRMP.

4.1 POST ADJUDICATION HISTORY HEADER RECORD

Table 3 – Post Adjudication History Header Record

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	PA – Post Adjudication History Header Record	M	P	A	2	1	2	Required
1Ø2-A2	VERSION/ RELEASE NUMBER	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	42 – Version 4.2	M	P	A	2	3	4	Required
879	SENDING ENTITY IDENTIFIER	Party creating the data enclosed or the entity for whom the data is being enclosed.	PRMP assigned six-digit trading partner ID	M	P	A	24	5	28	Required
8Ø6-5C	BATCH NUMBER	This number is assigned by the processor/sender. A number generated by the sender to uniquely identify this batch from others, especially when multiple batches may be sent in one day.		M	P	N	7	29	35	Required
88Ø-K2	CREATION DATE	Date that the file was created. Not older than 3Ø days from the actual submission date.	Format CCYYMMDD	M	P	N	8	36	43	Required
88Ø-K3	CREATION TIME	Time that the file was created.	Format HHMM	M	P	N	4	44	47	Required

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
88Ø-K7	RECEIVER ID	An identification number of the endpoint receiver of the data file.	PRMMIS	M	P	A	24	48	71	Required
6Ø1-Ø6	REPORTING PERIOD START DATE	The first day of the period being reported in the file.	Format CCYYMMDD	M	P	N	8	72	79	Required
6Ø1-Ø5	REPORTING PERIOD END DATE	The last day of the period being reported in the file.	Format CCYYMMDD	M	P	N	8	8Ø	87	Required
7Ø2-MC	FILE TYPE	Code identifying whether the file contained test or production data.	T – Test – In processing systems, the test environment P – Production – In processing systems, the live environment	M	P	A	1	88	88	Required
981-JV	TRANSMISSION ACTION	Indicates whether this is a replacement file, file updates, or a file delete.	O – Original Submission (New) – a new file	M	P	A	1	89	89	Required
888	SUBMISSION NUMBER	Indicates the number of times that a data set has been resent.	Blank – Not Specified ØØ – First Submission Ø1 – First Resubmission Ø2 – Second Resubmission Ø3 – 99 – Number of Resubmission	M	P	A	2	9Ø	91	Required
	FILLER			N/U	P	A	36Ø9	92	37ØØ	

4.2 POST ADJUDICATION HISTORY DETAIL RECORD

Table 4 – Post Adjudication History Detail Record

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	DE – Post Adjudication History Detail Record	M	P	A	2	1	2	Required
398	RECORD INDICATOR	Action to be taken on the record.	Ø – New Record	S	P	A	1	3	3	Required
SECTION DENOTES ELIGIBILITY CATEGORY:										
248	ELIGIBLE COVERAGE CODE	Coverage Level Code. Code indicating the level of coverage being provided for the insured.	IND – Individual	S	P	A	3	4	6	Required
898	USER BENEFIT ID	Member's benefit ID based upon User Group Number from Eligibility when submitted by Client.		N/U	P	A	1Ø	7	16	
899	USER COVERAGE ID	Member's coverage ID based upon User Group Number submitted by Client on eligibility data.		N/U	P	A	1Ø	17	26	
246	ELIGIBILITY GROUP ID	Identifier of the group that determines eligibility parameters for the member when submitted by the client.		N/U	P	A	15	27	41	
27Ø	LINE OF BUSINESS CODE	Line of Business Code from Client eligibility or as defined by trading partner agreement.		N/U	P	A	6	42	47	
267	INSURANCE CODE	Special group/member data as supplied on eligibility record when supplied by the client.		N/U	P	A	2Ø	48	67	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
22Ø	CLIENT ASSIGNED LOCATION CODE	The location of the member within the Client's Company from Client eligibility when submitted by the client.		N/U	P	A	2Ø	68	87	
222	CLIENT PASS THROUGH	Information from Client eligibility when submitted by the client.		N/U	P	A	2ØØ	88	287	
SUBSECTION DENOTES CARDHOLDER INFORMATION:										
3Ø2-C2	CARDHOLDER ID	Insurance ID assigned to the cardholder or identification number used by the plan.		M	C/P	A	2Ø	288	3Ø7	Required PRMMIS will only use the last 11 digits of the Puerto Rico Medicaid Program's member identification number.
716-SY	LAST NAME	Last name.		S	P	A	35	3Ø8	342	Required when available in the payer's adjudication system
717-SX	FIRST NAME	First name.		S	P	A	35	343	377	Required when available in the payer's adjudication system
718	MIDDLE INITIAL	Middle initial.		N/U	P	A	1	378	378	
28Ø	NAME SUFFIX	Individual name suffix.		N/U	P	A	1Ø	379	388	
726-SR	ADDRESS LINE 1	First line of address information.		N/U	P	A	4Ø	389	428	
727-SS	ADDRESS LINE 2	Second line of address information.		N/U	P	A	4Ø	429	468	
728	CITY	Free-form text for city name.		N/U	P	A	3Ø	469	498	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
729-TA	STATE/ PROVINCE ADDRESS	The State/Province Code of the address.		N/U	P	A	2	499	5ØØ	
73Ø	ZIP/POSTAL CODE	Code defining international postal code excluding punctuation.		N/U	P	A	15	5Ø1	515	
B36-1W	ENTITY COUNTRY CODE	Code of the country.		N/U	P	A	2	516	517	
214	CARDHOLDER DATE OF BIRTH	Date of Birth of Member.		N/U	P	N	8	518	525	
721-MD	GENDER CODE	Code identifying the gender of the individual.	Blank – Unknown or Unspecified 1 – Male 2 – Female	S	P	N	1	526	526	Required when available in the payer's adjudication system
274	MEDICARE PLAN CODE	This represents if the member is eligible for Medicare coverage as provided in eligibility data.		N/U	P	A	1	527	527	
288	PAYROLL CLASS	A field defined by the client indicating the payroll class of the member.		N/U	P	A	1	528	528	
SECTION DENOTES PATIENT INFORMATION:										
331-CX	PATIENT ID QUALIFIER	Code qualifying the 'Patient ID' (332-CY).	Ø6 – Medicaid ID – A number assigned by a state Medicaid agency	S	P	A	2	529	53Ø	Required
332-CY	PATIENT ID	ID assigned to the patient.		S	P	A	2Ø	531	55Ø	Required PRMMIS will only use the last 11 digits of the Puerto Rico Medicaid Program's member identification number.

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
716-SY	LAST NAME	Last name.		N/U	P	A	35	551	585	
717-SX	FIRST NAME	First name.		N/U	P	A	35	586	62Ø	
718	MIDDLE INITIAL	Middle initial.		N/U	P	A	1	621	621	
28Ø	NAME SUFFIX	Individual name suffix.		N/U	P	A	1Ø	622	631	
726-SR	ADDRESS LINE 1	First line of address information.		N/U	P	A	4Ø	632	671	
727-SS	ADDRESS LINE 2	Second line of address information.		N/U	P	A	4Ø	672	711	
728	CITY	Free-form text for city name.		N/U	P	A	3Ø	712	741	
729-TA	STATE/PROVINCE ADDRESS	The State/Province Code of the address.		N/U	P	A	2	742	743	
73Ø	ZIP/POSTAL CODE	Code defining international postal code excluding punctuation.		N/U	P	A	15	744	758	
A43-1K	PATIENT COUNTRY CODE	Code of the country.		N/U	P	A	2	759	76Ø	
3Ø4-C4	DATE OF BIRTH	Date of Birth of Member.	Default ØØØØØØØØ	S	P	N	8	761	768	Required when available in the payer's adjudication system
3Ø5-C5	PATIENT GENDER CODE	Code identifying the gender of the patient.	Default Ø	N/U	P	N	1	769	769	
247	ELIGIBILITY/PATIENT RELATIONSHIP CODE	Individual Relationship Code. Code indicating the relationship between two individuals or entities.	ØØ – Not Applicable	N/U	P	N	2	77Ø	771	
2Ø8	AGE	Calculated from Date of Birth (3Ø4-C4).	Default ØØØ	N/U	P	N	3	772	774	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
3Ø3-C3	PERSON CODE	Code assigned to a specific person within a family.		N/U	P	A	3	775	777	
3Ø6-C6	PATIENT RELATIONSHIP CODE	Code indicating relationship of patient to cardholder.	Ø – Not Specified	N/U	C	N	1	778	778	
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE	Code indicating that the pharmacy is clarifying eligibility for a patient.		N/U	C	A	1	779	779	
336-8C	FACILITY ID	ID assigned to the patient's clinic/host party.		N/U	P	A	1Ø	78Ø	789	
SECTION DENOTES BENEFIT CATEGORY:										
3Ø1-C1	GROUP ID	ID assigned to the cardholder group or employer group.		N/U	P	A	15	79Ø	8Ø4	
215	CARRIER NUMBER	Account Number assigned during installation.		M	P	A	9	8Ø5	813	Required PRMP assigned trading partner ID of MCO/MAO.
757-U6	BENEFIT ID	Assigned by processor to identify a set of parameters, benefits, or coverage criteria used to adjudicate a claim.		N/U	P	A	15	814	828	
24Ø	CONTRACT NUMBER	Account Number assigned during installation for segments of business.		N/U	P	A	8	829	836	
212	BENEFIT TYPE	Indicates the type of acceptable claims for the group based on the Benefit setup.		N/U	P	A	1	837	837	
279	MEMBER SUBMITTED	A one-position field indicating the type of member submitted claim		N/U	P	A	1	838	838	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	CLAIM PROGRAM CODE	program used to process this claim.								
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non-Point of Sale (POS) claims and/or modifying pricing logic.		N/U	P	A	1	839	839	
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non-Point of Sale (POS) claims and/or modifying pricing logic.		N/U	P	A	1	84Ø	84Ø	
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non-Point of Sale (POS) claims and/or modifying pricing logic.		N/U	P	A	1	841	841	
241	COPAY MODIFIER ID	Unique drug list ID that is coordinated for use with the clients copay setup. Processor defined codes.		N/U	P	A	1Ø	842	851	
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.		N/U	P	A	1	852	852	
293	PREFERRED ALTERNATIVE FILE ID	Indicates the preferred alternative file ID number used to determine processing.		N/U	P	A	1Ø	853	862	
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ – Not Specified by patient Ø1 – No other coverage – Code used in coordination of benefits transactions to convey that no	S	C	N	2	863	864	If available, report the appropriate value that represents other coverage for the drug/product. COB/TPL

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received. Ø3 – Other Coverage Billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered. Ø4 – Other coverage exists – payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed,							

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only. Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection, or network selection.							
291	PLAN BENEFIT CODE	Determines the method by which Insulin and OTC claims are paid. Defined by processor.		N/U	P	A	2	865	866	
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan.	192Ø – Medicaid 193Ø – Medicare If neither MAO nor Wraparound is the primary payer, enter four spaces.	M	P	A	4	867	87Ø	Use 193Ø (Medicare) when only MAO funding is used to pay the drug/product. Use 192Ø (Medicaid) when only Puerto Rico Medicaid funds are used to pay the drug/product. If neither, enter spaces. COB/TPL

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
SECTION DENOTES PHARMACY CATEGORY:										
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Code qualifying the 'Service Provider ID' (2Ø1-B1).	Ø1 – National Provider Identifier (NPI) Ø5 – Medicaid ID if atypical	M	C	A	2	871	872	Required
2Ø1-B1	SERVICE PROVIDER ID	ID assigned to a pharmacy or provider.		M	C	A	15	873	887	Required
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER (ALTERNATE)	Code qualifying the 'Service Provider ID' (2Ø1-B1).		N/U	P	A	2	888	889	
2Ø1-B1	SERVICE PROVIDER ID (ALTERNATE)	ID assigned to a pharmacy or provider.		N/U	P	A	15	89Ø	9Ø4	
886	SERVICE PROVIDER CHAIN CODE	Processor specific ID assigned to a chain by processor.		N/U	P	A	7	9Ø5	911	
833-5P	PHARMACY NAME	Pharmacy name.		M	P	A	7Ø	912	981	Required
726-SR	ADDRESS LINE 1	First line of address information.		M	P	A	4Ø	982	1Ø21	Required
727-SS	ADDRESS LINE 2	Second line of address information.		N/U	P	A	4Ø	1Ø22	1Ø61	
728	CITY	Free-form text for city name.		M	P	A	3Ø	1Ø62	1Ø91	Required
729-TA	STATE/PROVINCE ADDRESS	The State/Province Code of the address.		M	P	A	2	1Ø92	1Ø93	Required
73Ø	ZIP/POSTAL CODE	Code defining international postal code excluding punctuation.		M	P	A	15	1Ø94	11Ø8	Required
887	SERVICE PROVIDER COUNTY CODE	Indicates the county of the pharmacy.		N/U	P	A	3	11Ø9	1111	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
A93	SERVICE PROVIDER COUNTRY CODE	Indicates the country code of the provider.		N/U	P	A	2	1112	1113	
732	TELEPHONE NUMBER	Telephone Number.		N/U	P	N	1Ø	1114	1123	
B1Ø -8A	TELEPHONE NUMBER EXTENSION	Extension of the telephone number.		N/U	P	N	8	1124	1131	
146	PHARMACY DISPENSER TYPE QUALIFIER	Code qualifying the 'Pharmacy Dispenser Type' (29Ø).		N/U	P	A	1	1132	1132	
29Ø	PHARMACY DISPENSER TYPE	Type of pharmacy dispensing product.		N/U	P	A	2	1133	1134	
15Ø	PHARMACY CLASS CODE QUALIFIER	Code qualifying the 'Pharmacy Class Code' (289).		N/U	P	A	1	1135	1135	
289	PHARMACY CLASS CODE	Indicates class of the pharmacy.		N/U	P	A	1	1136	1136	
266	IN NETWORK INDICATOR	Indicates if the pharmacy dispensing the prescription is considered in network.		N/U	P	A	1	1137	1137	
545-2F	NETWORK REIMBURSEMENT ID	Field defined by the processor. It identifies the network, for the covered member, used to calculate the reimbursement to the pharmacy.		N/U	P	A	1Ø	1138	1147	
SECTION DENOTES PRESCRIBER CATEGORY:										
466-EZ	PRESCRIBER ID QUALIFIER	Code qualifying the 'Prescriber ID' (411- DB).	Ø1 – National Provider Identifier (NPI) Ø5 – Medicaid ID if atypical	M	C	A	2	1148	1149	Required

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
411-DB	PRESCRIBER ID	ID assigned to the prescriber.		M	C	A	15	115Ø	1164	Required
466-EZ	PRESCRIBER ID QUALIFIER (ALTERNATE)	Code qualifying the 'Prescriber ID' (411- DB).		N/U	P	A	2	1165	1166	
411-DB	PRESCRIBER ID (ALTERNATE)	ID assigned to the prescriber.		N/U	P	A	15	1167	1181	
296	PRESCRIBER TAXONOMY	The taxonomy is defined as a classification scheme that codifies provider type and provider area of specialization.		S	P	A	1Ø	1182	1191	Required when available in the payer's adjudication system.
295	PRESCRIBER CERTIFICATION STATUS	Indicates a provider's certification in the health plan program.		N/U	P	A	2	1192	1193	
716-SY	LAST NAME	Last name.		M	P	A	35	1194	1228	Required
717-SX	FIRST NAME	First name.		M	P	A	35	1229	1263	Required
732	TELEPHONE NUMBER	Telephone Number.		M	P	N	1Ø	1264	1273	Required
B1Ø-8A	TELEPHONE NUMBER EXTENSION	Extension of the telephone number.		N/U	C/P	N	8	1274	1281	
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	Code qualifying the 'Primary Care Provider ID' (421-DL).		N/U	C/P	A	2	1282	1283	
421-DL	PRIMARY CARE PROVIDER ID	ID assigned to the primary care provider. Used when the patient is referred to a secondary care provider.		N/U	C/P	A	15	1284	1298	
716-SY	LAST NAME	Last name.		N/U	P	A	35	1299	1333	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
717-SX	FIRST NAME	First name.		N/U	P	A	35	1334	1368	
SECTION DENOTES CLAIM CATEGORY:										
399	RECORD STATUS CODE	Identifies the transaction status as assigned by the processor.	1 – Paid – Code indicating that the transaction was adjudicated using plan rules and was payable. 2 – Rejected – Code indicating that the transaction was denied/rejected. 3 – Reversed – Code indicating that the paid transaction was cancelled. 4 – Adjusted – Code indicating that the previous transaction was changed. 5 – Captured – Code indicating the receipt of the transaction, but no judgment has been made regarding eligibility of the patient or payment. 6 – Reverse – Captured – Code indicating that the captured transaction was cancelled.	M	P	A	1	1369	1369	Required

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
218	CLAIM MEDIA TYPE	Claim submission type code.	Blank – Not Specified 1 – POS Claim – A Point-Of-Sale transaction submitted in a real-time mode. 2 – Batch Claim – A non-real-time transaction submitted when an immediate response is not available or required. 3 – Pharmacy Submitted Paper Claim (UCF) – A non-electronic transaction submitted via an NCPDP-developed Universal Claim Form. 4 – Member Submitted Paper Claim (Direct Member Reimbursement (DMR)) – A claim submitted by the member requesting reimbursement. 5 – Other – Different from the codes already specified.	M	P	A	1	137Ø	137Ø	Required
395	PROCESSOR PAYMENT	Provides additional information of the status	Blank – Not Specified	M	P	A	2	1371	1372	PRMP requires "Blank" for this data element.

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	CLARIFICATION CODE	of the payment of the claim.								
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	Prescription/Service Reference Number Qualifier	1 – Rx Billing Transaction – A billing for a prescription or OTC drug product. 2 – Service Billing – Transaction is a billing for a professional service performed.	M	C	A	1	1373	1373	Required
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	Reference number assigned by the provider for the dispensed drug/product and/or service provided.		M	C	N	12	1374	1385	Required
436-E1	PRODUCT/ SERVICE ID QUALIFIER	Code qualifying the value in 'Product/Service ID' (4Ø7-D7).	36 – NDC	M	C	A	2	1386	1387	Required
4Ø7-D7	PRODUCT/ SERVICE ID	ID of the product dispensed or service provided.		M	C	A	19	1388	14Ø6	Required NDC drug code if a compound drug is being reported; this field should be all zeros.
4Ø1-D1	DATE OF SERVICE	Identifies date that the prescription was filled or professional service rendered or subsequent payer began coverage following Part A expiration in a long-term care setting only.		M	C	N	8	14Ø7	1414	Required CCYYMMDD
578	ADJUDICATION DATE	Date that the claim or adjustment is processed.		M	P	N	8	1415	1422	Required

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
2Ø3	ADJUDICATION TIME	Time that the claim or adjustment is processed.		N/U	P	N	6	1423	1428	
283	ORIGINAL CLAIM RECEIVED DATE	The date that the pharmacy submitted the claim electronically for a paper claim-matching program.		N/U	P	N	8	1429	1436	
219	CLAIM SEQUENCE NUMBER	Indicates the sequence of this claim within the set of claims submitted.		N/U	P	N	5	1437	1441	
213	BILLING CYCLE END DATE	Cycle end date.		N/U	P	N	8	1442	1449	
239	COMMUNICATION TYPE INDICATOR	For Mail Service Claims Only – Identifies the type of communication used by either prescriber or patient to initiate the request for the fill.		N/U	P	A	2	145Ø	1451	
3Ø7-C7	PLACE OF SERVICE	Code identifying the place where a drug or service is dispensed or administered.		N/U	C	N	2	1452	1453	
384-4X	PATIENT RESIDENCE	Code identifying the patient's place of residence.	ØØ – Not Specified	N/U	C	N	2	1454	1455	
419-DJ	PRESCRIPTION ORIGIN CODE	Code indicating the origin of the prescription.	Ø – Not Known	N/U	C	N	1	1456	1456	
278	MEMBER SUBMITTED CLAIM PAYMENT RELEASE DATE	Indicates the date that the member-submitted claim became payable, which could differ from the check date.		N/U	P	N	8	1457	1464	
217	CLAIM DATE RECEIVED IN THE MAIL	Date that the paper claim was received in the mail.		N/U	P	N	8	1465	1472	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
268	INTERNAL MAIL ORDER PRESCRIPTION/ SERVICE REFERENCE NUMBER	Field designating the internal prescription number assigned by pharmacies.		N/U	P	A	15	1473	1487	
1Ø2-A2	VERSION/ RELEASE NUMBER (OF THE CLAIM)	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.		N/U	C	A	2	1488	1489	
216	CHECK DATE	Member Claims – Actual member check date. Nonmember Claims – Pharmacy check date.		N/U	P	N	8	149Ø	1497	
287	PAYMENT/ REFERENCE ID	Identifies ID assigned by sender to reference individual pharmacy and member reimbursement. Check or EFT trace number.		N/U	P	A	3Ø	1498	1527	
456-EN	ASSOCIATED PRESCRIPTION/ SERVICE REFERENCE NUMBER	Related 'Prescription/Service Reference Number' (4Ø2-D2) to which the service is associated.		N/U	C	N	12	1528	1539	
457-EP	ASSOCIATED PRESCRIPTION/ SERVICE DATE	Date of the 'Associated Prescription/Service Reference Number' (456-EN).		N/U	C	N	8	154Ø	1547	
442-E7	QUANTITY DISPENSED	Quantity dispensed, expressed in metric decimal units.		M	C	N	1Ø	1548	1557	Required Quantity dispensed – if a compound drug is being reported, this field should be all zeros.

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
4Ø3-D3	FILL NUMBER	The code indicating whether the prescription is an original or a refill.	ØØ – Original dispensing – The first dispensing Ø1 – 99 – Refill number – Number of the replenishment	M	C	N	2	1558	1559	Required Indicates new Rx (zero) or number of refills used.
4Ø5-D5	DAYS SUPPLY	Estimated number of days that the prescription will last.		M	C	N	3	156Ø	1562	Required
414-DE	DATE PRESCRIPTION WRITTEN	Date that the prescription was written.		M	C	N	8	1563	157Ø	Required CCYYMMDD
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	Ø – No Product Selection Indicated 1 – Substitution Not Allowed by Prescriber 2 – Substitution Allowed – Patient Requested Product Dispensed 3 – Substitution Allowed – Pharmacist Selected Product Dispensed 4 – Substitution Allowed – Generic Drug Not in Stock 5 – Substitution Allowed – Brand 6 – Override 7 – Substitution Not Allowed 8 – Substitution Allowed	M	C	A	1	1571	1571	Required

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			9 – Substitution Allowed By Prescriber, but Plan Requests Brand							
415-DF	NUMBER OF REFILLS AUTHORIZED	Number of refills authorized by the prescriber.	ØØ – No refills authorized Ø1 – 99 – Authorized Refill number – with '99' being refills unlimited	M	C	N	2	1572	1573	Required
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.		N/U	C	N	1	1574	1574	
6ØØ-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA – Each GM – Grams ML – Milliliters	M	C	A	2	1575	1576	Required
418-DI	LEVEL OF SERVICE	Coding indicating the type of service that the provider rendered.	ØØ – Not Specified Ø1 – Patient consultation Ø2 – Home delivery Ø3 – Emergency Ø4 – 24 hour service Ø5 – Patient consultation regarding generic product selection Ø6 – In-Home Service	M	C	N	2	1577	1578	Required
343-HD	DISPENSING STATUS	Code indicating that the quantity dispensed is a partial fill or the completion of a partial fill. Used only in situations where inventory	Blank – Not Specified P – Partial Fill C – Completion of Partial Fill	M	C	A	1	1579	1579	Required

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		shortages do not allow the full quantity to be dispensed.								
344-HF	QUANTITY INTENDED TO BE DISPENSED	Metric decimal quantity of medication that would be dispensed on original filling if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).		N/U	C	N	1Ø	158Ø	1589	
46Ø-ET	QUANTITY PRESCRIBED	Amount expressed in metric decimal units.		N/U	C	N	1Ø	159Ø	1599	
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	Days' supply for metric decimal quantity of medication that would be dispensed on original dispensing if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).		S	C	N	3	16ØØ	16Ø2	Required
254	FILL NUMBER CALCULATED	Code identifying whether the prescription is an original (ØØ) or by refill number (Ø1 – 99).		N/U	P	N	2	16Ø3	16Ø4	
4Ø6-D6	COMPOUND CODE	Code indicating whether or not the prescription is a compound.	Ø – Not Specified 1 – Not a Compound 2 – Compound	M	C	N	1	16Ø5	16Ø5	Required
996-G1	COMPOUND TYPE	Clarifies the type of compound.		N/U	C	A	2	16Ø6	16Ø7	
452-EH	COMPOUND ROUTE OF ADMINISTRATION	Code for the route of administration of the complete compound mixture.		N/U	C	N	2	16Ø8	16Ø9	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
995-E2	ROUTE OF ADMINISTRATION	This is an override to the "default" route referenced for the product. For a multi-ingredient compound, it is the route of the complete compound mixture.		M	C	A	11	161Ø	162Ø	Required
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).	ØØ – Not Specified Ø1 – International Classification of Diseases (ICD9) Ø2 – International Classification of Diseases-1Ø (ICD1Ø)	S	C	A	2	1621	1622	Required
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		S	C	A	15	1623	1637	Required
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).		N/U	C	A	2	1638	1639	
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		N/U	C	A	15	164Ø	1654	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).		N/U	C	A	2	1655	1656	
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		N/U	C	A	15	1657	1671	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).		N/U	C	A	2	1672	1673	
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		N/U	C	A	15	1674	1688	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).		N/U	C	A	2	1689	169Ø	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.		N/U	C	A	15	1691	17Ø5	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	17Ø6	17Ø7	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	17Ø8	17Ø9	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	171Ø	1711	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1712	1713	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1714	1715	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has		N/U	C	A	2	1716	1717	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		been identified or service has been rendered.								
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1718	1719	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	172Ø	1721	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1722	1723	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1724	1725	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1726	1727	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a		N/U	C	N	2	1728	1729	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		pharmacist to perform a professional service.								
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	173Ø	1731	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1732	1733	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1734	1735	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1736	1737	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1738	1739	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	174Ø	1741	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1742	1743	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1744	1745	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1746	1747	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1748	1749	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	175Ø	1751	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1752	1753	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1754	1755	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1756	1757	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1758	1759	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	176Ø	1761	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	1762	1763	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1764	1765	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1766	1767	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1768	1769	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.		N/U	C	A	2	177Ø	1771	
44Ø-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.		N/U	C	A	2	1772	1773	
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.		N/U	C	A	2	1774	1775	
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.		N/U	C	N	2	1776	1777	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	1778	1779	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	178Ø	1798	
878	REJECT OVERRIDE CODE	Indicates the reason for paying a claim when override is used.		N/U	P	A	1	1799	1799	
511-FB	REJECT CODE	Code indicating the error encountered.		N/U	C	A	3	18ØØ	18Ø2	
511-FB	REJECT CODE	Code indicating the error encountered.		N/U	C	A	3	18Ø3	18Ø5	
511-FB	REJECT CODE	Code indicating the error encountered.		N/U	C	A	3	18Ø6	18Ø8	
511-FB	REJECT CODE	Code indicating the error encountered.		N/U	C	A	3	18Ø9	1811	
511-FB	REJECT CODE	Code indicating the error encountered.		N/U	C	A	3	1812	1814	
SECTION DENOTES WORKER'S COMPENSATION CATEGORY:										
435-DZ	CLAIM/REFERENCE ID	Identifies the claim number assigned by Worker's Compensation Program.		N/U	C	A	3Ø	1815	1844	
434-DY	DATE OF INJURY	Date on which the injury occurred.		N/U	C	N	8	1845	1852	
SECTION DENOTES PRODUCT CATEGORY:										
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define		N/U	P	A	1	1853	1853	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		the database used for identifying the product.								
397	PRODUCT/ SERVICE NAME	Product or Service Description or Product Label Name.		N/U	P	A	3Ø	1854	1883	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.		N/U	P	A	3Ø	1884	1913	
6Ø1-24	PRODUCT STRENGTH	The strength of the product.		N/U	P	A	15	1914	1928	
243	DOSAGE FORM CODE	Dosage form code for product identified.		N/U	P	A	4	1929	1932	
	FILLER			N/U	P	A	8	1933	194Ø	
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.		N/U	P	N	1	1941	1941	
273	MAINTENANCE DRUG INDICATOR	Indicates if the drug is a maintenance drug under the client's benefit plan.		N/U	P	A	1	1942	1942	
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.		N/U	P	A	1	1943	1943	
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.		N/U	P	A	1	1944	1944	
297	PRESCRIPTION OVER THE COUNTER INDICATOR	The indicator that specifies this prescription is a federal/legend (Rx prescription only) or non-prescription drug (OTC).		N/U	P	A	1	1945	1945	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
42Ø-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.	Ø9 – Encounters	M	C	N	2	1946	1947	Required
42Ø-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.		N/U	C	N	2	1948	1949	
42Ø-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.		N/U	C	N	2	195Ø	1951	
25Ø	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.		N/U	P	A	1	1952	1952	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.		N/U	P	A	1	1953	1953	
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		N/U	P	A	17	1954	197Ø	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.		N/U	P	A	1	1971	1971	
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		N/U	P	A	17	1972	1988	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.		N/U	P	A	1	1989	1989	
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		N/U	P	A	17	199Ø	2ØØ6	
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.		N/U	P	A	1	2ØØ7	2ØØ7	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
294	PRESCRIBED DAYS SUPPLY	Indicates the original days' supply of the prescription. Applies to internal Mail Service only.		N/U	P	N	3	2ØØ8	2Ø1Ø	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.		N/U	P	A	1	2Ø11	2Ø11	
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2Ø12	2Ø28	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.		N/U	P	A	1	2Ø29	2Ø29	
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2Ø3Ø	2Ø46	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.		N/U	P	A	1	2Ø47	2Ø47	
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2Ø48	2Ø64	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.		N/U	P	A	1	2Ø65	2Ø65	
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		N/U	P	A	17	2Ø66	2Ø82	
SECTION DENOTES FORMULARY CATEGORY:										
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.		N/U	P	A	1	2Ø83	2Ø83	
221	CLIENT FORMULARY FLAG	Indicates that the client has a formulary.		N/U	P	A	1	2Ø84	2Ø84	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file as defined by processor.		N/U	P	A	8	2Ø85	2Ø92	
256	FORMULARY FILE ID	Identifies the formulary ID used during adjudication of the claim.		N/U	P	A	15	2Ø93	21Ø7	
255	FORMULARY CODE TYPE	Indicates how the Formulary Benefit is set up. As defined by processor.		N/U	P	A	1	21Ø8	21Ø8	
SECTION DENOTES PRICING CATEGORY:										
5Ø6-F6	INGREDIENT COST PAID	Drug ingredient cost paid included in the "Total Amount Paid" (5Ø9-F9).		M	C	D	8	21Ø9	2116	Required
5Ø7-F7	DISPENSING FEE PAID	Total amount to be paid by the claims processor.		M	C	D	8	2117	2124	Required
894	TOTAL AMOUNT PAID BY MCO or MAO	Total amount of the prescription regardless of party responsible for payment.		M	P	D	8	2125	2132	Required
523-FN	AMOUNT ATTRIBUTED TO SALES TAX	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to sales tax paid.		N/U	C	D	8	2133	214Ø	
5Ø5-F5	PATIENT PAY AMOUNT	Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over		M	C	D	8	2141	2148	Required

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		maximum amounts, penalties, etc.								
518-FI	AMOUNT OF COPAY	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to per prescription coinsurance.		S	C	D	8	2149	2156	Required
572-4U	AMOUNT OF COINSURANCE	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of a Brand product.		S	C	D	8	2157	2164	Required
519-FJ	AMOUNT ATTRIBUTED TO PRODUCT SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to per prescription copay.		N/U	C	D	8	2165	2172	
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to a periodic deductible.		N/U	C	D	8	2173	218Ø	
571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the processing fee imposed by the processor.		N/U	C	D	8	2181	2188	
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's provider network selection.		N/U	C	D	8	2189	2196	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/ BRAND DRUG	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of Brand product.		N/U	C	D	8	2197	22Ø4	
135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/NON-PREFERRED FORMULARY SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of Non-Preferred Formulary product.		N/U	C	D	8	22Ø5	2212	
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/ BRAND NON-PREFERRED FORMULARY SELECTION	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient's selection of a Brand Non-Preferred Formulary product.		N/U	C	D	8	2213	222Ø	
137-UP	AMOUNT ATTRIBUTED TO COVERAGE GAP	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to the patient being in the coverage gap (i.e., donut hole). A coverage gap is defined as the period or amount during which the previous coverage ends and before an additional coverage begins.		N/U	C	D	8	2221	2228	
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a Maximum Allowable Cost (MAC) program.		N/U	P	A	1	2229	2229	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.		N/U	P	A	2	223Ø	2231	
26Ø	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product, as defined by processor.		N/U	P	A	1	2232	2232	
284	OUT OF POCKET APPLY AMOUNT	Amount applied to the out of pocket expense.		N/U	P	D	8	2233	224Ø	
2Ø9	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.		N/U	P	D	9	2241	2249	
21Ø	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.		N/U	P	D	9	225Ø	2258	
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.		N/U	P	D	9	2259	2267	
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.		N/U	P	D	9	2268	2276	
43Ø-DU	GROSS AMOUNT DUE	Total price claimed from all sources.		M	C	D	8	2277	2284	Required Amount billed to the MCO (Amount being billed by the provider to the MCO). MASK 9999999V99 zero filled, no sign.
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.		N/U	P	D	9	2285	2293	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
4Ø9-D9	INGREDIENT COST SUBMITTED	Submitted product component cost of the dispensed prescription. This amount is included in the "Gross Amount Due (43Ø-DU).		S	C	D	8	2294	23Ø1	Send if Available
426-DQ	USUAL AND CUSTOMARY CHARGE	Amount charged to cash customers for the prescription exclusive of sales tax or other amounts claimed.		S	C	D	8	23Ø2	23Ø9	Send if Available
558-AW	FLAT SALES TAX AMOUNT PAID	Flat sales tax paid which is included in the "Total Amount Paid" (5Ø9-F9).		S	C	D	8	231Ø	2317	Send if Available
559-AX	PERCENTAGE SALES TAX AMOUNT PAID	Amount of percentage sales tax paid which is included in the "Total Amount Paid" (5Ø9- F9).		N/U	C	D	8	2318	2325	
56Ø-AY	PERCENTAGE SALES TAX RATE PAID	Percentage sales tax rate used to calculate "Percentage Sales Tax Amount Paid" (559-AX).		N/U	C	D	7	2326	2332	
561-AZ	PERCENTAGE SALES TAX BASIS PAID	Code indicating the percentage sales tax.		N/U	C	A	2	2333	2334	
521-FL	INCENTIVE AMOUNT PAID	Amount represents the contractually agreed upon incentive fee paid for specific services rendered. Amount is included in the "Total Amount Paid" (5Ø9-F9).		N/U	C	D	8	2335	2342	
562-J1	PROFESSIONAL SERVICE FEE PAID	Amount representing the contractually agreed upon fee for professional services rendered. This amount is included in the		N/U	C	D	8	2343	235Ø	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		"Total Amount Paid" (5Ø9-F9).								
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565- J4).	Ø1 – Delivery Cost Ø2 – Shipping Cost Ø3 – Postage Ø4 – Administrative Cost Ø5 – Incentive Ø6 – Cognitive Service Ø7 – Drug Benefit Ø8 – Compound Preparation Cost Submitted Ø9 – Sales Tax 1Ø – Medication Administration	M	C	A	2	2351	2352	Required
565-J4	OTHER AMOUNT PAID	Amount paid for additional costs claimed in 'Other Amount Claimed Submitted' (48Ø-H9).		S	C	D	8	2353	236Ø	Required
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565-J4).	See first occurrence of 564-J3 above.	S	C	A	2	2361	2362	Required
565-J4	OTHER AMOUNT PAID	Amount paid for additional costs claimed in 'Other Amount Claimed Submitted' (48Ø-H9).		S	C	D	8	2363	237Ø	Required
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565- J4).	See first occurrence of 564-J3 above.	S	C	A	2	2371	2372	Required
565-J4	OTHER AMOUNT PAID	Amount paid for additional costs claimed in 'Other Amount		S	C	D	8	2373	238Ø	Required

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		Claimed Submitted' (48Ø-H9).								
566-J5	OTHER PAYER AMOUNT RECOGNIZED	Total amount recognized by the processor of any payment from another source.		N/U	C	D	8	2381	2388	Not Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer. Ø5 – Amount of Copay (518-FI) as reported by previous payer. Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer.	S	C	A	2	2389	239Ø	Required COB/TPL

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer. Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø – Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer. 11 – Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer. 12 – Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as							

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			reported by previous payer. 13 – Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	2391	24ØØ	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Same Values as Above.	S	C	A	2	24Ø1	24Ø2	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	24Ø3	2412	Required COB/TPL
281	NET AMOUNT DUE	Net amount paid to provider by the payer or net amount due from the client to the payer, determined by trading partner agreement.		M	P	D	8	2413	242Ø	Required
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).		N/U	C	N	2	2421	2422	
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT	Amount in dollars met by the patient/family in a deductible plan.		N/U	C	D	8	2423	243Ø	
513-FD	REMAINING DEDUCTIBLE AMOUNT	Amount not met by the patient/family in the deductible plan.		N/U	C	D	8	2431	2438	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
514-FE	REMAINING BENEFIT AMOUNT	Amount remaining in a patient/family plan with a periodic maximum benefit.		N/U	C	D	8	2439	2446	
242	COST DIFFERENCE AMOUNT	Difference between client contracted amount and the pharmacy or member submitted amount.		N/U	P	D	8	2447	2454	
249	EXCESS COPAY AMOUNT	Amount of the copay that exceeds the approved amount for this claim.		N/U	P	D	8	2455	2462	
277	MEMBER SUBMIT AMOUNT	Ingredient cost as submitted by member (paper claims only).		N/U	P	D	8	2463	247Ø	
265	HOLD HARMLESS AMOUNT	Amount payable to member when paper claims amount exceeds Pharmacy Network Reimbursement.		N/U	P	D	8	2471	2478	
52Ø-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM	Amount to be collected from the patient that is included in "Patient Pay Amount" (5Ø5-F5) that is due to the patient exceeding a periodic benefit maximum.		N/U	C	D	8	2479	2486	
346-HH	BASIS OF CALCULATION – DISPENSING FEE	Code indicating how the reimbursement amount was calculated for "Dispensing Fee Paid" (5Ø7-F7).		N/U	C	A	2	2487	2488	
347-HJ	BASIS OF CALCULATION – COPAY	Code indicating how the copay reimbursement amount was calculated for "Dispensing Fee Paid" (5Ø5-F5).		N/U	C	A	2	2489	249Ø	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
348-HK	BASIS OF CALCULATION – FLAT SALES TAX	Code indicating how the reimbursement amount was calculated for "Flat Sales Tax Amount Paid" (558-AW).		N/U	C	A	2	2491	2492	
349-HM	BASIS OF CALCULATION – PERCENTAGE SALES TAX	Code indicating how the reimbursement amount was calculated for "Percentage Sales Tax Amount Paid" (559-AX).		N/U	C	A	2	2493	2494	
573-4V	BASIS OF CALCULATION – COINSURANCE	Code indicating how the coinsurance reimbursement amount was calculated for "Patient Pay Amount" (559-AX).		N/U	C	A	2	2495	2496	
557-AV	TAX EXEMPT INDICATOR	Code indicating that the payer and/or the patient is exempt from taxes.		N/U	C	A	1	2497	2497	
285	PATIENT FORMULARY REBATE AMOUNT	Credit that the patient receives on this claim from the drug manufacturer.		N/U	P	D	8	2498	25Ø5	
276	MEDICARE RECOVERY INDICATOR	Field to indicate if Medicare was billed in order to recover funds for current or previous claims billed to the client.		N/U	P	A	1	25Ø6	25Ø6	
275	MEDICARE RECOVERY DISPENSING INDICATOR	Field to indicate if days' supply on prescription was reduced due to plan limits.		N/U	P	A	1	25Ø7	25Ø7	
286	PATIENT SPEND DOWN AMOUNT	Claim dollars applied to patient's spend down account (example: Flexible Spending Account).		N/U	P	D	8	25Ø8	2515	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
263	HEALTH CARE REIMBURSEMENT ACCOUNT AMOUNT APPLIED	Health Care Reimbursement Account Amount Applied		N/U	P	D	8	2516	2523	
564-	HEALTH CARE REIMBURSEMENT ACCOUNT AMOUNT REMAINING	Client-defined benefit that provides funds to patients that can be used to offset Out of Pocket expenses.		N/U	P	D	8	2524	2531	
2Ø7	ADMINISTRATIVE FEE EFFECT INDICATOR	Indicates how the transaction should be counted for administrative fee determination.		N/U	P	A	1	2532	2532	
2Ø6	ADMINISTRATIVE FEE AMOUNT	Administrative fee charge per claim.		N/U	P	D	4	2533	2536	
269	INVOICED AMOUNT	Amount invoiced for this transaction. Determined by Processor.		N/U	P	D	11	2537	2547	
	FILLER			N/U	P	A	1Ø	2548	2557	
128-UC	SPENDING ACCOUNT AMOUNT REMAINING	The balance from the patient's spending account after this transaction was applied.		N/U	C	D	8	2558	2565	
129-UD	HEALTH PLAN-FUNDED ASSISTANCE AMOUNT	The amount from the health plan-funded assistance account for the patient that was applied to reduce 'Patient Pay Amount' (5Ø5-F5). This amount is used in Healthcare Reimbursement Account (HRA) benefits only. This		N/U	C	D	8	2566	2573	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		field is always a negative amount or zero.								
SECTION DENOTES PRIOR AUTHORIZATION CATEGORY:										
461-EU	PRIOR AUTHORIZATION TYPE CODE	Code clarifying the 'Prior Authorization Number Submitted' (462-EV) or benefit/plan exemption.		N/U	C	N	2	2574	2575	
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	Number submitted by the provider to identify the prior authorization.		N/U	C	N	11	2576	2586	
498-PY	PRIOR AUTHORIZATION NUMBER – ASSIGNED	Unique number identifying the prior authorization assigned by the processor.		N/U	P	N	11	2587	2597	
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.		N/U	P	N	2	2598	2599	
SECTION DENOTES ADJUSTMENT CATEGORY:										
2Ø4	ADJUSTMENT REASON CODE	Reason for adjustment		N/U	P	N	3	26ØØ	26Ø2	
2Ø5	ADJUSTMENT TYPE	Type of adjustment.		N/U	P	A	1	26Ø3	26Ø3	
897	TRANSACTION ID CROSS REFERENCE	For reversals, ID associated with original claim.		M	P	A	3Ø	26Ø4	2633	Required The TCN of the encounter being voided by this reversal is entered here.
SECTION DENOTES COORDINATION OF BENEFITS CATEGORY:										
225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier.		S	P	D	8	2634	2641	If available in payer's system.

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
										COB/TPL
245	ELIGIBILITY COB INDICATOR	COB code as provided on Client eligibility.	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient. 2 – Payer is Secondary – Plan is second payer for patient. 3 – Payer is Tertiary – Plan is third payer for patient.	S	P	A	1	2642	2642	Required when available in the payer's adjudication system. COB/TPL
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB. M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed	S	P	A	1	2643	2643	If the MAO/MCO has COB Carrier Amount available. COB/TPL

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			out of a retail pharmacy.							
232	COB PRIMARY PAYER ID	ID assigned to primary payer.	**MAOSNP** = When MAO pays for a drug. **MEDICAID** = When PR Medicaid funding is used to pay for the drug. **MEDB** = Medicare Part B (in the event that Part D does not cover). **MEDD** = Medicare Part D. **MEDIGAP** = An insurance plan that covers only Medicare/MAO cost sharing. **COMMERCIAL** = When the MAO Member has a private health insurance plan that must consider payment of a drug before the MAO can consider payment of the drug/product. **TRICARE** = If the MAO Member is a veteran where TRICARE must pay or deny the pharmacy claim before the MAO can consider paying for the drug.	M	C/P	A	1Ø	2644	2653	Required COB/TPL

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	FILLER			N/U	P	A	8	2654	2661	
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		S	C/P	D	8	2662	2669	Required – report the payment associated to the primary payer. The MAO SNP would be considered the primary payer when the Platino Member has an MAO and Puerto Rico Medicaid (i.e., dual eligibility). COB/TPL
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.		S	C/P	D	8	267Ø	2677	Required COB/TPL
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		S	C/P	D	8	2678	2685	Required COB/TPL
23Ø	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.		S	C/P	D	8	2686	2693	Required COB/TPL
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.	**MAOSNP** = When the MAO pays for a drug as a secondary payer to a Commercial insurance plan or TRICARE. **MEDIGAP** = When the MAO Member has a 'Medicare gap' insurance as a commercial	S	C/P	A	1Ø	2694	27Ø3	Required when the MAO/MCO and another insurance plan or Medicaid paid for the drug or cost sharing. COB/TPL

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			insurance plan that covers Medicare or MAO cost sharing. Medicare gap insurance is always secondary to Medicare or an MAO. **MEDICAID** = When the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, MEDICAID represents that the Puerto Rico Medicaid paid for the drug/product. The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** = When the Platino Member has a private health insurance plan that must consider payment of a drug/product, report							

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			'COMMERCIAL' as the Secondary Payer ID in Field #238. **TRICARE** = When the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim.							
	FILLER			N/U	P	A	8	27Ø4	2711	
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		S	C/P	D	8	2712	2719	Required when the Secondary Payer paid for the drug/product or the Platino Member's cost sharing. COB/TPL
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		S	C/P	D	8	272Ø	2727	Required when there is a Secondary Payer deductible that was assessed on the drug/product. COB/TPL
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		S	C/P	D	8	2728	2735	Required when there is a Secondary Payer coinsurance that was assessed on the drug/product. COB/TPL
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		S	C/P	D	8	2736	2743	Required when there is a Secondary Payer copayment

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
										that was assessed on the drug/product. COB/TPL
SECTION DENOTES REFERENCE CATEGORY:										
896	TRANSACTION ID	Internally assigned unique claim ID by the payer.		M	P	A	3Ø	2744	2773	Required Every claim in the file must contain the unique internal Transaction ID (TCN) assigned by PBM during adjudication.
5Ø3-F3	AUTHORIZATION NUMBER	Number assigned by the processor to identify an authorized transaction.		N/U	P	A	2Ø	2774	2793	
224	CLIENT SPECIFIC DATA	Trading partners mutually agreed upon specific data defined by client.		N/U	P	A	5Ø	2794	2843	
396	PROCESSOR SPECIFIC DATA	Trading partners mutually agreed upon specific data defined by processor.		N/U	P	A	5Ø	2844	2893	
997-G2	CMS PART D DEFINED QUALIFIED FACILITY	Indicates that the patient resides in a facility that qualifies for the CMS Part D benefit.		N/U	C	A	1	2894	2894	
SECTION DENOTES FIELDS ADDED IN VERSIONS CATEGORY:										
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	Ø1 – Deductible Ø2 – Initial Benefit Ø3 – Coverage Gap (donut hole) Ø4 – Catastrophic Coverage	M	C	A	2	2895	2896	Required COB/TPL

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			5Ø – Not paid under Part D; paid under Part C benefit (for MA-PD plan). 6Ø – Not paid under Part D. 61 – Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only. 62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only. 63 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid under Medicaid benefit only of the Medicare/Medicaid (MMP) plan. 7Ø – Part D drug not paid by Part D plan benefit; paid by the beneficiary under plan-sponsored negotiated pricing. 8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit,							

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing. 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan.							
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).		M	C	D	8	2897	29Ø4	Required COB/TPL
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).		N/U	C	A	2	29Ø5	29Ø6	
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).		N/U	C	D	8	29Ø7	2914	
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).		N/U	C	A	2	2915	2916	
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).		N/U	C	D	8	2917	2924	
393-MV	BENEFIT STAGE QUALIFIER	The amount of claim allocated to the Medicare stage identified by the		N/U	C	A	2	2925	2926	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
		'Benefit Stage Qualifier' (393-MV).								
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).		N/U	C	D	8	2927	2934	
69Ø-ZG	INVOICED DATE	The date that this claim was included on an invoice.		N/U	P	N	8	2935	2942	
691-ZH	OUT OF POCKET REMAINING AMOUNT	Dollars remaining until patient is totally in benefit, paying no out of pocket expenses.		N/U	P	D	8	2943	295Ø	
3Ø2-C2	CARDHOLDER ID (ALTERNATE)	Insurance ID assigned to the cardholder or identification number used by the plan.		N/U	P	A	2Ø	2951	297Ø	
692-ZJ	NUMBER OF GENERIC MANUFACTURERS	Number of manufacturers that produce this generic drug provided by drug compendium.		N/U	P	N	3	2971	2973	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	2974	2975	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	2976	2994	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	2995	2996	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	2997	3Ø15	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	3Ø16	3Ø17	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	3Ø18	3Ø36	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co- Agent ID' (476-H6).		N/U	C	A	2	3Ø37	3Ø38	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	3Ø39	3Ø57	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co- Agent ID' (476-H6).		N/U	C	A	2	3Ø58	3Ø59	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	3Ø6Ø	3Ø78	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	3Ø79	3Ø8Ø	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	3Ø81	3Ø99	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	31ØØ	31Ø1	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	31Ø2	312Ø	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).		N/U	C	A	2	3121	3122	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		N/U	C	A	19	3123	3141	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.	S	C	A	2	3142	3143	Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer. Ø5 – Amount of Copay (518-FI) as reported by previous payer. Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer. Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer. Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9 – Amount Attributed to Health							COB/TPL

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
			Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø – Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer. 11 – Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer. 12 – Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer. 13 – Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	3144	3153	Required COB/TPL
351-NP	OTHER PAYER-PATIENT	Code qualifying the "Other Payer-Patient	See 351-NP above for codes.	S	C	A	2	3154	3155	Required

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	RESPONSIBILITY AMOUNT QUALIFIER	Responsibility Amount (352-NQ)".								COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	3156	3165	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3166	3167	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	3168	3177	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3178	3179	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	318Ø	3189	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	319Ø	3191	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	3192	32Ø1	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY	Code qualifying the "Other Payer-Patient	See 351-NP above for codes.	S	C	A	2	32Ø2	32Ø3	Required COB/TPL

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	AMOUNT QUALIFIER	Responsibility Amount (352-NQ)".								
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	32Ø4	3213	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3214	3215	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	3216	3225	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3226	3227	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	3228	3237	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	3238	3239	Required COB/TPL
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	324Ø	3249	Required COB/TPL
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	See 351-NP above for codes.	S	C	A	2	325Ø	3251	Required COB/TPL

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
	AMOUNT QUALIFIER									
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.		S	C	D	1Ø	3252	3261	Required COB/TPL
A37	SPECIALTY CLAIM INDICATOR	Indicates whether a claim was filled by a specialty pharmacy or a specialty drug.		N/U	P	A	1	3262	3262	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		N/U	P	A	3	3263	3265	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		N/U	P	A	3	3266	3268	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		N/U	P	A	3	3269	3271	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		N/U	P	A	3	3272	3274	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.		N/U	P	A	3	3275	3277	
A39	COPAY WAIVER AMOUNT	Dollar amount funded by third party for a copay waiver program where a client funds a portion of their copay amount if they select a certain drug.		N/U	P	D	8	3278	3285	

Field	Field Name	Description	Values	Usage	Source	Format	Size	Start	End	PRMP Requirement
A33-ZX	CMS PART D CONTRACT ID	Designation assigned by CMS that identifies a specific Medicare Part D sponsor.		N/U	P	A	5	3286	329Ø	
A34-ZY	MEDICARE PART D PLAN BENEFIT PACKAGE (PBP)	Identifier assigned by CMS of a particular plan benefit package (Benefit Category) within a Medicare Part D contract.		N/U	P	N	3	3291	3293	
A73	MEDICARE DRUG COVERAGE CODE	Code to indicate if the claim was processed under the Part D Drug Benefit, the Part B Drug Benefit, or does not apply.		N/U	P	A	2	3294	3295	
	FILLER			N/U	P	A	423	3296	37ØØ	

Note: "COB/TPL" indicates that further directions can be found in Appendix A: Discussion of MAO COB/TPL Reporting.

4.2.1 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD1

Table 5 – Post Adjudication History Compound Detail Record1

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	CD – Post Adjudication History Compound Detail Record1.	M	P	A	2	1	2	Required
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	Prescription/Service Reference Number Qualifier	1 – Rx Billing Transaction- A billing for a prescription or OTC drug product.	M	C	A	1	3	3	Required

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			2 – Service Billing – Transaction is a billing for a professional service performed.							
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	Reference number assigned by the provider for the dispensed drug/product and/or service provided.		M	C	N	12	4	15	Required
477-EC	COMPOUND INGREDIENT COMPONENT COUNT	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		M	C	N	2	16	17	Required
SECTION DENOTES FIRST INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank – Not Specified Ø1 – UPC Ø2 – HRI Ø3 – NDC Ø4 – HIBCC 11 – NAPPI 12 – GTIN 15 – GCN 28 – FDB Med Name ID 29 – FDB Routed Med ID 3Ø – FDB Routed Dosage Form Med ID 31 – FDB Med ID	M	C	A	2	18	19	Required

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			32 – GCN_SEQ_NO 33 – HICL_SEQ_NO 99 – Other							
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.		M	C	A	19	2Ø	38	Required If a compound drug is being reported, this is the NDC of the FIRST component of the compound drug.
448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.		S	C	N	14	39	52	Required Amount expressed in metric decimal units of the product included in the compound mixture. MASK 9(7)V999 zero filled, no sign.
449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448- ED).		S	C	D	8	53	6Ø	Required
49Ø-UE	COMPOUND INGREDIENT	Code indicating the method by which the drug cost of an ingredient	ØØ – Default	S	C	N	2	61	62	Required

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
	BASIS OF COST DETERMINATION	used in a compound was calculated.	Ø1 – AWP (Average Wholesale Price) Ø2 – Local Wholesaler Ø3 – Direct Ø4 – EAC (Estimated Acquisition Cost) Ø5 – Acquisition Ø6 – MAC (Maximum Allowable Cost) Ø7 – Usual & Customary Ø8 – 34ØB/ Disproportionate Share Pricing/Public Health Service Ø9 – Other – Different from those implied or specified. 1Ø – ASP (Average Sales Price) 11 – AMP (Average Manufacturer Price) 12 – WAC (Wholesale Acquisition Cost) 13 – Special Patient Pricing 14 – Cost basis on un-reportable quantities							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			15 – Free product or no associated cost							
221	CLIENT FORMULARY FLAG	Indicates that the client has a formulary.	Blank – Not specified Y – Yes N – No	S	P	A	1	63	63	Indicates that the NDC for the FIRST component of the compound drug is not recognized by PRMP but the MCO covered the drug. Value 'Y'
397	PRODUCT/ SERVICE NAME	Product or Service Description or Product Label Name.		N/U	P	A	3Ø	64	93	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.		N/U	P	A	3Ø	94	123	
6Ø1-24	PRODUCT STRENGTH	The strength of the product.		N/U	P	A	1Ø	124	133	
243	DOSAGE FORM CODE	Dosage form code for product identified.		N/U	P	A	4	134	137	
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1 – First DataBank 2 – Medi-Span Product Line 3 – Micromedex/ Medical Economics 4 – Processor Developed 5 – Other 6 – Redbook 7 – Multum	S	P	N	1	138	138	Required

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	ØØ – Not specified 1 – Single Source 2 – Authorized Generic (aka "Branded Generic") 3 – Generic 4 – Over the Counter 5 – Multi-source Brand	S	P	N	1	139	139	
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank – Not Specified I – Drug on Formulary; Non-Preferred J – Drug not on Formulary; Non-Preferred K – Drug not on Formulary; Preferred N – Drug not on Formulary; Neutral P – Drug on Formulary Q – Drug not on Formulary T – Drug on Formulary; Preferred Y- Drug on Formulary; Neutral	S	P	A	1	14Ø	14Ø	
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is		S	P	A	1	141	141	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
		associated with a specific drug category.								
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank – Not Specified 1 – Schedule I Substance (no known use) 2 – Schedule II Narcotic Substances 3 – Schedule III Narcotic Substances 4 – Schedule IV Substances 5 – Schedule V Substances	S	P	A	1	142	142	
25Ø	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank – Not Specified Ø – Was Drug Efficacy Study Implementation (DESI) – At One Time But No Longer 1 – Drug Efficacy Study Implementation (DESI) Drug	S	P	A	1	143	143	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line	S	P	A	1	144	144	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – Nine-digit NDC A – American Hospital Formulary Service C – Contracting Organization G – First DataBank GCN Sequence Number H – First DataBank HICL Sequence Number M – Manufacturer (PICO) Assigned Code N – Eleven-digit NDC O – UPC							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			P – Product group T – First DataBank Therapeutic Class Code, Specific U – Universal System of Classification Code V – All products used Z – Mutually Agreed Upon Code							
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		S	P	A	17	145	161	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the 'Product Code' (6Ø1-18) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier	S	P	A	1	162	162	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			8 – First DataBank Medication Identifier 9 – Nine-digit NDC A – American Hospital Formulary Service C – Contracting Organization G – First DataBank GCN Sequence Number H – First DataBank HICL Sequence Number M – Manufacturer (PICO) Assigned Code N – Eleven-digit NDC O – UPC P – Product group T – First DataBank Therapeutic Class Code, Specific U – Universal System of Classification Code V – All products used Z – Mutually Agreed Upon Code							
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		S	P	A	17	163	179	
6Ø1-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the	Blank – Not Specified	S	P	A	1	18Ø	18Ø	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
		Product Code (6Ø1-18) field.	1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – Nine-digit NDC A – American Hospital Formulary Service C – Contracting Organization G – First DataBank GCN Sequence Number H – First DataBank HICL Sequence Number							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			M – Manufacturer (PICO) Assigned Code N – Eleven-digit NDC O – UPC P – Product group T – First DataBank Therapeutic Class Code, Specific U – Universal System of Classification Code V – All products used Z – Mutually Agreed Upon Code							
6Ø1-18	PRODUCT CODE	Code identifying the product being reported.		S	P	A	17	181	197	
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank – Not specified 1 – Yes 2 – No	S	P	A	1	198	198	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID	S	P	A	1	199	199	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – First DataBank Enhanced Therapeutic Class Codes A – American Hospital Formulary Service C – Contracting Organization D – First DataBank Therapeutic Class code, Generic E – First DataBank Therapeutic Class code, Standard M – Manufacturer (PICO) Assigned Code U – Universal System of Classification Code Z – Mutually Agreed Upon Code							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		S	P	A	17	2ØØ	216	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – First DataBank Enhanced Therapeutic Class Codes A – American Hospital Formulary Service C – Contracting Organization	S	P	A	1	217	217	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			D – First DataBank Therapeutic Class code, Generic E – First DataBank Therapeutic Class code, Standard M – Manufacturer (PICO) Assigned Code U – Universal System of Classification Code Z – Mutually Agreed Upon Code							
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		S	P	A	17	218	234	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage	S	P	A	1	235	235	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Form Medication Identifier 8 – First DataBank Medication Identifier 9 – First DataBank Enhanced Therapeutic Class Codes A – American Hospital Formulary Service C – Contracting Organization D – First DataBank Therapeutic Class code, Generic E – First DataBank Therapeutic Class code, Standard M – Manufacturer (PICO) Assigned Code U – Universal System of Classification Code Z – Mutually Agreed Upon Code							
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		S	P	A	17	236	252	
6Ø1-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank – Not Specified 1 – First DataBank Formulation ID 2 – Medi-Span Product Line	S	P	A	1	253	253	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Generic Product Identifier 3 – First DataBank 4 – Medi-Span Product Line Drug Descriptor ID 5 – First DataBank Medication Name Identifier 6 – First DataBank Routed Medication Identifier 7 – First DataBank Routed Dosage Form Medication Identifier 8 – First DataBank Medication Identifier 9 – First DataBank Enhanced Therapeutic Class Codes A – American Hospital Formulary Service C – Contracting Organization D – First DataBank Therapeutic Class code, Generic E – First DataBank Therapeutic Class code, Standard M – Manufacturer (PICO) Assigned Code							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			U – Universal System of Classification Code Z – Mutually Agreed Upon Code							
6Ø1-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.		S	P	A	17	254	27Ø	
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	Ø – Not Specified 1 – Not Unit Dose – Indicates that the product is not being dispensed in special unit dose packaging. 2 – Manufacturer Unit Dose – A code used to indicate a distinct dose as determined by the manufacturer. 3 – Pharmacy Unit Dose – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was "loaded" at the pharmacy – not purchased from the manufacturer as a unit dose. 4 – Pharmacy Unit Dose Patient Compliance Packaging. 5 – Pharmacy Multi-drug Patient	S	C	N	1	271	271	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Compliance Packaging. 6 – Remote Device Unit Dose – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7 – Remote Device Multi-drug Compliance – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8 – Manufacturer Unit of Use Package (not unit dose) – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
6ØØ -28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA – Each GM – Grams ML – Milliliters	S	C	A	2	272	273	
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	ØØ – Not Specified Ø1 – Prior Authorization Ø2 – Medical Certification Ø3 – EPSDT (Early Periodic Screening Diagnosis Treatment) Ø4 – Exemption from Copay and/or Coinsurance Ø5 – Exemption from RX Ø6 – Family Planning Indicator Ø7 – TANF (Temporary Assistance for Needy Families) Ø8 – Payer Defined Exemption	S	P	N	2	274	275	
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank – Not Specified Y – Reduced to MAC pricing N – Not reduced to MAC pricing	S	P	A	1	276	276	
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted	Blank – Not Specified Ø1 – Average Wholesale Price	S	P	A	2	277	278	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
		is calculated based on client pricing.	Ø2 – Acquisition Cost (ACQ) Ø3 – Manufacturer Direct Price Ø4 – Federal Upper Limit (FUL) Ø5 – Average Generic Price Ø6 – Usual & Customary Ø7 – Submitted Ingredient Cost Ø8 – State MAC Ø9 – Unit 1Ø – Usual & Customary or Copay							
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank – Not Specified Ø1 – UPC Ø2 – HRI Ø3 – NDC Ø4 – HIBCC Ø6 – DUR/PPS Ø7 – CPT4 Ø8 – CPT5 Ø9 – HCPCS 11 – NAPPI 12 – GTIN 14 – GPI 15 – GCN 16 – GFC 17 – DDID	S	C	A	2	279	28Ø	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			18 – First DataBank SmartKey 19 – Truven/ Micromedex Generic Master (GM) 2Ø – ICD9 21 – ICD1Ø 23 – NCCI 24 – SNOMED 25 – CDT 26 – DSM IV 27 – ICD1Ø-PCS 28 – FDB Med Name ID 29 – FDB Routed Med ID 3Ø – FDB Routed Dosage Form Med ID 31 – FDB Med ID 32 – GCN_SEQ_NO 33 – HICL_SEQ_NO 35 – LOINC 37 – AHFS 38 – SCD 39 – SBD 4Ø – GPCK 41 – BPCK 99 – Other							

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).		S	C	A	19	281	299	
26Ø	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product, as defined by processor.		S	P	A	1	3ØØ	3ØØ	
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank – Not Specified 1 – Medicare Part B (Plan Cutback) – A reduction in a quantity of a medical service covered by Medicare Part B. 2 – Medicare Part B with days' supply cutback – A reduction in the days' supply of a service/drug covered by Medicare Part B. C – Net Check limit cutback – A reduction in the net amount of a check. D – Days' Supply cutback – A reduction in the days' supply. I – Ingredient Cost cutback – A	S	P	A	1	3Ø1	3Ø1	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			reduction in the ingredient cost. Q – Quantity cutback – A reduction in the quantity.							
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file as defined by processor.		S	P	A	8	3Ø2	3Ø9	
2Ø9	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.		S	P	D	9	31Ø	318	
21Ø	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.		S	P	D	9	319	327	
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.		S	P	D	9	328	336	
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.		S	P	D	9	337	345	
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.		S	P	D	9	346	354	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	ØØ – Not Specified Ø1 – Ingredient Cost Paid as Submitted Ø2 – Ingredient Cost Reduced to AWP Pricing	S	C	N	2	355	356	Translator will have to crosswalk the four values below to a 'C', 'F', 'T' or 'Z' to put in the flat

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			Ø3 – Ingredient Cost Reduced to AWP Less X% Pricing Ø4 – Usual & Customary Paid as Submitted Ø5 – Paid Lower of Ingredient Cost Plus Fees Versus Usual & Customary Ø6 – MAC Pricing Ingredient Cost Paid Ø7 – MAC Pricing Ingredient Cost Reduced to MAC Ø8 – Contract Pricing Ø9 – Acquisition Pricing 1Ø – ASP (Average Sales Price) 11 – AMP (Average Manufacturer Price) 12 – 34ØB/ Disproportionate Share/Public Health Service Pricing 13 – WAC (Wholesale Acquisition Cost) 14 – Other Payer-Patient Responsibility Amount							file created by the translator. Ø8 = 'C' which is for capitated Ø1 = 'F' which is for FFS 14 = 'T' which is TPL ØØ = 'Z' which is for Zero billed/Provider did not charge

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
			15 – Patient Pay Amount 16 – Coupon Payment 17 – Special Patient Reimbursement 18 – Direct Price (DP) 19 – State Fee Schedule (SFS) Reimbursement 2Ø – National Average Drug Acquisition Cost (NADAC) 21 – State Average Acquisition Cost (AAC) 22 – Ingredient cost paid based on submitted Basis of Cost Free Product							
285	PATIENT FORMULARY REBATE AMOUNT	Credit that the patient receives on this claim from the drug manufacturer.		S	P	D	8	357	364	

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
SECTION DENOTES SECOND INGREDIENT: *SAME AS THE FIRST INGREDIENT*										
SECTION DENOTES THIRD INGREDIENT:										
SECTION DENOTES FOURTH INGREDIENT:										
SECTION DENOTES FIFTH INGREDIENT:										
SECTION DENOTES SIXTH INGREDIENT:										
SECTION DENOTES SEVENTH INGREDIENT:										
SECTION DENOTES EIGHTH INGREDIENT:										

4.2.2 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD2

Table 6 – Post Adjudication History Compound Detail Record2

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
PRMP only accepts Compound Detail Record1. ***DO NOT SEND Compound Detail Record2.***										
SECTION DENOTES NINTH INGREDIENT:										
SECTION DENOTES TENTH INGREDIENT:										
SECTION DENOTES ELEVENTH INGREDIENT:										
SECTION DENOTES TWELVTH INGREDIENT:										
SECTION DENOTES THIRTEENTH INGREDIENT:										
SECTION DENOTES FOURTEENTH INGREDIENT:										
SECTION DENOTES FIFTEENTH INGREDIENT:										

4.3 POST ADJUDICATION HISTORY TRAILER RECORD

Table 7 – Post Adjudication History Trailer Record

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	PRMP Requirement
6Ø1-Ø4	RECORD TYPE	Type of record being submitted.	PT – Post Adjudication History Trailer Record	M	P	A	2	1	2	
6Ø1-Ø9	TOTAL RECORD COUNT	Total number of records being submitted, including header and trailer.		M	P	N	1Ø	3	12	
895	TOTAL NET AMOUNT DUE	Summarization of Net Amount Due (281).		M	P	D	12	13	24	
693	TOTAL GROSS AMOUNT DUE	Total sum of the gross amount due fields on the claim level.		S	P	D	12	25	36	
694	TOTAL PATIENT PAY AMOUNT	Total sum of the patient pay amount fields on the claim level.		M	P	D	12	37	48	
	FILLER			N/U		A	3652	49	37ØØ	

Appendix A: Discussion of MAO COB/TPL Reporting When:

MAO Only Paid

Table 8 – MAO Only Paid

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
225	COB CARRIER SUBMIT AMOUNT		The amount submitted by the COB carrier.	If the MAO has COB Carrier Amount available, report Field #225 (COB CARRIER SUBMIT AMOUNT). If the MAO does not store the COB Carrier Amount, the field does not need to be completed.
245	ELIGIBILITY COB INDICATOR	Code as provided on Client eligibility.	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient 2 – Payer is Secondary – Plan is second payer for patient 3 – Payer is Tertiary – Plan is third payer for patient NCPDP 4.2: Required when available in the payer's adjudication system	Field #245 is REQUIRED. If the MAO paid the drug in full, report '1'.
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed out of a retail pharmacy.	Field #226 is situational. If the MAO has COB Carrier Amount available, report Field #226 (COB PRIMARY CLAIM TYPE).
232	COB PRIMARY PAYER ID	Primary Payer ID associated with the Primary Payer.	Use one of the following Primary Payer IDs when submitting encounter claims to the PRMMIS for Platino Members: **MAOSNP** If the MAO pays for a drug, Field #232 must indicate Primary Payer ID MAOSNP.	Field #232 (COB PRIMARY PAYER ID) is REQUIRED. If the MAO paid the drug in full, report MAOSNP.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			MAOSNP represents that the MAO paid for the drug/product. **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #238 must indicate Secondary Payer ID 'MEDICAID'. MEDICAID represents that Puerto Rico Medicaid paid for the drug. The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** (This scenario, from a COB Primary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug before the MAO can consider payment of the drug/product, report 'COMMERCIAL' as the Primary Payer ID in Field #232. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Primary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim before the MAO can consider paying for the drug, Field #232 must indicate Primary Payer ID 'TRICARE'."	
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		Field #228 is REQUIRED. Report the payment associated to the primary payer reported in Field #232

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
				(COB PRIMARY PAYER ID). If the MAOSNP paid the drug in full, report the MAO paid amount.
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.		Field #231 is situational. If the MAO paid the drug in full and the MAO cost sharing is negated ($Ø) or replaced by a nominal copay for a generic ($1) or brand name drug ($2), do not report.
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		Field #229 is situational. If the MAO paid the drug in full and the MAO cost sharing is negated ($Ø) or replaced by a nominal copay for a generic ($1) or brand name drug ($2), do not report.
23Ø	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.		Field #23Ø is situational. If the MAO paid the drug in full and the MAO cost sharing is negated ($Ø) or replaced by a nominal copay for a generic ($1) or brand name drug ($2) and the Platino member was charged a copayment, enter the nominal copay amount.
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.	**MAOSNP** If the MAO pays for a drug as a secondary payer to a Commercial insurance plan or TRICARE, Field #238 must indicate Secondary Payer ID 'MAOSNP.' MAOSNP represents that the MAO paid for the drug. **MEDIGAP** If the Platino Member has a 'Medicare gap' insurance as a commercial insurance plan that covers Medicare or MAO cost sharing.	Field #238 (COB SECONDARY PAYER ID) is situational. If the MAO paid the drug in full as the primary payer, do not report.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Medicare gap insurance is always secondary to Medicare or an MAO. MEDIGAP represents an insurance plan that covers only Medicare/MAO cost sharing. **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #238 must indicate Secondary Payer ID 'MEDICAID.' MEDICAID represents that the Puerto Rico Medicaid paid for the drug/product. The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug/product, report 'COMMERCIAL' as the Secondary Payer ID in Field #238. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim, Field #238 must indicate Secondary Payer ID 'TRICARE.'	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		Field #234 is situational. If the MAO paid the drug in full as the primary payer, do not report.
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		Field #237 is situational. If the MAO paid the drug in full as the primary payer, do not report.
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		Field #235 is situational. If the MAO paid the drug in full as the primary payer, do not report.
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		Field #236 is situational. If the MAO paid the drug in full as the primary payer, do not report.
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ – Not Specified by patient Ø1 – No other coverage – Code used in coordination of benefits transactions to convey that no other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received. Ø3 – Other Coverage Billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered. Ø4 – Other coverage exists – payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only – Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection, or network selection.	Field #3Ø8-C8 is REQUIRED. If the MAO paid the drug in full, report Ø1.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan. 192Ø = Medicaid 193Ø = Medicare	193Ø – MEDICARE – The federal program providing health insurance for people aged 65 and older and for disabled people of all ages.	Field #6Ø1-Ø1 is REQUIRED. If only MAO funding is used to pay the drug/product, report 193Ø (MEDICARE). If the drug is a wraparound paid drug (Puerto Rico Medicaid funds are used to pay the drug/product), then report 192Ø (Medicaid).
393-MV	MV BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	**393-MV BENEFIT STAGE QUALIFIER** Code qualifying the 'Benefit Stage Amount' (394-MW). Blank – Not Specified Ø1 – Deductible – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer. Ø2 – Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3 – Coverage Gap (donut hole) – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MAPD, after the initial coverage limit and until the total out of pocket paid for covered prescription drugs reaches a certain amount. Ø4 – Catastrophic Coverage – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 5Ø – Not paid under Part D; paid under Part C benefit (for MA-PD plan): • This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN. • The claim is NOT paid by the Part D plan benefit. • The claim IS paid for by Part C benefit (MA portion of the MA-PD). • When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5	Field #393 is situational. Use the applicable MV Benefit Stage Qualifier in Column D.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage. 6Ø – Not paid under Part D; paid as or under a supplemental benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit). • The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit. • When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • Since 6Ø is not specific to a Part D covered drug versus a non-Part D drug/non-qualified, either of the following situations may occur: 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value Ø18 –"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug.	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			61 – Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit. • When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only. • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit. • When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 7Ø – Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g., nonformulary, quantity limit, etc.).	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			• When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e., excluded drugs). • When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan: • When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Occurs 2 times. Code values as specified in the NCPDP. Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim.	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer Ø5 – Amount of Copay (518-FI) as reported by previous payer Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer 1Ø – Amount Attributed to Provider Network Selection	Field #351-NP is situational. Report the applicable value from Column D. If the MAO paid the drug in full, leave blank (Not Specified).

MAO Paid & Wraparound Picked Up Copay

Table 9 – MAO Paid & Wraparound Picked Up Copay

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier.		If the MAO has COB Carrier Amount available, report Field #225 (COB CARRIER SUBMIT AMOUNT).
245	ELIGIBILITY COB INDICATOR	Code as provided on Client eligibility.	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient 2 – Payer is Secondary – Plan is second payer for patient 3 – Payer is Tertiary – Plan is third payer for patient NCPDP 4.2: Required when available in the payer's adjudication system	Field #245 is REQUIRED. The MAO SNP would be considered the primary payer when the Platino Member has an MAO and Puerto Rico Medicaid (i.e., dual eligibles) and Puerto Rico Medicaid would be considered the second payer when no other insurance coverage exists.
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB. M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed out of a retail pharmacy.	Field #226 is situational. If the MAO has COB Carrier Amount available, report Field #226 (COB PRIMARY CLAIM TYPE).
232	COB PRIMARY PAYER ID	Primary Payer ID associated with the Primary Payer.		Field #232 (COB PRIMARY PAYER ID) is REQUIRED when both MAO funds and Medicaid funds were used to pay a drug/biological/item. Enter MAOSNP in Field #232 to represent that the MAO is the primary payer.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		Field #228 is REQUIRED. Report the payment associated to the primary payer report in Field #232 (COB PRIMARY PAYER ID). The MAO SNP would be considered the primary payer when the Platino Member has an MAO and Puerto Rico Medicaid (i.e., dual eligibles).
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.		Field #231 is required when the Primary Payer reported in Field #232 assessed deductible. Report the deductible associated to the primary payer reported in Field #232 (COB PRIMARY PAYER ID). If the Primary Payer reported in Field #232 did not assess deductible, leave blank.
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		Field #229 is required when the Primary Payer reported in Field #232 assessed coinsurance. Report the coinsurance associated with the primary payer reported in Field #232 (COB PRIMARY PAYER ID).
23Ø	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.		Field #23Ø is required when the Primary Payer reported in Field #232 assessed copayment. Report the copayment associated with the primary payer reported in Field #232 (COB PRIMARY PAYER ID).

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.		Field #238 (COB SECONDARY PAYER ID) is required when the MAO and another insurance plan or Medicaid paid for the drug or cost sharing. Enter MEDICAID when Medicaid funds were used secondary to the MAO funds to cover any portion of the payment for a drug/biological/item.
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		Field #234 is required when the Secondary Payer paid for the drug/product or the Platino Member's cost sharing (e.g., copayment).
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		Field #237 is required when there is a Secondary Payer deductible that was assessed on the drug/product. Report the deductible amount, if applicable.
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		Field #235 is required when there is a Secondary Payer coinsurance that was assessed on the drug/product. Report the coinsurance amount, if applicable.
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		Field #236 is required when there is a Secondary Payer copayment that was assessed on the drug/product. Report the copayment amount if applicable.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ – Not Specified by patient Ø1 – No other coverage – Code used in coordination of benefits transactions to convey that no other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received. Ø3 – Other coverage billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered. Ø4 – Other coverage exists – payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only – Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection or network selection.	Field #3Ø8-C8 is REQUIRED. Report the appropriate code from Column D that represents other coverage for the drug/product.
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan: 192Ø = Medicaid 193Ø = Medicare Blank = Neither	193Ø – MEDICARE – The federal program providing health insurance for people aged 65 and older and for disabled people of all ages.	Field #6Ø1-Ø1 is REQUIRED. If the MAO paid as the primary payer and Medicaid was reported as the secondary payer, enter 193Ø. This field should be completed based on primary payer when more than one funding source is used in payment related to MAO/Medicaid dual eligible coverage (i.e., Platino members).
393-MV	MV BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	**393-MV BENEFIT STAGE QUALIFIER** Code qualifying the 'Benefit Stage Amount' (394-MW). Blank – Not Specified	Field #393-MV is REQUIRED. Use the applicable MV Benefit Stage Qualifier in Column D.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Ø1 – Deductible – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer. Ø2 – Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3 – Coverage Gap (donut hole) – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MAPD, after the initial coverage limit and until the total out of pocket paid for covered prescription drugs reaches a certain amount. Ø4 – Catastrophic Coverage – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 5Ø – Not paid under Part D; paid under Part C benefit (for MA-PD plan): • This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN. • The claim is NOT paid by the Part D plan benefit. • The claim IS paid for by Part C benefit (MA portion of the MA-PD). • When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage. 6Ø – Not paid under Part D; paid as or under a supplemental benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			benefit is provided (drugs covered outside of the allowable Part D benefit). • The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit. • When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • Since 6Ø is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur: 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value Ø18 –"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 61 – Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit. • When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			566-J5 Other Payer Amount Recognized) of the claim. 62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit. • When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 7Ø – Part D drug not paid by Part D plan benefit; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. nonformulary, quantity limit, etc.). • When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 –	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e., excluded drugs). • When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan: • When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Occurs 2 times. Code values as specified in the NCPDP. Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim.	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer Ø5 – Amount of Copay (518-FI) as reported by previous payer Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer 1Ø – Amount Attributed to Provider Network Selection	Field #351-NP is REQUIRED. Report the applicable value from Column D.

Wraparound Paid (Medicaid Only)

Table 10 – Wraparound Paid (Medicaid Only)

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier.		If the MAO has COB Carrier Amount available, report Field #225 (COB CARRIER SUBMIT AMOUNT). If the MAO does not store the COB Carrier Amount, the field does not need to be completed.
245	ELIGIBILITY COB INDICATOR	Code as provided on Client eligibility.	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient 2 – Payer is Secondary – Plan is second payer for patient 3 – Payer is Tertiary – Plan is third payer for patient NCPDP 4.2: Required when available in the payer's adjudication system	Field #245 is REQUIRED. If Medicaid Wraparound paid the drug in full, report '1'.
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB. M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed out of a retail pharmacy.	Field #226 is situational. If the MAO has COB Carrier Amount available, report Field #226 (COB PRIMARY CLAIM TYPE).
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		Field #228 is REQUIRED. Report the payment associated to the primary payer report in Field #232 (COB PRIMARY PAYER ID). If the Medicaid Wraparound paid the drug in full, report the MAO paid amount.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.		Field #231 is situational. If Medicaid Wraparound paid the drug, deductible is not applicable. Do not report.
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		Field #229 is situational. If Medicaid Wraparound paid the drug, coinsurance is not applicable. Do not report.
23Ø	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.		Field #23Ø is situational. If Medicaid Wraparound paid the drug and a copayment is applied, report the copayment amount. If no copayment was applied, do not report.
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.	**MAOSNP** If the MAO pays for a drug as a secondary payer to a Commercial insurance plan or TRICARE, Field #238 must indicate Secondary Payer ID 'MAOSNP.' MAOSNP represents that the MAO paid for the drug. **MEDIGAP** If the Platino Member has a 'Medicare gap' insurance as a commercial insurance plan that covers Medicare or MAO cost sharing. Medicare gap insurance is always secondary to Medicare or an MAO. MEDIGAP represents an insurance plan that covers only Medicare/MAO cost sharing. **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #238 must indicate Secondary Payer ID 'MEDICAID.' MEDICAID represents that the Puerto Rico Medicaid paid for the drug/product.	Field #238 (COB SECONDARY PAYER ID) is situational. If Medicaid Wraparound paid the drug in full as the primary payer, do not report.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug/product, report 'COMMERCIAL' as the Secondary Payer ID in Field #238. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim, Field #238 must indicate Secondary Payer ID 'TRICARE.'	
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		Field #234 is situational. If Medicaid Wraparound paid the drug in full as the primary payer, do not report.
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		Field #237 is situational. If the Medicaid Wraparound paid the drug in full as the primary payer, do not report.
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		Field #235 is situational. If Medicaid Wraparound paid the drug in full as the primary payer, do not report.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		Field #236 is situational. If Medicaid Wraparound paid the drug in full as the primary payer, do not report.
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ – Not Specified by patient. Ø1 – No other coverage – Code used in coordination of benefits transactions to convey that no other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received. Ø3 – Other Coverage Billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered. Ø4 – Other coverage exists-payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only – Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection, or network selection.	Field #3Ø8-C8 is REQUIRED. If Medicaid Wraparound paid the drug in full, report Ø1.
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan: 192Ø = Medicaid 193Ø = Medicare Blank = Neither	192Ø – MEDICAID – A program, financed jointly by the federal government and the states, that provides health coverage for mostly low-income women and children as well as nursing home care for low-income elderly.	Field #6Ø1-Ø1is required. If the drug is a Medicaid Wraparound paid drug (Puerto Rico Medicaid funds are used to pay the drug/product), then report 192Ø (Medicaid).
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	**393-MV BENEFIT STAGE QUALIFIER** Code qualifying the 'Benefit Stage Amount' (394-MW). Blank – Not Specified Ø1 – Deductible – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer.	Field #393-MV is situational. If Medicaid Wraparound paid the drug in full, do not report.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Ø2 – Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3 – Coverage Gap (donut hole) – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MAPD, after the initial coverage limit and until the total out of your pocket paid for covered prescription drugs reaches a certain amount. Ø4 – Catastrophic Coverage – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 5Ø – Not paid under Part D; paid under Part C benefit (for MA-PD plan): • This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN. • The claim is NOT paid by the Part D plan benefit. • The claim IS paid for by Part C benefit (MA portion of the MA-PD). • When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage. 6Ø – Not paid under Part D; paid as or under a supplemental benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit).	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			• The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit. • When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • Since 6Ø is not specific to a Part D covered drug versus a non-Part D drug/non-qualified, either of the following situations may occur: 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value Ø18 –"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 2. For non-Part D/non-qualified drugs, Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 61 – Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • The claim is NOT paid by the Part D plan benefit, but is paid under the co-administered insured benefit. • When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. The claim is NOT paid by the Part D plan benefit, but is paid under the co-administered benefit. • When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 7Ø – Part D drug not paid by Part D plan benefit; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g., nonformulary, quantity limit, etc.). • When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare;	

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e., excluded drugs). • When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan: • When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Occurs 2 times. Code values as specified in the NCPDP. Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim.	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer. Ø5 – Amount of Copay (518-FI) as reported by previous payer. Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer. Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer.	Field #351-NP is situational. Report the applicable value from Column D. If Medicaid Wraparound paid the drug in full, leave blank.

NCPDP Field ID	NCPDP Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values or Guidance for PRMMIS	PRMMIS Instructions
			Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø – Amount Attributed to Provider Network Selection.	

Commercial Insurance as Primary and MAO as Secondary

Table 11 – Commercial Insurance as Primary and MAO as Secondary

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier.		If the MAO has COB Carrier Amount available, report Field #225 (COB CARRIER SUBMIT AMOUNT).
245	ELIGIBILITY COB INDICATOR	Code as provided on Client eligibility.	Blank – Not Specified 1 – Payer is Primary – Plan is first payer for patient 2 – Payer is Secondary – Plan is second payer for patient 3 – Payer is Tertiary – Plan is third payer for patient NCPDP 4.2: Required when available in the payer's adjudication system	Field #245 is REQUIRED. When a Commercial Health insurance Plan is a primary payer to Medicare Advantage, report '1'.
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank – Not Specified I – Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J – Major Medical – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB. M – Mail Service – Pharmaceutical claims dispensed out of a Mail Order Facility. R – Retail – Pharmaceutical claims dispensed out of a retail pharmacy.	Field #226 is situational. If the MAO has COB Carrier Amount available, report Field #226 (COB PRIMARY CLAIM TYPE).
232	COB PRIMARY PAYER ID	Primary Payer ID associated with the Primary Payer.	**MAOSNP** If the MAO pays for a drug, Field #232 must indicate Primary Payer ID MAOSNP. MAOSNP represents that the MAO paid for the drug/product. **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #238 must indicate Secondary Payer ID 'MEDICAID.' MEDICAID represents that Puerto Rico Medicaid paid for the drug.	Field #232 (COB PRIMARY PAYER ID) is REQUIRED. If a Commercial Health Insurance Plan is primary to Medicare Advantage, report 'COMMERCIAL'.

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			The only time that MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** (This scenario, from a COB Primary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug before the MAO can consider payment of the drug/product, report 'COMMERCIAL' as the Primary Payer ID in Field #232. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Primary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim before the MAO can consider paying for the drug, Field #232 must indicate Primary Payer ID 'TRICARE'.	
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.		Field #228 is REQUIRED. Report the Commercial Health Insurance Plan payment.
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.		Field #231 is required when the Primary Payer reported in Field #232 assessed deductible. Report the deductible associated to the Commercial Health Insurance Plan reported in Field #232

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
				(COB PRIMARY PAYER ID). If the Commercial Health Insurance Plan did not assess deductible, do not report.
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.		Field #229 is required when the Primary Payer reported in Field #232 assessed coinsurance. Report the coinsurance associated with the Commercial Health Insurance Plan reported in Field #232 (COB PRIMARY PAYER ID). If the Commercial Health Insurance Plan did not assess coinsurance, do not report.
23Ø	COB PRIMARY PAYER COPAY	Copay amount according to primary payer for product or service.		Field #23Ø is required when the Primary Payer reported in Field #232 assessed a copayment. Report the copayment associated with the Commercial Health Insurance Plan reported in Field #232 (COB PRIMARY PAYER ID). If the Commercial Health Insurance Plan did not assess a copayment, do not report.
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.	**MAOSNP** If the MAO pays for a drug as a secondary payer to a Commercial insurance plan or TRICARE, Field #238 must indicate Secondary Payer ID 'MAOSNP.' MAOSNP represents that the MAO paid for the drug. **MEDIGAP** If the Platino Member has a 'Medicare gap' insurance as a commercial insurance plan that covers Medicare or MAO cost sharing.	Field #238 is required when the MAO is the secondary payer to a Commercial Health Insurance Plan to report payment of Commercial Health Insurance deductible, coinsurance, and/or copayment. If Medicare Advantage paid any portion of the Commercial Health Insurance cost sharing, then

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			Medicare gap insurance is always secondary to Medicare or an MAO. MEDIGAP represents an insurance plan that covers only Medicare/MAO cost sharing. **MEDICAID** If the MAO does not cover the drug and Puerto Rico Medicaid funding is used to pay for the drug, Field #238 must indicate Secondary Payer ID 'MEDICAID.' MEDICAID represents that the Puerto Rico Medicaid paid for the drug/product. The only time MEDICAID is primary is when the MAO does not cover payment of the drug/product and the Platino member does not have a Commercial insurance or TRICARE primary that must be billed for consideration of payment of the drug/product. **COMMERCIAL** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member has a private health insurance plan that must consider payment of a drug/product, report 'COMMERCIAL' as the Secondary Payer ID in Field #238. A commercial insurance plan is insurance coverage that is not Medicare Part D, Medicare Part B, Medicare Advantage Organization – Special Needs Plan, or Medicaid. This scenario may or may not apply to each MAO. **TRICARE** (This scenario, from a COB Secondary Payer ID standpoint, may or may not apply to the Puerto Rico Medicare Advantage Organizations.) If the Platino Member is a veteran where TRICARE must pay or deny the pharmacy claim, Field #238 must indicate Secondary Payer ID 'TRICARE.'	report the secondary payer ID as 'MAOSNP.'

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.		Field #234 is required when the Secondary Payer paid any portion of the drug or Commercial Health Insurance Plan cost sharing (i.e., deductible, coinsurance, and/or copayment). Report the amount that Medicare Advantage paid.
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.		Field #237 is required when there is a Secondary Payer deductible that was assessed on the drug/product. When Medicare Advantage pays secondary to a primary Commercial Health Plan where no deductible is assessed, leave blank.
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.		Field #235 is required when there is a Secondary Payer coinsurance that was assessed on the drug/product. When Medicare Advantage pays secondary to a primary Commercial Health Plan where no coinsurance is assessed, leave blank.
236	COB SECONDARY PAYER COPAY	Copay amount according to secondary payer for product or service.		Field #236 is required when there is a Secondary Payer copayment that was assessed on the drug/product. When Medicare Advantage pays secondary to a primary Commercial Health Plan where no copayment is assessed, leave blank.

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
3Ø8-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	ØØ – Not Specified by patient. Ø1- No other coverage – Code used in coordination of benefits transactions to convey that no other coverage is available. Ø2 – Other coverage exists – payment collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment received. Ø3 – Other coverage billed – claim not covered – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment denied because the service is not covered. Ø4 – Other coverage exists – payment not collected – Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed, and payment has not been received. Ø8 – Claim is billing for patient financial responsibility only – Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection, or network selection.	Field #3Ø8-C8 is REQUIRED. Report the appropriate code from Column D that represents other coverage for the drug/product. When Medicare Advantage is secondary to a primary Commercial Health Insurance, report Ø2 when reporting the Commercial Health Insurance Plan as the primary payer.
6Ø1-Ø1	PLAN TYPE	Identifies the type of plan: 192Ø = Medicaid 193Ø = Medicare Blank = Neither	Four spaces	Field #6Ø1-Ø1 is REQUIRED. When Medicare Advantage is a secondary payer to a primary Commercial Health Insurance Plan, report 193Ø (MEDICARE).
393-MV	MV BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	**393-MV BENEFIT STAGE QUALIFIER** Blank – Not Specified Ø1 – Deductible – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer. Ø2 – Initial Benefit – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3 – Coverage Gap (donut hole) – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MAPD, after the initial coverage	Field #393-MV is REQUIRED. Use the applicable MV Benefit Stage Qualifier in Column D. When Medicare Advantage is responsible to pay Commercial Health Insurance cost sharing only as a secondary payer, report 'F9' (F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			limit and until the total out of your pocket paid for covered prescription drugs reaches a certain amount. Ø4 – Catastrophic Coverage – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 5Ø – Not paid under Part D; paid under Part C benefit (for MA-PD plan): • This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN. • The claim is NOT paid by the Part D plan benefit. • The claim IS paid for by Part C benefit (MA portion of the MA-PD). • When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • A Medicare Advantage Prescription Drug plan (MA-PD) is a Medicare Advantage (Part C) plan that includes prescription drug coverage. 6Ø – Not paid under Part D; paid as or under a supplemental benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit). • The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit.	

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			• When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • Since 6Ø is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur: 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value Ø18 –"Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 61 – Part D drug not paid by Part D plan benefit; paid as or under a co-administered insured benefit only: • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. • The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit. • When the qualifier value of 61 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.	

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			62 – Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only • This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit. • When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. **Note:** Non-qualified drugs are defined as not meeting the definition of a Part D drug. 7Ø – Part D drug not paid by Part D plan benefit; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g., nonformulary, quantity limit, etc.). • When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights."	

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
			8Ø – Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing: • This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e., excluded drugs). • When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 9Ø – Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan: • When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. • The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. • Code qualifying the 'Benefit Stage Amount' (394-MW).	

NCPDP 4.2 Other Payer	NCPDP 4.2 Field Description	NCPDP 4.2 Instructions	NCPDP 4.2 Valid Values and Guidance	PRMMIS Instructions
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Occurs 2 times. Code values as specified in the NCPDP. Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim.	Blank – Not Specified Ø1 – Amount Applied to Periodic Deductible (517-FH) as reported by previous payer. Ø2 – Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer. Ø3 – Amount Attributed to Sales Tax (523-FN) as reported by previous payer. Ø4 – Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer. Ø5 – Amount of Copay (518-FI) as reported by previous payer. Ø6 – Patient Pay Amount (5Ø5-F5) as reported by previous payer. Ø7 – Amount of Coinsurance (572-4U) as reported by previous payer. Ø8 – Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer. Ø9 – Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer. 1Ø – Amount Attributed to Provider Network Selection.	Field #351-NP is REQUIRED. When Medicare Advantage is a secondary payer to a Commercial Health Insurance Plan and only responsible to pay Commercial Health Insurance cost sharing only as a secondary payer, report Ø6.

Appendix B: Change Summary

Version	Issue Date	Modified By	Comments/Reason
1.Ø	Ø2/16/2Ø17	Wil Joslyn	Original document with formatting updates.
2.Ø	Ø6/3Ø/2Ø17	Wil Joslyn	Page 159: Added the following text to the 897 – TRANSACTION ID CROSS REFERENCE field (PRMP Requirement column): "The 18-digit transaction ID of the NCPDP encounter that is being voided by this reversal is entered here." Page 162: Updated the 896 – TRANSACTION ID field (PRMP Requirement column) with "Every claim in the file must contain the unique 18-digit Transaction ID assigned by MC-21 during adjudication." Page 193: Removed "ORIGINAL TRANSACTION ID" and "VOIDED TRANSACTION IDENTIFIER" rows. Changed the following FILLER row values to: Length to 423. Start position from 3314 to 3296.
3.Ø	12/15/2Ø19	Wil Joslyn	Update for "Other Payer" reporting for MAOs and general clean up.
		Page 1	Text added to Section 1 Introduction.
		Page 3	Text added to Section 2 NCPDP Post Adjudication Transaction Standard Version 4.2 File Information.
		Page 4	Text added to Section 2.3 Additional NCPDP Post Adjudication Transaction Standard Version 4.2 File Information.
		Page 4	Transaction Specific Information Column header "Mandatory or Situational" changed to "Usage" and new usage type added "N/U" for "Fields Not Used" by PRMMIS. All fields that are used by PRMMIS during processing are identified as "Required". Column header "PRDOH Requirement" changed to "PRMP Comment."
		Page 7	Header Record Field 879 "Sending entity Identifier" value changed to "PRMP assigned six-digit trading partner ID."
		Page 8	Field 88Ø-K7 – "Receiver ID" value changed to "PRMMIS."
		Page 9	Detail Record starts.

Version	Issue Date	Modified By	Comments/Reason
		Page 10	Field 3Ø2-C2 comment changed to "PRMMIS will only use the last 11 digits of the Puerto Rico Medicaid Program's member identification number."
		Page 10	Field 716-SY comment changed to "Required when available in the payer's adjudication system."
		Page 10	Field 717-SX comment changed to "Required when available in the payer's adjudication system."
		Page 11	Field 729-TA is not used by PRMMIS.
		Page 11	Field 214 is not used by PRMMIS.
		Page 11	Field 721-MD comment changed to "Required when available in the payer's adjudication system.
		Page 11	Field 274 is not used by PRMMIS.
		Page 11	Field 288 is not used by PRMMIS.
		Page 11	Field 331-CX has only one valid value (Ø6).
		Page 11	Field 332-CY comment changed to "PRMMIS will only use the last 11 digits of the Puerto Rico Medicaid Program's member identification number."
		Page 12	Field 716-SY is not used by PRMMIS.
		Page 12	Field 717-SX is not used by PRMMIS.
		Page 12	Field 729-TA is not used by PRMMIS.
		Page 12	Field 3Ø4-C4 comment changed to "Required when available in the payer's adjudication system."
		Page 12	Field 3Ø5-C5 is not used by PRMMIS.
		Page 12	Field 247 is not used by PRMMIS.
		Page 12	Field 2Ø8 is not used by PRMMIS.
		Page 13	Field 3Ø3-C3 is not used by PRMMIS.
		Page 13	Field 3Ø6-C6 is not used by PRMMIS.
		Page 13	Field 3Ø9-C9 is not used by PRMMIS.
		Page 13	Field 215 Comment changed to "PRMP assigned trading partner ID of MCO/MAO."

Version	Issue Date	Modified By	Comments/Reason
		Page 13	Field 212 is not used by PRMMIS.
		Page 13	Field 279 is not used by PRMMIS.
		Page 14	Field 282 is not used by PRMMIS – all three.
		Page 14	Field 292 is not used by PRMMIS.
		Page 14	Field 3Ø8-C8 Comment changed to "If available, report the appropriate value that represents other coverage for the drug/product."
		Page 16	Field 6Ø1-Ø1 added value "If neither MAO nor Wraparound is the primary payer, enter four spaces" and Comment changed to "Use 193Ø (Medicare) when only MAO funding is used to pay the drug/product. Use 192Ø (Medicaid) when only Puerto Rico Medicaid funds are used to pay the drug/product. If neither, enter spaces."
		Page 17	Field 2Ø2-B2 Value shortened to "Ø1 – National Provider Identifier (NPI), Ø5 – Medicaid ID if atypical" and Comment shortened to "Required."
		Page 17	Field 2Ø1-B1 Comment shortened to "Required."
		Page 17	Field 2Ø2-B2 is not used by PRMMIS.
		Page 17	Field 2Ø1-B1 is not used by PRMMIS.
		Page 17	Field 727-SS is not used by PRMMIS.
		Page 18	Field 732 is not used by PRMMIS.
		Page 19	Field B1Ø-8A is not used by PRMMIS.
		Page 18	Field 15Ø is not used by PRMMIS.
		Page 18	Field 266 is not used by PRMMIS.
		Page 18	Field 466-EZ is not used by PRMMIS.
		Page 19	Field 411-DB is not used by PRMMIS.
		Page 19	Field 296 comment changed to "Required when available in the payer's adjudication system."
		Page 19	Field 295 is not used by PRMMIS.
		Page 19	Field 716-SY is required by PRMMIS.
		Page 19	Field 717-SX is required by PRMMIS.
		Page 19	Field 81Ø-8A is required by PRMMIS.

Version	Issue Date	Modified By	Comments/Reason
		Page 22	Field 436-E1 has only one valid value.
		Page 23	Field 239 is not used by PRMMIS.
		Page 23	Field 3Ø7-C7 is not used by PRMMIS.
		Page 23	Field 384-4X is not used by PRMMIS.
		Page 23	Field 419-DJ is not used by PRMMIS.
		Page 23	Field 278 is not used by PRMMIS.
		Page 23	Field 217 is not used by PRMMIS.
		Page 24	Field 268 is not used by PRMMIS.
		Page 24	Field 1Ø2-A2 is not used by PRMMIS.
		Page 24	Field 216 is not used by PRMMIS.
		Page 26	Field 429-DT is not used by PRMMIS.
		Page 26	Field 6ØØ-28 is not used by PRMMIS.
		Page 27	Field 254 is not used by PRMMIS.
		Page 27	Field 996-G1 is not used by PRMMIS.
		Page 28	Field 492-WE PRMMIS will only use one Diagnosis Code.
		Page 28	Field 424-DO PRMMIS will only use one diagnosis Code.
		Pages 29 – 36	All 439-E4, 44Ø-E5, 441-E6, & 474-8E fields are not used by PRMMIS.
		Page 35	All 511-FB fields are not used by PRMMIS.
		Page 35 – 72	Fields 435-DZ, 434-DY, 532-FW, 397, & 261 are not used by PRMMIS.
		Page 36	Field 146 is not used by PRMMIS.
		Page 36	Field 297 is not used by PRMMIS.
		Page 37	Only one field, 42Ø-DK, is used by PRMMI.S
		Page 36 – 73	Fields 6Ø1-24, 243, & 425-DP are not used by PRMMIS.
		Page 36 – 74	Fields 273, 244, & 252 are not used by PRMMIS.
		Page 37 – 79	All occurrences of fields 6Ø1-19 & 6Ø1-18 are not used by PRMMIS.
		Page 38 – 85	All 6Ø1-26 & 6Ø1-25 fields are not used by PRMMIS.
		Page 38 – 91	Fields 257, 221, 889, 256, & 255 are not used by PRMMIS.

Version	Issue Date	Modified By	Comments/Reason
		Page 40 – 91	Fields 572-4U, 519-FJ, 517-FH, 571-NZ, 133-UJ, 134-UK, 135-UM, 136-UN, 137-UP, 272, 223, 26Ø, 284, 2Ø9, 21Ø, 211, & 253 are not used by PRMMIS
		Page 43	Field 561-AZ is not used by PRMMIS.
		Page 45	Field 566-J5 is not used by PRMMIS.
		Page 47 – 91	Fields 522-FM, 346-HH, 347-HJ, 348-HK, 349-HM, 573-4V, 557-AV, 276, 275, 2Ø7, 461-EU, 462-EV, & 299 are not used by PRMMIS.
		Page 51	Field 225 has a new comment, "If available in payer's system."
		Page 52	Field 226 has a new comment, "If the MAO has COB Carrier Amount available."
		Page 53	Field 232 has new possible values.
		Page 54	Field 228 has a new comment, "Required – report the payment associated to the primary payer. The MAO SNP would be considered the primary payer when the Platino Member has an MAO and Puerto Rico Medicaid (i.e., dual eligibility)."
		Page 54	Field 238 has new possible values and a new comment, "Required when the MAO and another insurance plan or Medicaid paid for the drug or cost sharing."
		Page 56	Field 234 has a new comment, "Required when the Secondary Payer paid for the drug/product or the Platino Member's cost sharing."
		Page 56	Field 237 has a new comment, "Required when there is a Secondary Payer deductible that was assessed on the drug/product."
		Page 56	Field 235 has a new comment, "Required when there is a Secondary Payer coinsurance that was assessed on the drug/product."
		Page 56	Field 236 has a new comment, "Required when there is a Secondary Payer copayment that was assessed on the drug/product."
		Page 58	Field 997-G2 is not used by PRMMIS.
		Page 58 – 59	Only the first pair of fields 393-MV & 394MW are used by PRMMIS.
		Page 60	Field 3Ø2-C2 is not used by PRMMIS.
		Page 60	Field 475-J9 is not used by PRMMIS.

Version	Issue Date	Modified By	Comments/Reason
		Page 62	Field 351-NP has a new comment, "Required when received as part of the original claim from the provider or as part of the Processor's response to the Submitted Claim."
		Page 67	Field A37 is not used by PRMMIS.
		Page 68	Field A73 is not used by PRMMIS.
		Page 68	New note added to end of detail record, "Note: "COB/TPL" Indicates that further directions can be found in Appendix A: Discussion of MAO COB/TPL Reporting When:"
		Page 74	Field 25Ø is not used by PRMMIS.
		Page 79	Field 251 is not used by PRMMIS.
		Page 88	Field 475-J9 is not used by PRMMIS.
		Page 90	Fields 476-H6 & 878 are not used by PRMMIS.
		Page 96	New Appendix A added "Discussion of MAO COB/TPL Reporting When:"
		DXC Technology	Formatting updated.
		DXC Technology	Appendix "Frequently Asked Questions" deleted.
4.Ø	11/19/2Ø2Ø	Gainwell Technologies	Gainwell Rebranding

ADDENDUM 6

Carrier to ASES
ver 4.1C_rev20230221

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 0 0 0 0 2

NÚMERO DE CONTRATO

Carrier to ASES Data Submissions

New File Layouts

Version 4.1C

February 21, 2023

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 0 0 0 0 2

NÚMERO DE CONTRATO

ASES

ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

MedInsight@asespr.org

TABLE OF CONTENTS

Version Changes 5

Introduction 8

Claims Transaction Handling 8

Provider, IPA and Network Files 9

Capitation Files 10

Capitation Adjustments 10

Data Validation and Audit Process 11

Claims, Capitation and Encounter Lag Reports 11

Primary Carrier ID 15

General Notes on Field Level Requirements 15

Data File Naming Conventions 17

CLAIMSERVICES INPUT FILE LAYOUT 19

***PROVIDERS* INPUT FILE LAYOUT** 54

***IPA INPUT* FILE LAYOUT** 61

***CAPITATION* INPUT FILE LAYOUT** 63

***NETWORK* INPUT FILE LAYOUT** 68

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
Carrier to ASES Data Submissions
File Layouts

ATTACHMENT I - MUNICIPALITY CODES 74

ATTACHMENT II - CARRIER CODES 78

ATTACHMENT III - SPECIALTY CODES 81

ATTACHMENT IV - PLACE OF SERVICE CODES 88

ATTACHMENT V - PROVIDER TYPE CODES 95

ATTACHMENT VI – PLAN VERSION LIST 96

ATTACHMENT VII – CAPITATION TYPE LIST 104

ATTACHMENT VIII - HOUR CODES 105

Version Changes

Version 3.0A

ASES file layouts ver. 3.0A for submission by Carriers for data generated from July 2018 forward

CAPITATION Input File Layout

CAPITATION TYPE field was modified.

PROVIDER Input File Layout

The descriptions for the provider address fields was changed to specify that it refers to the provider's physical address.
New fields added to the layout.

CLAIMSERVICES Input File Layout - Added

New fields added to the layout.

Data Validation and Auditing Change

New section regarding data validation and auditing added.

Version 3.0A rev3

Provider, Network, and IPA Files Layout

Frequency of Provider, Network, and IPA files changed from monthly to weekly.
Content of Provider, Network, and IPA files changed from only those entities that are present in claims to all active records.

CLAIMSERVICES Input File Layout

PLAN TYPE field and PLAN VERSION LIST were modified.

Version 3.0A rev4

Content of Provider and Network files changed from all active records to all active records, and "Out of Network" providers present in claims.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
Carrier to ASES Data Submissions
File Layouts

Version 3.0A rev5

Provider and Network files descriptions and/or validation rules were changed for required fields that are unavailable for "Out of Network" providers.

Version 4.0B

Additional Provider and Network files content requirements were added, for required fields that are unavailable for "Out of Network" providers.
New descriptions and/or validation rules were added to the CLAIMSERVICES Input File Layout, applicable to GHIP and Government Employee Carriers.
CARRIER CODES, PLAN VERSION LIST and Place of Service Codes were modified.

Version 4.0C

Claims Transaction Handling requirements were modified for reversals and adjustments.
Data File Naming Conventions requirements were modified.
Provider and Network files descriptions and/or validation rules were changed for required fields that are unavailable for providers/groups that do not qualify for an NPI.
Encounter Lag Reports requirements were added.
Capitation Adjustments specifications and Capitation Input File Layout fields were modified.
CLAIMSERVICES Input File Layout new field added, and field description was modified.
ATTACHMENT II - CARRIER CODES – updated
Descriptions and/or validation rules of the Municipality and Region fields were added, for Outside of Puerto Rico.

Version 4.1C

Descriptions and/or validation rules were added to the CLAIMSERVICES and Capitation Input File Layouts, to the Plan Type related fields, applicable to Government Employee Carriers.
Descriptions and/or validation rules were added to the CLAIMSERVICES, to the Primary Center field, applicable to claims for Plan Version 970.
ATTACHMENT IV - PLACE OF SERVICE CODES – updated
ATTACHMENT VI – PLAN VERSION LIST – updated

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
Carrier to ASES Data Submissions
File Layouts

IPA Code Deliverable Data Format at IPA, CAPITATION and NETWORK Input File Layouts were changed.
Specialty and Specialty Code fields at NETWORK Input File Layouts were changed.

Introduction

The island of Puerto Rico's Medicaid program, the Government Health Plan (GHP) was established in 1993 with the passing of Law 72. Through Law 72, the program to administer the Medicaid program for roughly 1.3 Milliman people, the Administración de Seguros de Salud (ASES) was established. In order to continuously review health care utilization, expenditures, and performance in Puerto Rico and to enhance the ability of ASES to make informed and cost-effective health care choices, ASES has partnered with Milliman, Inc. to provide ASES with a data warehouse and analytics system. ASES has been capturing data from its managed care health carriers for many years to populate in the data warehouse and other systems. This layout document provides health insurance carriers information to submit their health care claims, network, provider, IPA, and capitation data to ASES.

Claims Transaction Handling

All Claims files are to be submitted on a monthly basis, for all Claims PAID in the month of the file submitted. All adjustments of an adjudicated claim line are accepted in the CLAIMSERVICES file. Do not send claims that are in an open status, such as pended claims, held, rejected, or pre-adjudicated claims. Claims reversals and adjustments happen as follows:

Paid or Denied FFS Claims

Individual service lines are adjusted or reversed at the line level with additional adjustment services marked with a claim line status code of 'A' or 'R', while the original claim has a status code of 'P' for paid, 'D' for denied claims, or 'E' for encounter claims. The adjusted or reversed service:

- must include the claim id of the original claim to be adjusted or reversed, at the field named Original Claim Id Number, and
- may have the same claim ID and line number or a different claim ID and line number.

Encounter Claims

Claims representing encounters have no allowed or paid amounts and are therefore not able to be adjusted monetarily. If an encounter needs to be updated to change any of the fields of the encounter, the adjusting claim must have a claim line status code (sv_stat field) of 'E' and the claim ID and service line number must be the same as the encounter being adjusted. Our process will remove the original encounter so that duplicate encounters will not be counted in the data.

On the other hand, if an encounter needs to be submitted as a Fee For Service claim the carrier must:

- reverse the original service, by submitting the reversal with a claim line status code of 'R' and the same values as the original claim for the following fields: claim ID, service line number and Original Claim Id Number
- submit a new Fee for Service claim record, that may have the same claim ID and line number or a different claim ID and line number.

Provider, IPA and Network Files

The Provider, IPA, and Network files are to be submitted weekly, every Wednesday and must include the latest available data from the day prior to the submission date. For each weekly submission within a given month, keep the same file naming convention, but increment the sequence number, starting with 0, then 1, 2, 3.

The IPA file shall include every IPA that is active in your system. The PRV and NET files shall include every Provider and Network record that is active in the carrier's and/or sub-contractor's system, and "Out of Network" providers associated with currently submitted claim records. In addition, the IPA and Provider files shall include the IPA and providers associated with currently submitted capitation records. ASES will be using this data to keep a current complete list of available Providers and IPAs.

The Provider and Network files must include:

- all "In Network" providers directly contracted or sub-contracted with the carrier,
- any "Out of Network" providers included on the CLM file,
- all providers included on the CAP file (only applicable for the Provider File and excluding PMGs).

For "Out of Network" provider records, the carrier's will report as much information as available on their systems. The carrier shall submit "Out of Network" provider records with a contract effective date equal to '99991231'. For any required fields for which the carrier does not have valid information, the fields must be left blank.

ASES is requesting that provider NPIs are to always be used as the PROV_ID in order to assist in provider attribution and reporting across all Carriers. ASES will not accept the carrier's own provider id as the provider ID for medical claim, unless the carrier presents a valid reason for not using NPI's. Consequently, for providers that don't qualify to obtain an NPI by the nature of its business, the carrier may submit the Tax Id of the provider as the PROV_ID to which the capitation payment is made. The carrier will have to present an official notification to ASES of every provider that was reported with a Tax Id in lieu of an NPI.

For pharmacy claims only

For pharmacy providers, only the NPI number will be accepted as the provider ID. Carriers must include pharmacy providers in their provider files sent to ASES and the IDs must be consistent within the carriers' claims.

Capitation Files

All Capitation files are to be submitted on a monthly basis, for all Capitation PAID in the month of the file submitted. The amount to be reported on capitation records must represent any costs associated with providing services which are not reported in claims and encounters. This may come from formal contracts with providers such as HCO/PCPs, or any other financial arrangement or allocation of costs.

The cap_amount field should represent a calculation which includes the earned capitation for the period for each member. Other types of deductions which may be taken out of the provider's payment such as repayment of advances, retentions for reserves should not be included in the calculation.

The gross_cap_amount field should represent a calculation that includes the earned capitation for the period for each member (not the group average).

The net_cap_amount field should represent a calculation which includes the earned capitation for the period for each member (gross_cap_amount) less claims paid amounts, if any, chargeable against the provider risk. Other types of deductions which may be taken out of the provider's payment such as repayment of advances, retentions for reserves should not be included in the calculation.

Capitation records shall be provided for all members enrolled in the PMG's regardless of their risk coverage. The risk coverage type will be identified with a new risk type field.

Capitation Adjustments

There may be circumstances in which capitation payments which have already been reported, need to be adjusted or reversed in a later month. To accomplish this, the Capitation records will behave differently than Claims and Services. The carrier will send a new record

for the provider / member / experience date with the amount(s) to be added or subtracted from the previously reported amount(s), specifically for the following fields: Capitation Amount, Gross Capitation Amount, Net Capitation Amount, Capitation Days and Capitation Percent. If a capitation of $10.00 is to be reversed then the new record should contain the same information as the original but with a new Capitation Date, a Capitation Amount of -$10.00, and the corresponding adjustments to the Gross Capitation Amount, Net Capitation Amount, Capitation Days and Capitation Percent fields as well. Inside MedInsight the capitation for that Provider / Member for that particular date will be the aggregate of all the records and this example will result in $0.00.

Note that, as Capitation net amounts for any particular record may be negative, a reversal in such a case would be a positive amount.

Data Validation and Audit Process

After the files are loaded, Milliman will employ an automated validation process, File Field and Quality Checks (FFQC), to ensure that the format and content of each submitted file is valid and complete. Monthly files that do not pass the reconciliation process and the data audit process will be rejected. Load threshold levels for individual data elements submitted are validated against those pre-established levels defined by ASES and Milliman.

Failure to conform to any of the submission requirements will result in the rejection and return of the applicable data file(s). No records from such a file will be retained in the system and the carrier will be required to re-submit the rejected file in its entirety before the next month's files become due. Such re-submitted files must be carefully named using the sequence number part of the naming convention to ensure the name is distinct from the rejected file and is named in the correct order.

Due to the large amount and complexity of the data processed, it is more efficient to resubmit an entire file rather than to correct data within the file. Partial replacement files or record specific corrections will not be accepted.

Claims, Capitation and Encounter Lag Reports

Carriers are required to submit encounter, claims and capitation payment reports, called lag reports, on a monthly basis. These reports will be used to reconcile the data submitted. Claims and capitation data that do not match the lag reports on paid amount, and/or encounter claims data that do not match the lag reports on record counts within a reasonable percentage will be deemed invalid and must be corrected.

The claims and capitation lag reports submitted by the carrier will be considered to be financially accurate and may be used for other purposes, including negotiations or other financial analyses. Therefore, it is in the carrier's best interests to produce lag reports that are either from another source that the actual files that are submitted, or to verify that the lag reports tie to financial reports.

The required claims lag reports need to be an Excel file with the following characteristics:

1. Claims paid amounts by:
   a. Region code of member as defined by ASES,
   b. Incurred month with deliverable data format YYYYMM,
   c. Paid month with deliverable data format YYYYMM, and
2. Claim type for claims, where can be filled in with one of the following default values: Medical, Pharmacy and Dental.
3. The report must include at least all paid and incurred months going back 2 full years prior to the month the report is run.
4. Naming of the claims lag reports should be as follows:

CLAIMLAG_ccyymms.xls(x)

Where:

Characters 1-9	Always "CLAIMLAG_"		
Characters 10-11	cc	=	Carrier Code (See attachment II)
Characters 12-13	yy	=	Last two digits of year
Characters 14-15	mm	=	Month – last full paid month in the lags.
Character 16	s	=	sequence number of file submission.
Character 17	Always "."		
Characters 18-20(21)	Extension code for excel file, can be xls or xlsx depending on Excel version.		

An example of how the claims lag report data should look for claims is as follows:

Claim Type	Region	Incurred Month	Paid Month	Paid Amount
Medical	East	201801	201801	50,823.43
Medical	South	201801	201802	45,534.00
Medical	North	201801	201803	986,796.36

Pharmacy	East	201801	201801	686.89
Pharmacy	South	201801	201802	2,342.22
Dental	North	201801	201803	780,989.16
…	…	…	…	…

The required capitation lag reports need to be an Excel file with the following characteristics:

1. Capitation paid amounts by:
   a. Region code of member as defined by ASES,
   b. Capitation experience month (period for which the capitation payment applies) with deliverable data format YYYYMM,
2. Paid month with deliverable data format YYYYMM.
3. The report must include at least all paid and experience months going back 2 full years prior to the month the report is run.
4. Naming of the capitation lag reports should be as follows:

CAPLAG_ccyymms.xls(x)

Where:

Characters 1-7	Always "CAPLAG_"		
Characters 8-9	cc	=	Carrier Code (See attachment II)
Characters 10-11	yy	=	Last two digits of year
Characters 12-13	mm	=	Month – last full paid month in the lags.
Character 14	**s**	=	sequence number of file submission.
Character 15	Always "."		
Characters 16-18(19)	Extension code for excel file, can be xls or xlsx depending on Excel version.		

An example of how the capitation lag report data should look for claims is as follows:

Region	Incurred Month	Paid Month	Capitation Paid Amount
East	201801	201801	5,023.43
South	201801	201802	4,534.00
North	201801	201803	98,796.36
East	201801	201801	66.89

South	201801	201802	242.22
North	201801	201803	70,989.16
…	…	…	…

The required encounter claims lag reports need to be an Excel file with the following characteristics:

1. Count of Claims records representing encounters by:
   a. Region code of member as defined by ASES,
   b. Incurred month with deliverable data format YYYYMM,
   c. Paid month with deliverable data format YYYYMM,
2. Claim type for claims, where can be filled in with one of the following default values: Medical, Pharmacy and Dental.
3. The report must include at least all paid and incurred months going back 2 full years prior to the month the report is run.
4. Naming of the claims lag reports should be as follows:

ENCOUNTERLAG_ccyymms.xls(x)

Where:

Characters 1-13	Always "ENCOUNTERLAG_"		
Characters 14-15	cc	=	Carrier Code (See attachment II)
Characters 16-17	yy	=	Last two digits of year
Characters 18-19	mm	=	Month – last full paid month in the lag.
Character 20	s	=	sequence number of file submission.
Character 21	Always "."		
Characters 22-24(25)	Extension code for excel file, can be xls or xlsx depending on Excel version.		

An example of how the encounter claims lag report data should look for claims is as follows:

Claim Type	Region	Incurred Month	Paid Month	Encounters Count
Medical	East	201801	201801	5,000
Medical	South	201801	201802	24,200
Medical	North	201801	201803	7,654
…	…	…	…	…

Primary Carrier ID

The *Primary Carrier ID* field in the ClaimServices Input File Layout identifies the entity (MBHO, Sub Contractor Entity, or TPA) which provides services to the enrollees throughout a special or capitated financial arrangement. Another field called *Carrier ID* field contains the ID of the carrier directly contracted with ASES and the one generating the ClaimServices Input File. The ClaimServices Input File will contain the same value in the *Carrier ID* and *Primary Carrier ID* fields when the carrier generating the ClaimServices Input File is the carrier providing services to the enrollees. If this entity does not have an assigned carrier ID from ASES, the *Primary Carrier ID* can be filled in with one of the following 4 default values that represents the type of entity:

MH – Mental Health
VS – Vision
DN – Dental
OT – Other/Unknown

General Notes on Field Level Requirements

Date Fields - All date fields in the following data layout are defined to the same size and format as YYYYMMDD. An 8 byte field where YYYY = 4 digit year, MM = 2 digit month and DD = 2 digit day. 1 digit month and day values must always have the leading zero (0). Date fields must contain a valid date with months between 01 and 12 and days between 01 and maximum day in month. July 1, 2006 will be coded as 20060701.

Amount Fields – All amount fields representing money must be numeric and are defined as 9 bytes in the format s9(7)v99 where v represents and implied decimal point. This allows a maximum of 7 digits for dollars plus the last two digits for cents. These numbers are always right justified and zero filled to the left. As examples:

$1.23 will be coded as	000000123
$100.00 will be coded as	000010000

All amount fields are positive and follow the above definition unless clearly specified otherwise.

End of Record Filler – All file layouts have been designed to end with a filler field of 1 byte which must always be coded as an "*" character. This is done to avoid issues between different systems when generating and transferring ASCII files in which ending field may be empty. The fixed End of Record Filler guarantees that all records in a file can be constructed to the fixed length format as defined in the layouts.

Justification and filling of Fields – The layouts have all been specified to provide fixed length fields and fixed length records. While other methods can be used, it is felt that this provides the best common ground for working with multiple entities each of which uses varying systems. To be sure everyone understands the same about the comments on justification and filling the following examples are given to help keep this concept clear.

All numeric fields must be filled completely with numeric digits. If there are exceptions these are clearly spelled out in the documentation of the layouts. Typically numeric field are right justified and to keep them numeric must be zero filled. In a field specified as numeric such a s9(7)v99 the following conventions apply:

- `S` - Leading sign
- `9(7)` - 7 decimal digits
- `V` - Implied decimal point
- `99` - 2 digits after the implied decimal point

The following examples illustrate how data will look in the field:

Value	Field
12.50	000001250
101	000010100
1,234.56	000123456
1,000,000	100000000
-1,234.56	-00123456

All alphanumeric fields must be filled completely. If the value of data in the field is less than the width of the field then care must be taken to ensure that the field is filled with blanks. Allowing "NULLS" or other special characters through may cause unexpected results and make reading, loading and validation of the data difficult. Typically alphanumeric field are left justified and filled to the right with blanks to complete the field. In a field specified as alphanumeric such a X(20) the following examples illustrate how data will look in the field where the [ ] characters represent the start and end of the field –

Value	**Field**
P.R.	[P.R.]
José Rivera	[José Rivera]
blanks	[ ]
(Metro-North Region)	[(Metro-North Region)]

MPI Number fields – In all files in which MPI Number is required, carriers should code all 9s if the MPI is unknown. This should not be true for any current beneficiary. This exception will continue until such time as ASES determines that the issue of MPI being unavailable has disappeared from historical data. For Government Employee MPI should be filled with Contract Number.

Data File Naming Conventions

All data files to be delivered to ASES by the carriers must be compressed and follow the naming conventions below. Files which do not fit the naming convention will be ignored and the carrier deemed to have failed in delivery of such a file.

File names must adhere strictly to this naming convention as the structure includes information for identification of the carrier, dates and file type. If not named correctly the file cannot be processed properly.

The general format of file names will be –

Dccyymms.fff.zip

Where:	Character 1	Always "**D**"		
	Characters 2-3	**cc**	=	Carrier Code (See attachment II)

Character 4-5	**yy**	=	Last two digits of year
Characters 6-7	**mm**	=	Month
Character 8	**s**	=	sequence number of file submission.

All submission start with s = 0 and continue in numeric if files are re-submitted to 9
If files must be re-submitted beyond 9, then alphabetic characters will be used a, b, c …

Character 9		Always "."
Characters 10-12		Extension code identifying type of file
	CLM for	CLAIMSERVICES
	PRV for	PROVIDERS
	IPA for	IPA
	CAP for	CAPITATIONS
	NET for	NETWORK
Characters 13-16	.zip =	Extension code identifying a compressed file

Files are always dated for the month being reported. For example, when sending claims paid in July 2018 the **yymm** part of the file name will be **1807** while the file will be sent to ASES in August.
Examples of completing this naming convention are –

For imaginary carrier 99 in the files for ClaimServices and payments in April 2018 will be named as follows –

ClaimServices	D9918040.CLM.ZIP
Providers	D9918040.PRV.ZIP
IPA	D9918040.IPA.ZIP
Capitation	D9918040.CAP.ZIP
Network	D9918040.NET.ZIP

When the Capitation file is rejected, the corrected file will be re-submitted as
D9918041.CAP.ZIP

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	**Carrier ID**	Value that identifies carrier which is reporting claims. Must be a valid code. See Carrier Code List in Attachment II	**99**	Required Must be two (2) digits (numeric).). Must equal a valid Carrier ID as assigned by ASES.
2	region_code	**Region Code**	Region of member as defined by ASES Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West "P" = SPECIAL "X" = All Regions "O" = Outside Puerto Rico	**X**	Required Must be valid ASES Region code For plan type "01", the Region Code must be a valid region code, and the value cannot be "X" or "O". **For plan type "04", "05", "06" and "09" value must be "X".**

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
3	plan_type	**Plan Type**	ASES defined Plan Type 01 = GHIP 02 = MA-SNP 03 = MA-PD 04 = Law 95 Commercial 05 = Law 95 Advantage 06 = Law 95 ELA-GHP **07 = Commercial non-Law 95** **08 = Advantage non-Law 95** **09= LAW 95 Pensioned Police**	**XX**	Required **Must equal "01", "02", "03", "04", "05", "06", "09"** Value "01" must correspond to a GHIP carrier or to an MBHO, PBM, or other assigned carrier code which is not Medicare Platino. Values of "02" or "03" must correspond to Medicare Platino Carrier ID. Values of "04" or "05" must correspond to Government Employee Carrier ID. Value "06" must correspond to Government Employee Carrier ID for ELA-GHP ("ELA Puros"). **Values of "07" or "08" must correspond to carrier, which is not plan type "01"-"06" or "09".** **Value "09" must correspond to government employee carrier ID for Pensioned Police.**
4	contract_type	**Contract Type**	Contract type to distinguish multiple plans within Plan Type. For government employee claims indicates contract type: 1 = Family 2 = Couple 3 = Individual 4 = Optional Dependent	**X**	**Required for Plan Type "04", "05", "06" and "09" (Government Employee)** Not required for Plan Type "01", "02", or "03".
5	claim_id	**Claim ID**	Unique Identification number within Carrier for the claim.	**X(20)**	Required Left justified, blank filled to 20 characters if value is less than 20 characters.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
6	sv_line	**Service Line Number**	Number identifying individual service within a given claim.	**XXXXX**	Required Must be a maximum of 5 digits. ID of the Service Line within the Claim ID. Duplicates within Claim ID and Service Line Number on the same submission will be considered errors (the combination of the claim_id plus the service_line_no must be unique within the carrier).
7	bill_type	**Bill Type**	Originating bill type – U=UB-04 / Institutional H=HCFA/CMS1500 / Individual / Professional P=Pharmacy Claim D=Dental Claim	**X**	Required Must equal "U", "H", "P" or "D".
8	ub_bill_type	**UB Type of Bill**	Type of Bill on the UB claim form. The type of bill encodes facility type, bill classification, and description.	**XXX**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be one of the standard three digit codes as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual.
9	sv_stat	**Claim Line Status**	Indicates payment action on the service represented by this record. P= Paid D=Denied A=Adjustment R=Reversal E=Encounter	**X**	Required Must equal "P", "D", "A", "R" or "E" If value is "E", service will have zero Paid Amount.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
10	adj_code	**Adjustment Reason Code**	Adjustment reason code explaining why a claim payment was adjusted. Codes used are the X12 code list maintained by CMS and NUCC. The code set can be found at the following site: http://www.x12.org/codes/claim-adjustment-reason-codes/	**XXX**	Must be present on claims with a Claim Line Status (sv_stat field) equal to "A". Right justified. For claims without adjustment, this field must be left blank.
11	forced_claim_ind	**Forced Claim Indicator**	This code indicates if the claim was processed by forcing it through a manual override process.	**X**	'Y'- Yes 'N' - No
12	adm_date	**Admit Date**	For UB-04 claims this is the date of admission. For other claims this is the Service From Date of the earliest service.	**YYYYMMDD**	Required Must be a valid date.
13	dis_date	**Discharge Date**	For UB-04 claims this is the date of discharge. For other claims this is the Service To date of the latest service.	**YYYYMMDD**	Required Must be a valid date Must be equal or later than Admit Date
14	from_date	**Service From Date**	Begin date of the treatment.	**YYYYMMDD**	Required Must be a valid date.
15	to_date	**Service To Date**	End date of the treatment.	**YYYYMMDD**	Required Must be a valid date Must be on or after Service From Date
16	paid_date	**Payment Date**	For an Encounter, this will be the date the transaction is processed by the carrier. For non-encounters, this will be the date of payment for paid claims or the process date for denied claims.	**YYYYMMDD**	Required Must be a valid date Must be on or after Service To Date

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
17	rec_date	**Received Date**	Date when claim was received in carrier in YYYYMMDD format	**YYYYMMDD**	Required Must be a valid date Must be equal or greater than Discharge Date
18	entry_date	**Entry Date**	Date when claim was entered into the carrier's system. YYYYMMDD format.	**YYYYMMDD**	Required Must be a valid date Must be equal or greater than Received Date
19	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Claims Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
20	mpi	**MPI Number or Contract Number**	Master Patient Index (MPI) As supplied in ASES Eligibility Data For government employee this will be the contract number	**X(13)**	Required Must be a valid MPI number For government employee only, contract number Must be left justified, blank filled to the right
21	primary_center	**Primary Center**	Identify the Primary Care Center (IPA/HCO) of the member. Code as assigned by the carrier.	**X(10)**	Must be present on all claims of Plan Type "01", except on claims from plan version 970. May be present on claims of other Plan Types When present it indicates the Primary Care Center (IPA/HCO etc.) of the member. Must be left justified and blank filled to complete the field. Must be found on the IPA table matched by Carrier ID and IPA.
22	ssn_mainh	**HOH Social Security**	Social Security number of Head of Household (HOH) of family. This is available from the Family record in ASES eligibility data sent to carriers.	**X(9)**	Required Must be all numeric Must be a full 9 digits, right justified, zero filled
23	ssn	**Patient Social Security**	Social Security Number of member	**X(9)**	Required Must be all numeric Must be a full 9 digits, right justified, zero filled

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
24	member_suffix	**ASES Member Suffix**	Identifies the beneficiary within the family group. For non-governmental employees - Must be the two digit member suffix as supplied in ASES Eligibility data. For governmental employees - Must be one of the following: 01 = Principal - (Main Holder) 02 = Spouse - Direct 03 = Spouse - Joint (Mancomunado) 04 = Children - Direct 05 = Optional - Direct (parents) 06 =Substantial 07 = Co-Habitant 08 = Co-Habitant - Joint (Mancomunado)	**99**	Required Must be ASES Assigned member suffix. All numeric value 01 to 99.
25	patient_name	**Patient Name**	Member Name	**X(30)**	Required Must be left justified, blank filled to the right.
26	household_id	**ASES Household ID**	Household ID as supplied in ASES Eligibility data	**X(11)**	Required ASES / ODSI Household ID. Alphanumeric full 11 characters. For government employee use SSN Main Holder. Must be left justified, blank filled to the right.
27	sex	**Sex Code**	Gender of member M = Male F = Female	**X**	Required Must equal "M" or "F"
28	birth_date	**Birth Date**	Member Date of Birth in YYYYMMDD format	**YYYYMMDD**	Required Must be a valid date Cannot be in later than the Extract Date. Cannot be greater than 150 years ago compared to Extract Date. Must be equal or earlier than Admit Date.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
29	municipality_res	**Municipality Residence**	Municipality of residence of member. See Municipality Codes in Attachment I.	**XXXX**	Required Must be a valid ASES Municipality Code All numeric, right justified, zero filled Must correspond to a municipality within Region Code
30	municipality_code	**Municipality Service**	Municipality in which services are provided based on provider address. See municipality Codes in Attachment I.	**XXXX**	Required Must be a valid ASES Municipality Code All numeric, right justified, zero filled. For outside of Puerto Rico, code 0666 is included in the list of Municipality Codes.
31	drg_code	**DRG Code**	Diagnosis Related Group Code	**XXXX**	Must be a valid DRG Code
32	drg_type	**DRG Type Code**	DRG Type Code, representing the type of DRG Code submitted on the claim.	**X**	Required when DRG is provided. Must be one of the following: 1= MS DRG 2= CMS DRG 3= AP DRG 4= APR DRG
33	drg_outlier_amt	**DRG Outlier Amount**	Additional amount paid by carrier on a claim that is associated with either a cost outlier or length of stay outlier.	**S9(7)v99**	For claims submitted on Uniform Bill (UB) claim form. Must be zero for encounters. Must be zero for Services with Payment Status of "D". On non-UB claims must be blank.
34	drg_rel_weight	**Relative DRG Weight**	Indicates the relative weight for the DRG on the claim. Each year CMS assigns a relative weight to each DRG. These weights indicate the relative costs for treating patients during the prior year.	**X(6)**	If populated, must be a valid weight without any decimal points. Left justified, blank filled. A DRG weight of 2.397 should be reported as 2397.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
35	pre_auth_num	**Pre-Authorization Number**	The number identifying pre-authorization. An unique identification number, that indicates the services provided on this claim have been authorized by the carrier (Also called Prior Authorization)	**X(20)**	Should be supplied when available. Left justified, blank filled to 20 characters if value is less than 20 characters.
36	proc_code	**Procedure Code**	For non-Pharmacy Standard procedure code conforming to HCPCS/CPT or HCSPC/CDT as appropriate	**X(15)**	For claims from CMS1500 / UB-04, when present must be a HCPCS/CPT code. For Dental claims must be a valid dental HCPCS/CDT code. For Pharmacy claims this must be all blanks.
37	cpt_mod_1	**Procedure Modifier Code 1**	Modifier code valid for the Procedure Code	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be valid as a modifier for the Procedure code.
38	cpt_mod_2	**Procedure Modifier Code 2**	Modifier code valid for the Procedure Code	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be valid as a modifier for the Procedure code Must be left blank for encounters
39	cpt_mod_3	**Procedure Modifier Code 3**	Modifier code valid for the Procedure Code	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.
40	cpt_mod_4	**Procedure Modifier Code 4**	Modifier code valid for the Procedure Code A series of procedure code modifiers used with the corresponding Procedure Codes. For example, some states use modifiers to indicate assistance in surgery or anesthesia services.	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
41	cpt_mod_5	**Procedure Modifier Code 5**	Modifier code valid for the Procedure Code A series of procedure code modifiers used with the corresponding Procedure Codes.	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.
42	cpt_mod_6	**Procedure Modifier Code 6**	Modifier code valid for the Procedure Code A series of procedure code modifiers used with the corresponding Procedure Codes.	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.
43	rev_code	**Revenue Code**	For UB-04 Claims NUBC Revenue Code	**X(4)**	Required for UB-04 claims. When present it must be a valid Revenue code. Must be zero filled to the left.
44	rx_ndc	**National Drug Code**	For Pharmacy only. National Drug Code value for prescribed drug in 5 4 2 format	**X(11)**	Required on Pharmacy claims. Must be a valid NDC code in 5 4 2 format filling all 11 bytes. For non-Pharmacy claims must be blank.
45	tooth_code	**Tooth Code**	For Dental only ADA standard tooth number as required by CDT code when procedure directly affects a tooth.	**XXX**	Must be present on Dental claims when Procedure code requires Tooth Code. Must be left justified and blank filled to complete the field. For non-Dental claims must be blank.
46	surface_code	**Surface Code**	For Dental only ADA standard surface code as required by CDT code when procedure directly affects one or more surfaces.	**X(7)**	Must be present on Dental claims when procedure code requires Surface Code. Must be a valid Surface Code. Must be left justified and blank filled to complete the field. For non-Dental claims must be blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
47	lcd_diag_01	**Primary ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims. Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
48	lcd_diag_02	**Second ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims. Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
49	lcd_diag_03	**Third ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
50	lcd_diag_04	**Fourth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
51	Icd_diag_05	**Fifth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
52	Icd_diag_06	**Sixth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
53	Icd_diag_07	**Seventh ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
54	Icd_diag_08	**Eighth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
55	Icd_diag_09	**Ninth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
56	Icd_diag_10	**Tenth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
57	Icd_diag_11	**Eleventh ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
58	Icd_diag_12	**Twelfth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
59	icd_proc_01	**Primary ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Principal Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
60	icd_proc_02	**Second ICD10 Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
61	icd_proc_03	**Third ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
62	icd_proc_04	**Fourth ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
63	icd_proc_05	**Fifth ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
64	icd_proc_06	**Sixth ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
65	pcp_prov_id	**PCP Provider**	National Provider Identifier (NPI) of the member's PCP.	**X(20)**	Required for Plan Type "01" claims Must be a valid Provider ID found in the provider files. Must be 10 digit numeric NPI

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
66	att_prov_id	**Attending Provider**	National Provider Identifier (NPI) of the provider delivering the service. If not directly available from the claim it should be filled from the Billing Provider. On pharmacy claims this is the prescribing physician.	**X(20)**	Required Must be a valid Provider ID found in the provider files. Must be 10 digit numeric NPI.
67	att_taxonomy	**Attending Provider Taxonomy**	Indicates the corresponding provider taxonomy of billing entity/provider, to define provider's type, classification, and area of specialization. The taxonomy code for the institution billing/caring for the beneficiary.	**X(12)**	Required Left justified, blank field to the right.
68	ref_prov_id	**Referring Provider**	National Provider Identifier (NPI) of referring provider, when applicable.	**X(20)**	When present, must be a valid Provider ID found in the provider files. When present, must be valid NPI number.
69	ref_prov_taxonomy	**Referring Provider Taxonomy**	Indicates the corresponding provider taxonomy of referring provider, to define provider's type, classification, and area of specialization.	**X(12)**	Left justified, blank field to the right.
70	bill_prov_id	**Billing Provider**	National Provider Identifier (NPI) of the provider billing for the service.	**X(20)**	Required Must be a valid Provider ID found in the provider files. Must be 10 digit numeric NPI.
71	network_affiliation	**Network Affiliation**	Indicates if the service provider is in the preferred provider network or not. Y = Yes N = No	**X**	Required Must be "Y" or "N".

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
72	primary_carrier_id	**Primary Carrier ID**	Value that identifies the primary carrier providing service to the patient. May be the same as the carrier_id field or another carrier as a sub-contractor – a MBHO, Vision, or Dental plan. See Carrier ID List in Attachment II	**XX**	Required Must be two (2) digits (alpha-numeric). Must equal a valid Carrier ID as assigned by ASES if one has been assigned. If sub-contracted entity does not have a carrier code assigned by ASES, the following default codes may be used to represent the type of sub-contracted entity is the primary carrier: MB – Mental Health VS – Vision DN – Dental OT – Other/Unknown Carrier Type
73	pos_code	**Place of Service**	Place of Service Code identifying the place in which the service is delivered. See POS Code List in Attachment IV	**XX**	Required Must be a valid Place of service Code.
74	cob_code	**COB Code**	Identify if the beneficiary has other Health Insurance for this service. "Y if member has other health insurance, "N" otherwise.	**X**	Required Must be "Y" or "N"
75	amt_billed	**Billed Amount**	For non-Pharmacy Cost of service as billed by the provider.	**S9(7)v99**	Required for non-Pharmacy claims. Must be a number on all non-pharmacy records. Cannot be left blank for non-pharmacy.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
76	amt_allowed	**Allowed Amount**	For non-Pharmacy Amount allowed for the service by the carrier.	**S9(7)v99**	Required for non-Pharmacy claims. Must be a number on all records Must be zero for encounters or denied services (Payment Status (sv_stat) = "E" or "D") Cannot be left blank For sv_stat "P" (Payment Status = "paid") this must be greater than zero.
77	deduct	**Deductible**	Amount paid by member before payments by the carrier begin for this service	**S9(7)v99**	Required Must be a number on all records Must be zero for encounters Cannot be left blank.
78	copay	**Co-Pay**	Amount paid by member as dollar co-payment for this service	**S9(7)v99**	Required Must be a number on all records Must be zero for encounters Cannot be left blank.
79	cob	**COB Amount**	Amount paid by other Health Insurance attributable to this service.	**S9(7)v99**	Required Must be a number on all records Must be zero for encounters Cannot be left blank.
80	coins	**Coinsurance Amount**	Amount paid by member as percentage of cost for this service	**S9(7)v99**	Required Must be a number on all records Must be zero for encounters Cannot be left blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
81	amt_paid	**Paid Amount**	Amount paid by carrier for this service	**S9(7)v99**	Required Must be zero for encounters Must be zero for Services with Payment Status of "D" For Services with sv_stat = "P" (Payment Status = Paid) one of the following calculations must be valid within a record – For non-Pharmacy: amt_paid = amt_allowed - deduct - copay - cob - coins For Pharmacy: amt_paid = rx_ingr_cost - deduct - copay - cob - coins + rx_disp_fee **For Plan Type "02", "03", "04", "05", "06", "09" only - amt_paid may be zero if the appropriate calculation above results in 0.00.** For Plan Type "01" the amt_paid must be greater than zero.
82	enc_proxy_price	**Encounter Proxy Price**	This field shows the amount that would have been paid for this exact same service if it had been processed as a Fee For Service claim. It does not represent an actual dollar disbursement.	**S9(7)v99**	Required on Encounter claims. On non-encounter claims, it must be blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
83	rx_disc	**Drug Discount**	For Pharmacy only Amount Discounted at the Pharmacy This is the discount given from AWP to get the Ingredient Cost When drug is paid from a MAC list the discount amount will be Zero (0) This field does not form part of the calculation to get Amount Paid but can be used with Ingredient Cost to work back to AWP.	**S9(7)v99**	Required on Pharmacy claims. On non-Pharmacy claims must be blank.
84	rx_ingr_cost	**Ingredient Cost**	For Pharmacy only. Cost of ingredient(s) dispensed for this Service.	**S9(7)v99**	Required on Pharmacy claims. Must be greater than zero. On non-Pharmacy claims must be blank.
85	rx_disp_fee	**Dispensing Fee**	For Pharmacy only. Dispensing fee charged by pharmacy.	**S9(7)v99**	Required on Pharmacy claims. Must be a number On non-Pharmacy claims must be blank.
86	rx_total_disp	**Total Quantity Dispensed**	For Pharmacy only. Total quantity of drug dispensed by pharmacy.	**S9(7)v99**	Required on Pharmacy claims. For non-Pharmacy claims must be blank. May include decimal point. This field is only applicable when the NDC code billed can be quantified in discrete units. Left justified, blank filled.
87	rx_days_supply	**Prescription Days**	For Pharmacy only. Number of days prescribed and dispensed.	**999**	Required on Pharmacy claims Must be greater than zero On non-Pharmacy claims must be blank.
88	rx_drug_type	**Drug Type Code**	For Pharmacy only. Code identifying type of drug on pharmacy claims.	**XX**	Required on Pharmacy claims When present it must be one of the valid codes. On non-Pharmacy claims must be blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
89	rx_daw	**Dispensed As Written**	For Pharmacy only. Code indicating "Dispense as written" status of the prescription on pharmacy claims	**X(6)**	Required on Pharmacy claims When present it must be one of the valid codes. On non-Pharmacy claims must be blank Valid Codes are – 0 - NO DISPENSE AS WRITTEN 1 - PHYSICIAN writes DISPENSE AS WRITTEN 2 - PATIENT REQUESTED 3 - PHARMACIST SELECTED BRAND 4 - GENERIC NOT IN STOCK 5 - BRAND DISPENSED, PRICED AS GENERIC 6 - OVERRIDE 7 - SUBSTITUTION NOT ALLOWED; BRAND MANDATED BY LAW 8 - GENERIC NOT AVAILABLE 9 - OTHER
90	rx_refill_cnt	**Refill Count**	For Pharmacy only. The number of refills specified by the physician writing the prescription on pharmacy claims.	**9(6)**	Required on Pharmacy claims When present must be a number On non-Pharmacy claims must be blank.
91	rx_par	**Participating Pharmacy Flag**	For Pharmacy only Indicates whether prescription was dispensed by a participating pharmacy on pharmacy claims Valid values – "Y" = participating pharmacy "N" = non-participating pharmacy	**X(7)**	Required on Pharmacy claims Left justified, blank filled Must be "Y" or "N" On non-Pharmacy claims must be blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
92	compound_dosage_form	**Compound Dosage Form**	For Pharmacy only. Indicates the Dosage form of the complete compound mixture. Compound code are identified as: 01 = Capsule 02 = Ointment 03 = Cream 04 = Suppository 05 = Powder 06 = Emulsion 07 = Liquid 10 = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup 17 = Lozenge 18 = Enema Blank = Not Specified	**XX**	Required on Pharmacy claims On non-Pharmacy claims must be blank All numeric, right justified, zero filled.
93	compound_drug_ind	**Compound Drug Indicator**	For Pharmacy only. Indicator for whether to specify if the drug is compound or not. Y= Drug is compound N= Drug is not compound	**X**	Required on Pharmacy claims. On non-Pharmacy claims must be blank. Must be "Y" or "N"
94	date_prescribed	**Prescription Date**	For Pharmacy claims, this is the date where a prescription was written for the member individual.	**YYYYMMDD**	Required on Pharmacy claims. Must be a valid date. Must be on or before Service From Date. For non-Pharmacy claims must be blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
95	ndc_unit_type	**NDC Unit of Measure**	A code to indicate the basis by which the quantity of the National Drug Code is expressed. Value must be equal to a valid value. Valid Values: "F2" = International Unit "GR" = Gram "ME" = Milligram "ML" = Milliliter "UN" = Unit	**XX**	Required on Pharmacy claims. For non-Pharmacy claims must be blank. Describes the basis of the amount reported on the NDC Quantity-QUANTITY and RX-CLAIM-QUANTITY-ALLOWED Fields.
96	prescription_num	**Prescription ID**	The unique identification number assigned by the pharmacy or supplier to the prescription. This number is used to avoid duplicated Claims, but allows multiple service lines within the same claim.	**X(20)**	Required Left justified, blank filled to 20 characters if value is less than 20 characters.
97	rx_quantity_allowed	**RX quantity allowed**	The maximum allowable quantity of a drug or service that may be dispensed per prescription per date of service or per month.	**X(9)**	Required on Pharmacy claims For non-Pharmacy claims must be blank. Must be without any decimal points May include decimal point. For example, an amount of 30 should be coded as 3000. This field is only applicable when the NDC code being billed can be quantified in discrete units and should be described by the **NDC-UNIT-OF-MEASURE** field. Left justified, blank filled.
98	rebate_eligible_indicator	**Rebate Eligible Indicator**	An indicator to identify claim lines with an NDC that is eligible for the drug rebate program.	**X**	"Y"- Yes "N"- No

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
99	ub_dis_stat	**UB Discharge Status Code**	On UB-04 claims, Patient Status Code at discharge.	**XX**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be one of the standard two digit codes as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual.
100	risk_type	**Risk Type**	Distinguishes for this service whether risk belongs to PCP(/Group) or carrier. If cost should be charged to PCP(/Group) then value = "PCP" Shared risk agreement should be identified as "SHR" Otherwise value = "CAR" (Carrier). Where there is no risk sharing the value should be entered as "CAR". PBM ONLY – when a PBM is submitting this file this field should be coded as "UNK" for Unknown.	**XXX**	Required Must be filled Must be "PCP" , "SHR" or "CAR" For PBM only value can be "UNK"
101	stop_loss_flag	**Stop Loss Flag**	When Risk Type is "PCP", set to "Y" if stop loss for PCP(/Group) has been reached for PCP on member Otherwise "N". When Risk Type is "CAR", set to "N" PBM ONLY – set to "N"	**X**	Required Must be filled ""Y" or "N"
102	applied_cost	**Cost Applied To**	For Medicare Platino, defines whether service is part of the ASES coverage, the CMS (MA) coverage or both. When filled the valid values are – 1=ASES 2=CMS 3=BOTH (SPLIT)	**X**	Required for Plan Type "02" and "03" (Medicare Platino) Must be filled and be a valid value. **Not Required for Plan Type "01", "04", "05", "06","09"**

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
103	ases_split_amt	**ASES Split Amount**	For Medicare Platino, indicates the part of the Paid Amount allocated to ASES coverage.	**S9(7)v99**	Must be filled if Cost Applied To = "1" or "3" **Not Required for Plan Type "01", "04", "05" , "06" or "09".**
104	cms_split_amt	**CMS Split Amount**	For Medicare Platino, indicates the part of the Paid Amount allocated to CMS (MA) coverage.	**S9(7)v99**	Required for Plan Type "02" and "03" (Medicare Platino) Must be filled if Cost Applied To = 2 or 3 **Not Required for Plan Type "01", "04", "05", "06" or "09"**
105	off_island	**Off Island Flag**	Indicator for whether service was located off of the islands of Puerto Rico, Culebra, and Vieques.	**X**	Required Y=Off Island N=On Island
106	plan_version	**Plan Version**	Plan Version to distinguish multiple plans within the Plan Type. Always three numeric characters, e.g. 001 See Plan Version List in Attachment VI	**XXX**	Required Must be a 3 digit Plan Version Code Carrier ID, Plan Type, and Plan Version must validate with a plan definition contracted with ASES. **Required for Plan Type "02", "03" (Medicare Platino), "04", "05", "06" and "09"** Not Required for Plan Type "01"
107	sv_units	**Units of Service**	Number of occurrences of service	**9(10)**	When present must be a number.
108	claim_type	**Claim Type**	Claim Type: I=Inpatient O=Outpatient P=Professional	**X**	Required for all medical claims. For Rx and Dental claims, this field can be left blank. Must equal "I", "O" or "P" if populated.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
109	admission_hour	**Admission Hour**	For UB-04 claims, this is the hour of admission. The hour code must be a two-digit code, based on 24-hour clock. See Hour Codes in Attachment VIII	**XX**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual. See attachment VIII for the codes to be used.
110	discharge_hour	**Discharge Hour**	For UB-04 claims this is the hour of discharge. The hour code must be a two-digit code, based on 24-hour clock.	**XX**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual. See Hour Codes in Attachment VIII
111	admission_type	**Admit Type**	Admit type code indicates the primary reason (priority) for admission. Admission codes: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma 9 = Information Not Available	**X**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be as described in the National Uniform Bill (UB) data specifications manual.
112	adm_prov_id	**Admitting Provider Id**	National Provider Identifier (NPI) of member's admitting provider.	**X(20)**	When present, must be a valid Provider ID found in the provider files. When present, must be valid NPI number.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
113	adm_prov_taxonomy	**Admitting Provider Taxonomy**	Indicates the corresponding provider taxonomy of admitting provider, to define provider's type, classification, and area of specialization.	**X(12)**	Generally, the provider taxonomy requires 10 bytes. However, two additional bytes have been provided for future expansion. Must be left justified and blank filled to the right
114	check_eff_date	**Check Date**	Check Date is the date when the check or electronic remittance for payment is processed.	**YYYYMMDD**	Must be a valid date. Must be on or after Service To Date. Not required for denied claims.
115	check_num	**Check Number**	Check Number is the check or electronic remittance number for payment.	**X(50)**	Must be left blank for Services with Payment Status of "E". Left justified, blank filled to 50 characters if value is less than 50 characters. Not required for denied claims.
116	claim_rem_code_01	**First Remittance Advice Remark Codes (RARCs)**	Indicates the first RARCs to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.	**XXXX**	Must be left blank for Services with Payment Status of "E". Must be left justified and blank filled.
117	claim_rem_code_02	**Second Remittance Advice Remark Codes (RARCs)**	Indicates the second RARCs to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.	**XXXX**	Must be left blank for Services with Payment Status of "E". Must be left justified and blank filled.
118	claim_rem_code_03	**Third Remittance Advice Remark Codes (RARCs)**	Indicates the third RARCs to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.	**XXXX**	Must be left blank for Services with Payment Status of "E". Must be left justified and blank filled.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
119	claim_rem_code_04	**Fourth Remittance Advice Remark Codes (RARCs)**	Indicates the fourth RARCs to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.	**XXXX**	Must be left blank for Services with Payment Status of "E". Must be left justified and blank filled.
120	poa_ind_1	**First Present on Admission (POA) Indicator**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
121	poa_ind_2	**Second Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
122	poa_ind_3	**Third Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
123	poa_ind_4	**Fourth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
124	poa_ind_5	**Fifth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
125	poa_ind_6	**Sixth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
126	poa_ind_7	**Seventh Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
127	poa_ind_8	**Eighth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
128	poa_ind_9	**Ninth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
129	poa_ind_10	**Tenth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
130	poa_ind_11	**Eleventh Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
131	poa_ind_12	**Twelfth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
132	occurrence_code_01	**First Occurrence Code**	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
133	occurrence_code_02	**Second Occurrence Code**	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
134	occurrence_code_03	Third Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
135	occurrence_code_04	Fourth Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
136	occurrence_code_05	Fifth Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
137	occurrence_code_06	Sixth Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
138	occurrence_code_07	Seventh Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
139	occurrence_code_08	Eighth Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
140	occurrence_code_09	Ninth Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
141	occurrence_code_10	Tenth Occurrence Code	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
142	original_claim_id	**Original Claim ID Number**	For adjustments or reversals, must be the original claim ID reported by the carrier.	**X(20)**	Must be present on claims with a Claim Line Status (sv_stat field) equal to "A" or "R". Right justified. For claims without adjustment or reversal, this field must be left blank. Left justified, blank filled to 20 characters if value is less than 20 characters.
143	Filler	End of Record Filler	Fixed filler with "*"	**X**	Required Must be = "*"

RECORD LENGTH	**977**

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	prov_carrier	**Prov Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	prov_id	**Prov ID**	Must be the NPI, or if none exists, may be the Tax Id.	**X(20)**	Required Must be left justified and blank filled to the right. If NPI is used, must be 10 digit numeric NPI. For all providers found in the CLAIMSERVICES files, must be the NPI.
3	prov_lname	**Prov Lname**	For an individual, Last Names (Apellidos) For an entity (other than an individual), the entity name	**X(50)**	Required Must be left justified, blank filled to the right
4	prov_fname	**Prov Fname**	For an individual, First Name (Nombre)	**X(30)**	Required for Individual providers Must be left justified, blank filled to the right
5	prov_mname	**Prov Mname**	For an individual, Middle Name	**X(30)**	Optional Must be left justified, blank filled to the right
6	prov_name_type	**Prov Name Type Indicator**	Indicator that tells if the provider is an individual or an entity. Valid values are: "I" = Individual "E" = Entity	**X(1)**	Required
7	prov_addr1	**Prov Addr1**	First line of provider's physical address	**X(45)**	Required Must be the physical address and use second and third line as needed. Must be left justified, blank filled to the right
8	prov_addr2	**Prov Addr2**	Second line of provider's physical address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
9	prov_addr3	**Prov Addr3**	Third Line of provider's physical address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
10	prov_city	**Prov City**	Provider's city	**X(45)**	Required Must be left justified, blank filled to the right
11	prov_state	**Prov State**	Provider's state	**X(45)**	Required Must be left justified, blank filled to the right

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
12	prov_zip	**Prov Zip**	Provider's Zip code Either 5 digit or plus 4 format without dashes	**X(9)**	Required Must be left justified, blank filled to the right Significant characters must be numeric and 5 or 9 digits in length
13	prov_country	**Prov Country**	Provider's country	**X(45)**	Required Must be left justified, blank filled to the right
14	prov_tel	**Prov Telephone**	Provider's telephone number. *SEE NOTES – Changes and Additions in Data File Layouts: PROVIDER telephone numbers*	**X(20)**	Required Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
15	prov_ext	**Prov Ext**	Provider's telephone extension	**X(20)**	Optional Must be left justified, blank filled to the right
16	prov_email	**Prov Email**	Provider's e-mail address	**X(40)**	Optional If supplied it must fit e-mail address format rules Must be left justified, blank filled to the right
17	prov_contact	**Prov Contact**	Name of contact person if provider is not an individual	**X(50)**	Optional Must be left justified, blank filled to the right
18	prov_type	**Prov Type**	Type of provider. See Provider Type Codes in Attachment V	**X(20)**	Required Must be left justified, blank filled to the right Must be a valid Provider Type Code
19	taxonomy1	**Taxonomy 1**	Report the NUCC healthcare provider taxonomy code. If not available, see Specialty Code in Attachment III	**X(10)**	Required Must be left justified, blank filled to the right Must be a valid taxonomy Code.
20	spec1	**Specialty Code 1**	Provider Specialty (first). See Specialty Code in Attachment III	**X(20)**	Required Must be left justified, blank filled to the right Must be a valid Specialty Code
21	taxonomy2	**Taxonomy 2**	Report the NUCC healthcare provider taxonomy code. If not available, see Specialty Code in Attachment III	**X(10)**	Optional Must be left justified, blank filled to the right Must be a valid taxonomy Code.
22	spec2	**Specialty Code 2**	Provider Specialty (second). See Specialty Code in Attachment III	**X(20)**	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
23	taxonomy3	**Taxonomy 3**	Report the NUCC healthcare provider taxonomy code. If not available, see Specialty Code in Attachment III	**X(10)**	Optional Must be left justified, blank filled to the right Must be a valid taxonomy Code.
24	spec3	**Specialty Code 3**	Provider Specialty (third). See Specialty Code in Attachment III	**X(20)**	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code
25	taxonomy4	**Taxonomy 4**	Report the NUCC healthcare provider taxonomy code. If not available, see Specialty Code in Attachment III	**X(10)**	Optional Must be left justified, blank filled to the right Must be a valid taxonomy Code.
26	spec4	**Specialty Code 4**	Provider Specialty (fourth). See Specialty Code in Attachment III	**X(20)**	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code
27	network_specialist	**Preferred Network Specialist**	Indicates if the service provider is a participating specialist of the preferred network in the PMG	**X**	Required Must be "Y" or "N"
28	federal_tax_id	**Federal Tax ID**	SSN for individuals, EIN for entities.	**X(20)**	Required Left justified, blank filled to the right Must be 9 digits in significant positions
29	tax_id_indicator	**Federal Tax ID Indicator**	Identifies if the federal tax ID provided in field *federal_tax_id* is a SSN or EIN. Valid values: "SSN" "EIN"	**X(3)**	Required Should be supplied when available
30	licence_number	**License Number**	State License Number	**X(15)**	Required Should be supplied when available Must be left justified, blank filled to the right
31	npi	**NPI**	National Provider Identifier	**X(10)**	Required Must be 10 digit numeric NPI. For all providers found in the CLAIMSERVICES files, the NPI must be provided. If none exists must be "N/A".

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
32	dea_number	**DEA Number**	DEA number	**X(20)**	Optional Should be supplied when available Must be left justified, blank filled to the right
33	medicare_number	**Medicare Number**	Medicare number	**X(20)**	Optional Must be left justified, blank filled to the right
34	medicaid_number	**Medicaid Number**	Medicaid number	**X(20)**	Optional. Must be left justified, blank filled to the right.
35	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Provider Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
36	clia_id	**CLIA Number**	Indicates the Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures. CLIA number consists of ten alphanumeric positions.	**X(10)**	Required for providers with specialty code equals to "Clinical Laboratory". Left justified, blank field to the right.
37	accepting_new_pat	**Accepting New Patient Indicator**	Indicates if the provider is accepting new patients (members) or not. Valid values: 0 = No 1 = Yes 8 = N/A – The individual only practices as a member of a group.	**X**	Must be a valid value.
38	dob	**Birth Date**	For an individual, Provider Date of Birth in YYYYMMDD format	**YYYYMMDD**	Required for an individual; left blank for an entity. Must be a valid date Cannot be in later than the Extract Date. Cannot be greater than 150 years ago compared to Extract Date.

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
39	dod	**Death Date**	For an individual Provider, Date of Death in YYYYMMDD format.	**YYYYMMDD**	Optional for an individual; left blank for an entity Should be supplied when available Must be a valid date Cannot be in later than the Extract Date Cannot be greater than 150 years ago compared to Extract Date. Cannot be equal or less than the date of birth. A provider with a date of death before the Extract Date cannot be listed as a provider for an eligible individual.
40	facility_group_ind_code	**Facility Group Indicator Code**	Indicates whether the SUBMITTING-STATE-PROV-ID is assigned to an individual, a group of providers, or a facility.	**XX**	Required Must be a valid value "01" = Facility – The entity identified by the associated SUBMITTING-STATE-PROV-ID is a facility. "02" = Group – The entity identified by the associated SUBMITTING-STATE-PROV-ID is a group of individual practitioners. "03" = Individual – The entity identified by the associated SUBMITTING-STATE-PROV-ID is an individual practitioner. For Pharmacy claims must be blank
41	license_entity	**License Issuing Entity ID**	Indicates the identity of the entity issuing the license or accreditation.	**X(50)**	Required whenever a value is captured in the LICENSE-OR-ACCREDITATION-NUMBER data element. Must be left justified, blank filled to the right (Enter the applicable state code, county code, municipality name, "DEA", professional society's name, or the CLIA accreditation body's name.) If LICENSE-TYPE = 1 (State, county, or municipality professional or business license) and the license-issuing entity is a state, then enter the applicable ANSI state numeric code. If LICENSE-TYPE = 2 (DEA license), then enter the text string "DEA". If LICENSE-TYPE = 3 (Professional society accreditation), then enter the text string identifying the professional society issuing the accreditation. If LICENSE-TYPE = 4 (CLIA accreditation), then enter the text string identifying the CLIA accreditation body's name. If LICENSE-TYPE = 5 (Other accreditation), then enter the text string identifying the entity issuing the accreditation. If LICENSE-TYPE = 9 (Unknown), then enter "Unknown".

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
42	license_type	**License Type**	A code to identify the kind of provider's license. Valid values: "1" = State, county, or municipality professional or business license "2" = DEA license "3" = Professional society accreditation "4" = CLIA accreditation "5" = Other "9" = Unknown	**X**	Required whenever a provider is required by the state's agency requires one in order to be a Medicaid/CHIP provider. Must be a valid value. If provider has more than one license, please report the one with lowest valid value. Example: for a provider with both "1" = State, county, or municipality professional or business license and "2" = DEA license, report "1" = State, county, or municipality professional or business license.
43	prov_dba	**Provider DBA Name**	The provider's name that is commonly used by the public when the "doing-business-as" (`) name is different from the legal name. DBA is an abbreviation for "doing business as." Registering a DBA is required to operate a business under a name that differs from the company's legal name.	**X(50)**	Leave the field empty when DBA name equals the legal name
44	sex	**Sex Code**	For an individual, indicates the provider's gender. Valid values: M = Male F = Female U = Unknown	**X**	Must be a valid value
45	credential_eff_date	**Credential Effective Date**	The most recent credentialing/recredentialing date of the provider. If the provider does not require credentialing, enter "1/1/1900" in this column.	**YYYYMMDD**	Required

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
46	credential_exp_date	**Credential Expiration Date**	The most recent credentialing/recredentialing expiration date of the provider. If the provider does not require credentialing, enter "1/1/1900" in this column.	**YYYYMMDD**	Optional
47	contract_eff_date	**Contract effective date**	The provider's contract effective date.	**YYYYMMDD**	Required for contracted providers. For "Out of Network" providers, please report as '99991231'.
48	contract_term_date	**Contract termination date**	The provider's contract termination date.	**YYYYMMDD**	For providers with an open-ended contract please report as '99991231'. For a provider with an unknown contract termination date, leave blank.
49	Filler	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
RECORD LENGTH					**963**

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

IPA INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	**Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II.	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	**ipa**	**IPA Code**	**Code assigned by carrier to identify IPA/HCO. Maximum of 4 characters.**	**X(10)**	Required **IPA/HCO code assigned by Carrier** **Must be left justified, blank filled to the right**
3	ipa_desc	**IPA Description**	Name of IPA/HCO	**X(80)**	Required Must be left justified, blank filled to the right
4	ipa_addr1	**IPA Addr1**	IPA/HCO's first line of address	**X(45)**	Required Must be left justified, blank filled to the right
5	ipa_addr2	**IPA Addr2**	IPA/HCO's second line of address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
6	ipa_addr3	**IPA Addr3**	IPA/HCO's third line of address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
7	ipa_city	**IPA City**	IPA/HCO's city	**X(45)**	Required Must be left justified, blank filled to the right
8	ipa_state	**IPA State**	IPA/HCO's state	**X(45)**	Required Must be left justified, blank filled to the right
9	ipa_zip	**IPA Zip**	IPA/HCO's zip code. Either 5 digit or plus 4 format without dashes	**X(9)**	Required Must be left justified, blank filled to the right Significant characters must be numeric. Must be 5 or 9 digits in length.
10	ipa_country	**IPA Country**	IPA/HCO's country	**X(45)**	Required Must be left justified, blank filled to the right
11	ipa_home_phone	**IPA Home Phone**	Home telephone number of contact person for IPA/HCO	**X(20)**	Optional Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
12	ipa_work_phone	**IPA Work Phone**	Principal work telephone number of IPA/HCO.	**X(20)**	Required Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
13	ipa_ext	**IPA Ext**	Telephone extension at IPA Work Phone for contact person	**X(20)**	Optional Must be left justified, blank filled to the right

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

IPA INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
14	federal_tax_id	**Federal Tax ID**	EIN of IPA	**X(20)**	Required Must be left justified and blank filled to the right Significant characters must be numeric and 9 digits in length
15	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the IPA Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
16	ipa_npi	**IPA NPI**	National Provider Identifier (NPI) of the IPA., where possible.	**X(10)**	Required Left justified, blank field to the right.
17	ipa_adm_lname	**IPA Administrator Lname**	IPA/HCO Administrator Last Names (Apellidos)	**X(50)**	Required Must be left justified, blank filled to the right
18	Ipa_adm_fname	**IPA Administrator Fname**	IPA/HCO Administrator First Name (Nombre)	**X(30)**	Optional Must be left justified, blank filled to the right
19	prov_mname	**IPA Administrator Mname**	IPA/HCO Administrator Middle Name	**X(30)**	Optional Must be left justified, blank filled to the right
20	Filler	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
RECORD LENGTH					**580**

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	**Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II.	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	cap_id	**Capitation ID**	Capitation payment ID must be a unique ID within carrier; except for the adjustments or reversals that must be the unique ID previously reported. This number is used to avoid duplicated Capitation records.	**X(20)**	Required Must be left justified, blank filled to the right Must be a unique ID within Carrier
3	cap_type	**Capitation Type**	Capitation type code defined as: "01"= Admin "02"= Dental "03"= DME … See Attachment VII	**99**	Required Must be two (2) digits (numeric). Must be a valid code. See Capitation Type List in Attachment VII
4	cap_date	**Capitation Date**	Date capitation paid.	**YYYYMMDD**	Required Must be a valid date
5	expr_date	**Experience Date**	Experience date of capitation payment. This is the date for which the capitation payment applies.	**YYYYMMDD**	Required Must be a valid date
6	prov	**Provider ID**	Must be the NPI, or if none exists, may be the Tax Id of the provider to which the capitation payment is made.	**X(20)**	Required Must be a valid Provider ID found in PRV File. Must be left justified and blank filled to the right. If NPI is used, must be 10 digit numeric NPI. If Tax Id is used, must be 9 digits in significant positions.
7	pcp_npi	**Provider NPI**	National Provider Identifier (NPI) of the provider to which the capitation payment is made.	**X(10)**	Required Must be the NPI, or if none exists, must be "N/A". Left justified, blank field to the right.
8	ipa	**IPA ID**	**Carrier assigned ID of IPA/HCO. This must be filled when IPA/HCO is involved (Must always be filled for Plan Type "01" by MCOs/TPAs)**	**X(10)**	Required If Carrier ID corresponds to Plan Type "01" **Must be a valid IPA Code for the Carrier and found in the IPA file. Left justified, blank field to the right.**

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
9	region_code	**Region**	Region of member Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West 'P" = SPECIAL "X" = All Regions "O" = Outside Puerto Rico	**X**	Required Must be valid ASES Region code For plan type "01", the Region Code must be a valid region code, and the value cannot be "X" or "O". **For plan type "04", "05" "06" and "09", value must be "X".**
10	municipality_code	**Municipality**	Municipality of residence of member. See Municipality Code in Attachment I.	**XXXX**	Required Must be ASES Municipality Code All numeric, right justified, zero filled Must correspond to a municipality within Region Code For outside of Puerto Rico, code 0666 is included in the list of Municipality Codes.
11	member_ssn	**Member SSN**	Social Security Number of member	**9(9)**	Required Must be 9 digits (numeric) Right justified, zero filled
12	household_id	**ASES Household ID**	Household ID as supplied in ASES Eligibility data	**X(11)**	Required ASES / ODSI Household ID. Alphanumeric full 11 characters. For government employee use SSN Main Holder. Must be left justified, blank filled to the right.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
13	member_suffix	**Member Suffix**	Identifies the beneficiary within the family group. For non-governmental employees - Must be the two digit member suffix as supplied in ASES Eligibility data. For governmental employees - Must be one of the following: 01 = Principal - (Main Holder) 02 = Spouse - Direct 03 = Spouse - Joint (Mancomunado) 04 = Children - Direct 05 = Optional - Direct (parents) 06 =Substantial 07 = Co-Habitant 08 = Co-Habitant - Joint (Mancomunado)	**99**	Required Must be 2 digits (numeric)
14	cap_amt	**Capitation Amount**	Capitation amount paid to provider MAY BE NEGATIVE *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	**S9(7)v99**	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
15	gross_cap_amt	**Gross Capitation Amount**	Gross Capitation amount paid to provider per MPI for all risk types. **MAY BE NEGATIVE** *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	**S9(7)v99**	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
16	net_cap_amt	**Net Capitation Amount**	Net Capitation amount paid to provider per MPI for all risk types. **MAY BE NEGATIVE** *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	**S9(7)v99**	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
17	risk_type	**MPI Risk Type**	Distinguishes for this service whether risk belongs to PCP(/Group) or carrier. If cost should be charged to PCP(/Group) then value = "PCP" If the risk is shared then the value =' SHR' Otherwise value = "CAR" (Carrier). Where there is no risk sharing the value should be entered as "CAR".	**XXX**	Required Must be filled Must be "PCP" , "SHR" or "CAR" For PBM the only value should be "UNK"
18	tier	**Member capitation tier**	Member capitation tier 0001 Medicare A&B Male 0002 Medicare A Male 0006 Medicare A&B Female 0007 Medicare A Female 0008 0-11 Months 0009 12-23 Months 0010 24 Months - 10 Years 0011 11 - 18 Years 0024 19 - 35 Female 0025 19 - 35 Male 0026 36 - 54 Female 0027 36 - 54 Male 0028 55 - 64 Female 0029 55 - 64 Male 0031 65 + Female 0032 65 + Male	**X(4)**	Required
19	days	**Capitation days**	Number of days included in capitation amount.	**S99**	Required Must be a number 3 byte field Signed, may be negative only for adjustments or reversals Sign must appear in leftmost byte, other 2 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
20	mem_percent	**Capitation percentage**	Percentage (days / month days)	**S999**	Required Must be a number 4 byte field Signed, may be negative only for adjustments or reversals Sign must appear in leftmost byte, other 3 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
21	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Capitation Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
22	mpi	**MPI Number or Contract Number**	Master Patient Index (MPI) As supplied in ASES Eligibility Data For government employee this will be the contract number	**X(13)**	Required Must be a valid MPI number For government employee only, contract number Must be left justified, blank filled to the right
23	Federal_Tax_ID	**Federal Tax ID (SSN or EIN)**	The federal identification number of the provider to which the capitation payment is made. If the provider does not have a federal identification number, enter '999999999' in this column. SSN for individuals, EIN for entities.	**X(20)**	Required Left justified, blank filled to the right Must be 9 digits in significant positions
24	filler	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
RECORD LENGTH					**193**

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier	**Carrier ID**	ASES assigned carrier code. Must be (2) digits (numeric)	**99**	Required Must be two (2) digit s (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	provider_type	**Provider Type**	PCP, Specialist, Dentist, X-Ray, Ancillary Services, Special Case, Laboratory, Other Facility, Hospital	**X(20)**	Required Must be left justified, blank filled to the right
3	month	**Month**	Date field with the first day of month. Ex: 5/1/2014	**YYYYMMDD**	Required Must be a valid date.
4	region	**Region**	The ASES region code. (If the provider has multiple locations specify the Region for current address) Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West "P" = SPECIAL "O" = Outside Puerto Rico	**X**	Required
5	**pmg**	**IPA Code**	**The identification number of the primary medical group. If not applicable enter "N/A".** **Code assigned by carrier to identify IPA/HCO. Maximum of 4 characters**	**X(10)**	**Required** **IPA/HCO code assigned by Carrier** **Must be left justified, blank filled to the right**
6	pmg_name	**PMG Name**	The name or title of the primary medical group. If not applicable enter "N/A"	**X(80)**	Required
7	npi	**NPI**	The national provider identification number. All providers are required to have an NPI number.	**X(10)**	Required
8	provider_duplicate_entry	**Provider Duplicate Entry**	Indicate if the provider is entered multiple times in the list. A provider may be entered multiple times if the provider has more than one office location providing services. Enter a "**0**" for the first entry of the provider in the list. Enter an "**X**" for any duplicate entries of the same provider in the list.	**X**	Required

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
9	assigned_lives	**Assigned lives**	The number of assigned lives to the provider as of the last day of the reporting period. If the provider has multiple office locations, the number of assigned lives must be entered for the first entry (not a duplicated entry) for the provider. This number should include the sum of all office locations of the provider. If the provider does not have or require assigned lives, enter "0" in this column.	**9999**	Required
10	credential	**Credential**	Identify if the provider is up to date with all credentialing requirements as of the last day of the reporting period. Enter "Yes" for a fully credentialed/recredentialed provider, enter "No" if the provider requires credentialing/recredentialing. If the provider is not required to submit credentialing/recredentialing, enter "N/A" in this column.	XXX	Required
11	credential_eff_date	**Credential Effective Date**	The most recent credentialing/recredentialing date of the provider. If the provider does not require credentialing, enter "1/1/1900" in this column.	**YYYYMMDD**	Required
12	credential_exp_date	**Credential Expiration Date**	The most recent credentialing/recredentialing expiration date of the provider. If the provider does not require credentialing, enter "1/1/1900" in this column.	**YYYYMMDD**	Optional
13	federal_tax_id	**Provider SSN or EIN**	The federal identification number of the provider. SSN for individuals, EIN for entities.	**X(20)**	Required Left justified, blank filled to the right Must be 9 digits in significant positions
14	prov_id	**Provider ID**	Must be the NPI, or if none exists, may be the Tax Id.	**X(20)**	Required Must be left justified and blank filled to the right If NPI is used, must be 10 digit numeric NPI.
15	ccn	**CCN**	CMS Certification Number formerly known as the Medicare Provider Number.	**X(20)**	Optional
16	contract_eff_date	**Contract effective date**	The provider's contract effective date.	**YYYYMMDD**	Required For "Out of Network" providers, please report as '99991231'.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
17	contract_term_date	**Contract termination date**	The provider's contract termination date.	**YYYYMMDD**	Required For providers with an open-ended contract please report as '99991231'. For a provider with an unknown contract termination date, leave blank.
18	**specialty**	**Specialty**	**Provider Specialty (first). See Specialty Code description in Attachment III**	**X(40)**	Optional
19	**specialty_code**	**Specialty Code**	**Provider Specialty (first). See Specialty Code in Attachment III**	**XX**	**Required** **Must be left justified, blank filled to the right** **Must be a valid Specialty Code**
20	name	**Name**	The full name of the provider.	**X(80)**	Optional Must be left justified, blank filled to the right
21	last_name1	**Last Name 1**	For an individual, the last name of the provider. If the provider has two last names, this should be the first name. For an entity (other than an individual), the entity name	**X(30)**	Required Must be left justified, blank filled to the right
22	last_name2	**Last Name 2**	For an individual, the last name of the provider. If the provider has two last names, this should be the second name.	**X(30)**	Optional Must be left justified, blank filled to the right
23	first_name	**First Name**	For an individual, the first name of the provider.	**X(50)**	Required Must be left justified, blank filled to the right
24	mi	**MI**	For an individual, the middle name of the provider.	**X(30)**	Optional Must be left justified, blank filled to the right
25	addr1	**Address Line 1**	The first line of the physical address of the provider.	**X(45)**	Required Must be the physical address and use second line as needed. Must be left justified, blank filled to the right
26	addr2	**Address Line 2**	The second line of the physical address of the provider.	**X(45)**	Must be left justified, blank filled to the right
27	city	**City**	The city of the provider.	**X(45)**	Optional Must be left justified, blank filled to the right
28	zip	**Zip code**	Provider's Zip code Either 5 digit or plus 4 format without dashes	**X(9)**	Required Must be left justified, blank filled to the right Significant characters must be numeric and 5 or 9 digits in length

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
29	phone	**Phone**	Provider's telephone number. *SEE NOTES – Changes and Additions in Data File Layouts: PROVIDER telephone numbers*	**X(20)**	Required Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
30	fax	**Fax**	The primary fax number of the provider. *SEE NOTES – Changes and Additions in Data File Layouts: PROVIDER telephone numbers*	**X(20)**	Optional Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
31	sunday	**Sunday working hours**	The Sunday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
32	monday	**Monday working hours**	The Monday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
33	tuesday	**Tuesday working hours**	The Tuesday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
34	wednesday	**Wednesday working hours**	The Wednesday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
35	thursday	**Thursday working hours**	The Thursday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
36	friday	**Friday working hours**	The Friday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
37	saturday	**Saturday working hours**	The Saturday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
38	ncpdp_id	**NCPDP ID**	The National Council for Prescription Drugs ID	**X(10)**	Optional
39	state	**State**	The provider's address state.	**X(45)**	Optional Must be left justified, blank filled to the right
40	license_number	**License number**	The Provider's license number.	**X(10)**	Required Should be supplied when available Must be left justified, blank filled to the right
41	contact_person	**Contact person**	The provider's contact person.	**X(80)**	Optional

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*	
RECORD LENGTH						**962**

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENTS

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	REGION	CODE
Adjuntas	S	0004
Aguada	Z	0008
Aguadilla	Z	0012
Aguas Buenas	E	0016
Aibonito	G	0020
Añasco	Z	0024
Arecibo	A	0028
Arroyo	G	0032
Barceloneta	A	0036
Barranquitas	G	0040
Bayamón	B	0044
Cabo Rojo	Z	0048
Caguas	E	0052
Camuy	A	0056
Canovanas	F	0060
Carolina	F	0064
Cataño	B	0068
Cayey	E	0072
Ceiba	F	0076
Ciales	A	0080
Cidra	E	0084
Coamo	G	0088
Comerio	B	0092
Corozal	B	0096
Culebra	F	0100

Ordered By Code		
CODE	MUNICIPALITY	REGION
0004	Adjuntas	S
0008	Aguada	Z
0012	Aguadilla	Z
0016	Aguas Buenas	E
0020	Aibonito	G
0024	Añasco	Z
0028	Arecibo	A
0032	Arroyo	G
0036	Barceloneta	A
0040	Barranquitas	G
0044	Bayamón	B
0048	Cabo Rojo	Z
0052	Caguas	E
0056	Camuy	A
0060	Canovanas	F
0064	Carolina	F
0068	Cataño	B
0072	Cayey	E
0076	Ceiba	F
0080	Ciales	A
0084	Cidra	E
0088	Coamo	G
0092	Comerio	B
0096	Corozal	B
0100	Culebra	F

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	**REGION**	**CODE**
Dorado	B	0104
Fajardo	F	0108
Florida	A	0112
Guanica	S	0116
Guayama	G	0120
Guayanilla	S	0124
Guaynabo	B	0128
Gurabo	E	0132
Hatillo	A	0136
Hormigueros	Z	0140
Humacao	E	0144
Isabela	Z	0148
Jayuya	S	0152
Juana Diaz	G	0156
Juncos	E	0160
Lajas	Z	0164
Lares	A	0168
Las Marias	Z	0172
Las Piedras	E	0176
Loiza	F	0180
Luquillo	F	0184
Manatí	A	0188
Maricao	Z	0192
Maunabo	G	0196
Mayagüez	Z	0200

Ordered By Code		
CODE	**MUNICIPALITY**	**REGION**
0104	Dorado	B
0108	Fajardo	F
0112	Florida	A
0116	Guanica	S
0120	Guayama	G
0124	Guayanilla	S
0128	Guaynabo	B
0132	Gurabo	E
0136	Hatillo	A
0140	Hormigueros	Z
0144	Humacao	E
0148	Isabela	Z
0152	Jayuya	S
0156	Juana Diaz	G
0160	Juncos	E
0164	Lajas	Z
0168	Lares	A
0172	Las Marias	Z
0176	Las Piedras	E
0180	Loiza	F
0184	Luquillo	F
0188	Manatí	A
0192	Maricao	Z
0196	Maunabo	G
0200	Mayagüez	Z

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	**REGION**	**CODE**
Moca	Z	0204
Morovis	A	0208
Naguabo	E	0212
Naranjito	B	0216
Orocovis	G	0220
Patillas	G	0224
Peñuelas	S	0228
Ponce	S	0232
Puerta de Tierra	J	0264
Puerto Nuevo	J	0270
Quebradillas	A	0236
Rincon	Z	0240
Rio Grande	F	0244
Rio Piedras	J	0272
Sabana Grande	Z	0248
Salinas	G	0252
San German	Z	0256
San José	J	0274
San Juan	J	0266
San Lorenzo	E	0276
San Sebastian	Z	0280
Santa Isabel	G	0284
Toa Alta	B	0288
Toa Baja	B	0292
Trujillo Alto	F	0296

Ordered By Code		
CODE	**MUNICIPALITY**	**REGION**
0204	Moca	Z
0208	Morovis	A
0212	Naguabo	E
0216	Naranjito	B
0220	Orocovis	G
0224	Patillas	G
0228	Peñuelas	S
0232	Ponce	S
0236	Quebradillas	A
0240	Rincon	Z
0244	Rio Grande	F
0248	Sabana Grande	Z
0252	Salinas	G
0256	San German	Z
0264	Puerta de Tierra	J
0266	San Juan	J
0270	Puerto Nuevo	J
0272	Rio Piedras	J
0274	San José	J
0276	San Lorenzo	E
0280	San Sebastian	Z
0284	Santa Isabel	G
0288	Toa Alta	B
0292	Toa Baja	B
0296	Trujillo Alto	F

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	**REGION**	**CODE**
Utuado	A	0300
Vega Alta	B	0304
Vega Baja	A	0308
Vieques	F	0312
Villalba	G	0316
Yabucoa	E	0320
Yauco	S	0324
Outside Puerto Rico	O	0666

Ordered By Code		
CODE	**MUNICIPALITY**	**REGION**
0300	Utuado	A
0304	Vega Alta	B
0308	Vega Baja	A
0312	Vieques	F
0316	Villalba	G
0320	Yabucoa	E
0324	Yauco	S
0666	Outside Puerto Rico	O

* 0666 is valid only for use with Municipality Service on CLAIMSERVICES Input File and/or Municipality on CAPITATION Input File.

NOTE: Any municipality code may appear in region SPECIAL.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
01	(discontinued) Triple-S Salud, Inc.	MCO
02	(discontinued) Humana	MCO
03	(discontinued) Triple-S Salud, Inc.	TPA
04	(discontinued) First Medical Health Plan, Inc.	MCO
05	(discontinued) PMC Medicare Choice, LLC	MCO
06	(discontinued) Triple-S Salud, Inc.	MCO
07	(discontinued) Molina Healthcare of Puerto Rico, Inc.	MCO
08	(discontinued) MMM Multi Health, LLC	MCO
09	First Medicaid Health Plan, Inc. (NHM)	MCO
10	MMM Multi Health, LLC (NHM)	MCO
11	(discontinued) Molina Healthcare of Puerto Rico, Inc. (NHM)	MCO
12	Plan de Salud Menonita (NHM)	MCO
13	Triple-S Salud, Inc. (NHM)	MCO
17	(discontinued) MCS	MCO
25	(discontinued) La Cruz Azul de P.R.	MCO
27	(discontinued) MCS Life	Medicare Platino
28	(discontinued) Red Medica	Medicare Platino
29	MMM Healthcare, INC	Medicare Platino
31	(discontinued) Triple-S Salud, Inc.	Medicare Platino
33	Preferred Medicare Choice	Medicare Platino
34	MCS Advantage	Medicare Platino
35	(discontinued) COSVIMed	Medicare Platino
37	(discontinued) Salud Dorada con Medicare	Medicare Platino

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
39	(discontinued) MAPFRE	Medicare Platino
41	(discontinued) Health Medicare Ultra	Medicare Platino
42	Humana	Medicare Platino
44	(discontinued) Auxilio Platino	Medicare Platino
45	(discontinued) Constellation Health, LLC	Medicare Platino
46	Triple-S Advantage	Medicare Platino
47	(discontinued) American Health	Medicare Platino
48	(discontinued) MMM-First Plus	Medicare Platino
49	(discontinued) First Medical Health Plan, Inc.	Medicare Platino
51	(discontinued) Triple-S Salud, Inc.	TPA – Direct Contract
52	(discontinued) Humana	TPA – Direct Contract
53	(discontinued) MCS	TPA – Direct Contract
54	(discontinued) Triple-S Salud, Inc.	TPA – Direct Contract
55	(discontinued) COSVI	TPA – Direct Contract
60	(discontinued) Caremark	PBM
62	ABARCA	PBM
64	MC-21	PBM
70	(discontinued) ASSMCA	Mental Health Pilot
71	Plan de Salud Hospital Menonita	Government Employee
72	MMM Healthcare, INC	Government Employee
73	(discontinued) National Life Insurance Company	Government Employee
74	(discontinued) Ryder Health Plan, Inc.	Government Employee
75	Triple-S Salud Inc.	Government Employee

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
76	(discontinued) BHP	MBHO
77	Humana Health Plan of Puerto Rico, Inc.	Government Employee
78	(discontinued) MAPFRE	Government Employee
79	MCS Life Insurance Company	Government Employee
80	(discontinued) PROSSAM	Government Employee
81	Asociacion de Maestros de Puerto Rico	Government Employee
82	First Medical Health Plan, Inc.	Government Employee
83	(discontinued) APS	MBHO
84	(discontinued) APS	Government Employee
85	PMC Medicare Choice, LLC	Government Employee
86	(discontinued) Molina Healthcare of Puerto Rico, Inc.	Government Employee
87	Triple-S Advantage	Government Employee
88	(discontinued) MMM-First Plus	Government Employee
89	(discontinued) Panamerican Life Insurance Group (PALIG)	Government Employee
90	(discontinued) Delta Dental	Government Employee
91	MMM Multi Health, LLC	Government Employee
95	(discontinued) FHC	MBHO
96	(discontinued) American Health Medicare	Government Employee

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan	
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
15	Speech Language Pathologist in Private Practice
16	Obstetrics / Gynecology
17	Hospice and palliative care
18	Ophthalmology
19	Oral Surgery
20	Orthopedic Surgery
21	Cardiac electrophysiology

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
22	Pathology
23	Sports medicine
24	Plastic and Reconstructive Surgery
25	Physical Medicine / Rehabilitation
26	Psychiatry
27	Geriatric psychiatry
28	Colorectal Surgery (Formerly Proctology)
29	Pulmonary Diseases
30	Diagnostic Radiology
31	Intensive cardiac rehabilitation
32	Anesthesiologist Assistant
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
42	Certified Nurse Midwife
43	Certified Registered Nurse Assistant (CRNA)
44	Infectious Disease

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
45	Mammography Screening Center
46	Endocrinology
47	Independent Diagnostics Testing Facility
48	Podiatry
49	Ambulatory Surgical Center
50	Nurse Practitioner
51	Medical Supply Company with Orthotist
52	Medical Supply Company with Prosthetist
53	Medical Supply Company with Orthotist-Prosthetist
54	Other Medical Supply Company
55	Individual Certified Orthotist
56	Individual Certified Prosthetist
57	Individual Certified Orthotist-Prosthetist
58	Medical Supply Company with pharmacist
59	Ambulance Service Provider
60	Public Health and Welfare Agency
61	Voluntary Health or Charitable Agency
62	Psychologist
63	Portable X-ray Supplier
64	Audiologist
65	Physical Therapist
66	Rheumatology
67	Occupational Therapy

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
68	Clinical Psychologist
69	Clinical Laboratory
70	Multi-Specialty Clinic or Group Practice
71	Registered Dietician / Nutritional Professional
72	Pain Management
73	Mass Immunization Roster Billers
74	Radiation Therapy Center
75	Slide Preparation Facilities
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
80	Licensed Clinical Social Worker
81	Critical Care (Intensivists)
82	Hematology
83	Hematology / Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
87	All Other Suppliers
88	Unknown Supplier / Provider Specialty
89	Certified Clinical Nurse Specialist
90	Medical Oncology

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Intervention Radiology
96	Optician
97	Physician Assistant
98	Gynecological Oncology
99	Unknown Physician Specialty
A1	Skilled Nursing Facility
A2	Intermediate Care Nursing Facility
A3	Other Nursing Facility
A4	Home Health Agency
A5	Pharmacy
A6	Medical Supply Company with Respiratory Therapist
A7	Department Store
A8	Grocery Store
BB	Blood Bank
CV	Cardiac Catheterization Facility
DC	Detox Center
DD	Dentist
DF	Dialysis Facility
EC	Emergency Care Facility
EN	Endodontist

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
G1	Geneticist
HE	Health Educator
HN	Home Health Nurse
HV	HIV Ambulatory Antibiotic Facility
IC	Intensive Care Unit
IT	Infusion Therapy
LI	Lithotripsy
N1	Neonatology
NI	Neonatal ICU
O1	Occupational Medicine
OP	Optical
P1	Perinatology
P2	Pediatric Surgery
PC	Clinic – Primary Level
PE	Periodontist
PH	Private Hospital
PP	Private Psychiatric Hospital
PS	Psychiatric Partial Hospital
RT	Respiratory Therapist
SH	State Hospital
SP	State Psychiatric Hospital
ST	Short Term Intervention Center (Behavioral Health-Stabilization Unit)
XR	X-ray Facility

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
Z4	Cardiovascular Surgery Program

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan		
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	**Telehealth Provided Other than in Patient's Home**	**The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.**
03	School	A facility whose primary purpose is education.
04	**Homeless Shelter**	**A facility or location whose primary purpose is to provide temporary housing to homeless individuals. (e.g., emergency shelters, individual or family shelters).**
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
09	Prison / Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	**Telehealth Provided in Patient's Home**	**The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.**
11	Office	Location, other than a hospital, Skilled Nursing Facility (SNF), military treatment facility, community health center, State or local public health clinic, or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services.
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18	Place of Employment- Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus- Outpatient Hospital	A portion of a hospital, which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room - Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility, which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: • Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility. • 24 hour a day emergency cares services. • Day treatment, other partial hospitalization services, or psychosocial rehabilitation services. • Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission. • Consultation and education services.
54	Intermediate Care Facility/ Individuals with Intellectual Disabilities	A facility which primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who, does not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care, which provides a total 24-hour therapeutically, planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58	**Non-residential Opioid Treatment Facility**	**A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT).**
59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility, which is located in a rural medically, underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other service facilities not specified above.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT V - PROVIDER TYPE CODES

CODE	Description
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan	
AM	Ambulance
AS	Ambulatory Surgical Center
BB	Blood Bank
CL	Clinical Facility
DE	Dentist
DM	Durable Medical Equipment (DME)
EM	Emergency Facility
HH	Home Health Agency
HO	Hospital
HS	Hospice
LA	Laboratory
MD	Medical Doctor (Physician)
RX	Pharmacy
SN	Skilled Nursing Facility (SNF)
UF	Urgent Care facility
XR	Radiology Facility
ZZ	Other

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VI – PLAN VERSION LIST

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
01	09	100				Plan Vital
01	09	110				Plan Vital
01	09	120				Plan Vital
01	09	130				Plan Vital
01	09	220				Plan Vital
01	09	230				Plan Vital
01	09	300				Plan Vital
01	09	310				Plan Vital
01	09	320				Plan Vital
01	09	330				Plan Vital
01	09	970				Encarcelados
01	10	100				Plan Vital
01	10	110				Plan Vital
01	10	120				Plan Vital
01	10	130				Plan Vital
01	10	220				Plan Vital
01	10	230				Plan Vital
01	10	300				Plan Vital
01	10	310				Plan Vital
01	10	320				Plan Vital
01	10	330				Plan Vital
01	10	970				Encarcelados
01	12	100				Plan Vital
01	12	110				Plan Vital
01	12	120				Plan Vital
01	12	130				Plan Vital
01	12	220				Plan Vital
01	12	230				Plan Vital
01	12	300				Plan Vital
01	12	310				Plan Vital
01	12	320				Plan Vital

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
01	12	330				Plan Vital
01	12	970				Encarcelados
01	13	100				Plan Vital
01	13	110				Plan Vital
01	13	120				Plan Vital
01	13	130				Plan Vital
01	13	220				Plan Vital
01	13	230				Plan Vital
01	13	300				Plan Vital
01	13	310				Plan Vital
01	13	320				Plan Vital
01	13	330				Plan Vital
01	13	970				Encarcelados
02	29	004				Medicare Platino - MA-SNP
02	29	005				Medicare Platino - MA-SNP
02	29	014				Medicare Platino - MA-SNP
02	29	015				Medicare Platino - MA-SNP
02	29	017				Medicare Platino - MA-SNP
02	29	018				Medicare Platino - MA-SNP
02	29	019				Medicare Platino - MA-SNP
02	29	020				Medicare Platino - MA-SNP
02	29	023				Medicare Platino - MA-SNP
02	29	024				Medicare Platino - MA-SNP
02	29	025				Medicare Platino - MA-SNP
02	29	026				Medicare Platino - MA-SNP
02	33	005				Medicare Platino - MA-SNP
02	33	006				Medicare Platino - MA-SNP
02	33	007				Medicare Platino - MA-SNP
02	33	008				Medicare Platino - MA-SNP
02	33	009				Medicare Platino - MA-SNP
02	33	010				Medicare Platino - MA-SNP
02	33	015				Medicare Platino - MA-SNP

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
02	33	016				Medicare Platino - MA-SNP
02	33	017				Medicare Platino - MA-SNP
02	33	018				Medicare Platino - MA-SNP
02	33	019				Medicare Platino - MA-SNP
02	33	020				Medicare Platino - MA-SNP
02	34	003				Medicare Platino - MA-SNP
02	34	004				Medicare Platino - MA-SNP
02	34	011				Medicare Platino - MA-SNP
02	34	012				Medicare Platino - MA-SNP
02	34	029				Medicare Platino - MA-SNP
02	34	030				Medicare Platino - MA-SNP
02	34	031				Medicare Platino - MA-SNP
02	34	032				Medicare Platino - MA-SNP
02	34	035				Medicare Platino - MA-SNP
02	34	036				Medicare Platino - MA-SNP
02	34	043				Medicare Platino - MA-SNP
02	34	044				Medicare Platino - MA-SNP
02	34	045				Medicare Platino - MA-SNP
02	34	046				Medicare Platino - MA-SNP
02	34	047				Medicare Platino - MA-SNP
02	34	048				Medicare Platino - MA-SNP
02	34	049				Medicare Platino - MA-SNP
02	34	050				Medicare Platino - MA-SNP
02	34	051				Medicare Platino - MA-SNP
02	34	052				Medicare Platino - MA-SNP
02	34	053				Medicare Platino - MA-SNP
02	34	054				Medicare Platino - MA-SNP
02	34	055				Medicare Platino - MA-SNP
02	34	056				Medicare Platino - MA-SNP
02	42	005				Medicare Platino - MA-SNP
02	42	006				Medicare Platino - MA-SNP
02	42	007				Medicare Platino - MA-SNP

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
02	42	008				Medicare Platino - MA-SNP
02	42	013				Medicare Platino - MA-SNP
02	42	014				Medicare Platino - MA-SNP
02	42	015				Medicare Platino - MA-SNP
02	42	016				Medicare Platino - MA-SNP
02	42	017				Medicare Platino - MA-SNP
02	42	018				Medicare Platino - MA-SNP
02	42	019				Medicare Platino - MA-SNP
02	42	020				Medicare Platino - MA-SNP
02	42	021				Medicare Platino - MA-SNP
02	42	022				Medicare Platino - MA-SNP
02	42	023				Medicare Platino - MA-SNP
02	42	024				Medicare Platino - MA-SNP
02	46	003				Medicare Platino - MA-SNP
02	46	004				Medicare Platino - MA-SNP
02	46	005				Medicare Platino - MA-SNP
02	46	006				Medicare Platino - MA-SNP
02	46	007				Medicare Platino - MA-SNP
02	46	008				Medicare Platino - MA-SNP
02	46	011				Medicare Platino - MA-SNP
02	46	012				Medicare Platino - MA-SNP
02	46	013				Medicare Platino - MA-SNP
02	46	014				Medicare Platino - MA-SNP
02	46	015				Medicare Platino - MA-SNP
02	46	016				Medicare Platino - MA-SNP
02	46	017				Medicare Platino - MA-SNP
02	46	018				Medicare Platino - MA-SNP
02	46	019				Medicare Platino - MA-SNP
02	46	020				Medicare Platino - MA-SNP
02	46	025				Medicare Platino - MA-SNP
02	46	026				Medicare Platino - MA-SNP
02	46	027				Medicare Platino - MA-SNP

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
02	46	028				Medicare Platino - MA-SNP
04	71	401	Oro	Regular	MCO	
04	71	402	Plata	Regular	MCO	
04	71	402	Altenativa 1 Plata	Regular	MCO	
04	71	404	Alternativa 2 Rubi	Regular	MCO	
04	71	405	Diamante	Regular	MCO	
04	71	407	Mandatoria	Regular	MCO	
04	71	408	Alterno 1	Regular	MCO	
04	71	409	Alterno 2	Regular	MCO	
06	71	400	Coverage 400 (ELA)	Regular	HMO	
09	71	400	Coverage 400 (ELA)	Retired Policemen	HMO	
05	72	501	Oro	Regular	HMO	
05	72	502	Plata	Regular	HMO	
05	72	503	Bronce	Regular	HMO	
05	72	504	Rubi	Regular	HMO	
05	72	505	ELA Flex	Auto-Enrollment	HMO POS	
05	72	506	ELA Relax	Auto-Enrollment	HMO POS	
05	72	507	MMM ELA Relax (HMO-POS)	Auto-Enrollment	HMO	
05	72	508	MMM ELA Premium (HMO-POS)	Auto-Enrollment	HMO	
05	72	509	MMM ELA Advantage	Auto-Enrollment	HMO	
05	72	510	ELA CASH	Regular	HMO	
05	72	511	ELA GRANDE	Regular	HMO	
05	72	512	ELA DINAMICO	Regular	HMO	
04	75	401	Oro	Regular	MCO	
04	75	402	Plata	Regular	MCO	
04	75	403	Bronce	Regular	MCO	
04	75	404	Rubi	Regular	MCO	
04	75	405	Diamante	Regular	MCO	
04	75	406	Complementaria de Medicare	Regular	MCO	
04	75	407	Mandatoria Universal	Regular	MCO	
04	75	408	Alterna 1 Equilibrio	Regular	MCO	
06	75	400	Coverage 400 (ELA)	Regular	HMO	

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
09	75	400	Coverage 400 (ELA)	Retired Policemen	HMO	
05	77	501	Oro	Regular	HMO	
05	77	502	Plata	Regular	HMO	
05	77	503	Bronce	Regular	HMO	
05	77	504	Rubi	Regular	HMO	
05	77	505	PR I	Auto-Enrollment	HMO	
05	77	506	PR II	Auto-Enrollment	HMO	
05	77	507	PR III	Auto-Enrollment	PPO	
05	77	508	US Acess Only	Auto-Enrollment	HMO	
05	77	509	HMO FL	Auto-Enrollment	HMO	
05	77	510	ELA Rubí MAX	Auto-Enrollment	HMO	
05	77	511	ELA HMO Bronce	Auto-Enrollment	HMO	
05	77	512	ZAFIRO		HMO	
05	77	513	Basic Deluxe		HMO	
04	78	401	Oro	Regular	MCO	
04	78	402	Plata	Regular	MCO	
04	78	403	Bronce	Regular	MCO	
04	78	404	Rubi	Regular	MCO	
04	78	405	Diamante	Regular	MCO	
04	78	406	Complementaria de Medicare	Regular	MCO	
04	78	407	Mandatoria	Regular	MCO	
04	78	408	Alterno 1	Regular	MCO	
04	78	409	Alterno 2	Regular	MCO	
05	79	501	Oro	Regular	HMO	
05	79	502	Plata	Regular	HMO	
05	79	503	Bronce	Regular	HMO	
05	79	504	Rubi	Regular	HMO	
05	79	505	ELA Crédito	Auto-Enrollment	HMO	
05	79	506	ELA Ahorro	Auto-Enrollment	HMO	
05	79	507	ELA Crédito Rubí	Auto-Enrollment	HMO	
05	79	508	ELA ENLACE ACERO OSS-PDS	Auto-Enrollment	HMO	
05	79	509	Gobierno Ahorro	Auto-Enrollment	HMO	

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
05	79	510	ELA TE AYUDA OSS-PDS	Regular	HMO	
05	79	511	ELA MAXIMO OSS-PDS	Regular	HMO	
05	79	512	ELA Gobierno Extra	Regular	HMO	
04	80	401	Oro	Regular	MCO	
04	80	402	Plata	Regular	MCO	
04	80	403	Bronce	Regular	MCO	
04	80	404	Rubi	Regular	MCO	
04	80	405	Diamante	Regular	MCO	
04	80	406	Complementaria de Medicare	Regular	MCO	
04	80	407	Mandatoria	Regular	MCO	
04	80	408	Alterno 1	Regular	MCO	
04	80	409	Alterno 2	Regular	MCO	
04	80	410	Mandatorio ULTRA	Regular	MCO	
04	80	411	Alternativa 1 MAX	Regular	MCO	
04	80	412	Alternativa 2 FIT	Regular	MCO	
04	82	403	Bronce	Regular	MCO	
04	82	404	Alternativa 1 Premium ELA RUBI	Regular	MCO	
04	82	405	Diamante	Regular	MCO	
04	82	406	Complementaria de Medicare	Regular	MCO	
04	82	407	Alternativa 2 Classic ELA RUBI	Regular	MCO	
04	82	408	Alterno 1	Regular	MCO	
04	82	409	Alterno 2	Regular	MCO	
06	82	400	Coverage 400 (ELA)	Regular	HMO	
09	82	400	Coverage 400 (ELA)	Retired Policemen	HMO	
05	87	501	Oro	Regular	HMO	
05	87	502	Plata	Regular	HMO	
05	87	503	Bronce	Regular	PPO	
05	87	504	Rubi	Regular	HMO	
05	87	505	ELA Royal	Auto-Enrollment	HMO	
05	87	506	ELA Óptimo	Auto-Enrollment	HMO	
05	87	507	ELA Royal Plus	Auto-Enrollment	HMO	
05	87	508	ELA Titán	Auto-Enrollment	HMO	

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
05	87	509	ELA Óptimo Plus	Auto-Enrollment	HMO	
05	88	501	MMM ELA Advantage	Regular	PPO	
05	88	502	Plata	Regular	PPO	
05	88	503	Bronce	Regular	PPO	
05	88	504	Rubi	Regular	PPO	
05	88	505	Premium	Auto-Enrollment	PPO	
05	88	506	Premium 2	Auto-Enrollment	PPO	
05	88	507	Plus	Auto-Enrollment	PPO	
06	91	400	Coverage 400 (ELA)	Regular	HMO	
09	91	400	Coverage 400 (ELA)	Retired Policemen	HMO	

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VII – CAPITATION TYPE LIST

Cap type code	Cap type description
01	Admin
02	Dental
03	DME
04	Emergency Room
05	Extended Hours Services
06	Glasses and Contact Lenses
07	Home Health Care
08	Hospital
09	Lab/Medical Imaging
10	Medical Transportation
11	Mental Health
12	Mental Health Facility
13	Occupational/Physical/Speech Therapy
14	On Call Services
15	Pharmacy
16	Preventative
17	Primary Care Physician
18	Primary Medical Group
19	Prosthetics and Orthotics
20	RAF
21	Specialist
22	Other

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VIII - HOUR CODES

CODE	Description
Codes included in this table are designed for completeness of fields that require providing the hour using a two-digit code, based on 24-hour clock.	
01	1:00 a.m.
02	2:00 a.m.
03	3:00 a.m.
04	4:00 a.m.
05	5:00 a.m.
06	6:00 a.m.
07	7:00 a.m.
08	8:00 a.m.
09	9:00 a.m.
10	10:00 a.m.
11	11:00 a.m.
12	12:00 noon
13	1:00 p.m.
14	2:00 p.m.
15	3:00 p.m.
16	4:00 p.m.
17	5:00 p.m.
18	6:00 p.m.
19	7:00 p.m.
20	8:00 p.m.
21	9:00 p.m.
22	10:00 p.m.
23	11:00 p.m.
00	12:00 a.m.

ADDENDUM 6

Carrier to ASES
ver 4.1C_rev20230221

ADDENDUM 7

Carrier to ASES ver 5.1A

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 0 0 0 0 2

NÚMERO DE CONTRATO

Carrier to ASES Data Submissions

New File Layouts

Version 5.1A

August 25, 2025

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 00002

NÚMERO DE CONTRATO

ASES

ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

MedInsight@asespr.org

TABLE OF CONTENTS

Version Changes 5

Introduction 8

Claims Transaction Handling 8

Provider, IPA and Network Files 9

Capitation Files 10

Capitation Adjustments 10

Data Validation and Audit Process 11

Claims, Capitation and Encounter Lag Reports 11

Primary Carrier ID 15

General Notes on Field Level Requirements 15

Data File Naming Conventions 17

CLAIMSERVICES INPUT FILE LAYOUT 19

***PROVIDERS* INPUT FILE LAYOUT** 63

***IPA INPUT* FILE LAYOUT** 70

***CAPITATION* INPUT FILE LAYOUT** 72

***NETWORK* INPUT FILE LAYOUT** 78

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
Carrier to ASES Data Submissions
File Layouts

ATTACHMENT I - MUNICIPALITY CODES 84

ATTACHMENT II - CARRIER CODES 88

ATTACHMENT III - SPECIALTY CODES 91

ATTACHMENT IV - PLACE OF SERVICE CODES 98

ATTACHMENT V - PROVIDER TYPE CODES 105

ATTACHMENT VI – PLAN VERSION LIST 106

ATTACHMENT VII – CAPITATION TYPE LIST 115

ATTACHMENT VIII - HOUR CODES 116

ATTACHMENT IX - SUBMISSION CLARIFICATION CODES 117

Version Changes

Version 3.0A

ASES file layouts ver. 3.0A for submission by Carriers for data generated from July 2018 forward

CAPITATION Input File Layout

CAPITATION TYPE field was modified.

PROVIDER Input File Layout

The descriptions for the provider address fields were changed to specify that it refers to the provider's physical address.
New fields added to the layout.

CLAIMSERVICES Input File Layout - Added

New fields added to the layout.

Data Validation and Auditing Change

New section regarding data validation and auditing added.

Version 3.0A rev3

Provider, Network, and IPA Files Layout

Frequency of Provider, Network, and IPA files changed from monthly to weekly.
Content of Provider, Network, and IPA files changed from only those entities that are present in claims to all active records.

CLAIMSERVICES Input File Layout

PLAN TYPE field and PLAN VERSION LIST were modified.

Version 3.0A rev4

Content of Provider and Network files changed from all active records to all active records, and "Out of Network" providers present in claims.

Version 3.0A rev5

Provider and Network files descriptions and/or validation rules were changed for required fields that are unavailable for "Out of Network" providers.

Version 4.0B

Additional Provider and Network files content requirements were added, for required fields that are unavailable for "Out of Network" providers.
New descriptions and/or validation rules were added to the CLAIMSERVICES Input File Layout, applicable to GHIP and Government Employee Carriers.
CARRIER CODES, PLAN VERSION LIST and Place of Service Codes were modified.

Version 4.0C

Claims Transaction Handling requirements were modified for reversals and adjustments.
Data File Naming Conventions requirements were modified.
Provider and Network files descriptions and/or validation rules were changed for required fields that are unavailable for providers/groups that do not qualify for an NPI.
Encounter Lag Reports requirements were added.
Capitation Adjustments specifications and Capitation Input File Layout fields were modified.
CLAIMSERVICES Input File Layout new field added, and field description was modified.
ATTACHMENT II - CARRIER CODES – updated
Descriptions and/or validation rules of the Municipality and Region fields were added, for Outside of Puerto Rico.

Version 4.1C

Descriptions and/or validation rules were added to the CLAIMSERVICES and Capitation Input File Layouts, to the Plan Type related fields, applicable to Government Employee Carriers.
Descriptions and/or validation rules were added to the CLAIMSERVICES, to the Primary Center field, applicable to claims for Plan Version 970.
ATTACHMENT IV - PLACE OF SERVICE CODES – updated
ATTACHMENT VI – PLAN VERSION LIST – updated

IPA Code Deliverable Data Format at IPA, CAPITATION and NETWORK Input File Layouts were changed.
Specialty and Specialty Code fields at NETWORK Input File Layouts were changed.

Version 4.2A

CLAIMSERVICES Input File Layout
New fields admitting diagnosis and birth weight added to the layout.
PROVIDERS Input File Layout validation rule was changed for Medicaid Number field.

Version 5.0A

CLAIMSERVICES Input File Layout new fields added, and fields description were modified.
CAPITATION Input File Layout new field added
PROVIDERS Input File Layout validation rules were changed for License Number and Medicaid Number fields.
ATTACHMENT III - SPECIALTY CODES – updated
ATTACHMENT IX - SUBMISSION CLARIFICATION CODES – added

Version 5.1A

Data File Naming Conventions – the structure was modified to includes information for identification of the layout version.
CLAIMSERVICES Input File Layout new fields added, and fields description were modified.
ATTACHMENT II - CARRIER CODES - updated
ATTACHMENT VI – PLAN VERSION LIST – updated





Introduction

The island of Puerto Rico's Medicaid program, the Government Health Plan (GHP) was established in 1993 with the passing of Law 72. Through Law 72, the program to administer the Medicaid program for roughly 1.3 Milliman people, the Administración de Seguros de Salud (ASES) was established. In order to continuously review health care utilization, expenditures, and performance in Puerto Rico and to enhance the ability of ASES to make informed and cost-effective health care choices, ASES has partnered with Milliman, Inc. to provide ASES with a data warehouse and analytics system. ASES has been capturing data from its managed care health carriers for many years to populate in the data warehouse and other systems. This layout document provides health insurance carriers information to submit their health care claims, network, provider, IPA, and capitation data to ASES.

Claims Transaction Handling

All Claims files are to be submitted on a monthly basis, for all Claims PAID in the month of the file submitted. All adjustments of an adjudicated claim line are accepted in the CLAIMSERVICES file. Do not send claims that are in an open status, such as pended claims, held, rejected, or pre-adjudicated claims. Claims reversals and adjustments happen as follows:

Paid or Denied FFS Claims

Individual service lines are adjusted or reversed at the line level with additional adjustment services marked with a claim line status code of 'A' or 'R', while the original claim has a status code of 'P' for paid, 'D' for denied claims, or 'E' for encounter claims. The adjusted or reversed service:

- must include the claim id of the original claim to be adjusted or reversed, at the field named Original Claim Id Number, and
- may have the same claim ID and line number or a different claim ID and line number.

Encounter Claims

Claims representing encounters have no allowed or paid amounts and are therefore not able to be adjusted monetarily. If an encounter needs to be updated to change any of the fields of the encounter, the adjusting claim must have a claim line status code (sv_stat field) of 'E' and the claim ID and service line number must be the same as the encounter being adjusted. Our process will remove the original encounter so that duplicate encounters will not be counted in the data.

On the other hand, if an encounter needs to be submitted as a Fee For Service claim the carrier must:

- reverse the original service, by submitting the reversal with a claim line status code of 'R' and the same values as the original claim for the following fields: claim ID, service line number and Original Claim Id Number
- submit a new Fee for Service claim record, that may have the same claim ID and line number or a different claim ID and line number.

Provider, IPA and Network Files

The Provider, IPA, and Network files are to be submitted weekly, every Wednesday and must include the latest available data from the day prior to the submission date. For each weekly submission within a given month, keep the same file naming convention, but increment the sequence number, starting with 0, then 1, 2, 3.

The IPA file shall include every IPA that is active in your system. The PRV and NET files shall include every Provider and Network record that is active in the carrier's and/or sub-contractor's system, and "Out of Network" providers associated with currently submitted claim records. In addition, the IPA and Provider files shall include the IPA and providers associated with currently submitted capitation records. ASES will be using this data to keep a current complete list of available Providers and IPAs.

The Provider and Network files must include:

- all "In Network" providers directly contracted or sub-contracted with the carrier,
- any "Out of Network" providers included on the CLM file,
- all providers included in the CAP file (only applicable for the Provider File and excluding PMGs).

For "Out of Network" provider records, the carrier's will report as much information as available on their systems. The carrier shall submit "Out of Network" provider records with a contract effective date equal to '99991231'. For any required fields for which the carrier does not have valid information, the fields must be left blank.

ASES is requesting that provider NPIs are to always be used as the PROV_ID in order to assist in provider attribution and reporting across all Carriers. ASES will not accept the carrier's own provider id as the provider ID for medical claim, unless the carrier presents a valid reason for not using NPI's. Consequently, for providers that don't qualify to obtain an NPI by the nature of its business, the carrier may submit the Tax Id of the provider as the PROV_ID to which the capitation payment is made. The carrier will have to present an official notification to ASES of every provider that was reported with a Tax Id in lieu of an NPI.

For pharmacy claims only

For pharmacy providers, only the NPI number will be accepted as the provider ID. Carriers must include pharmacy providers in their provider files sent to ASES and the IDs must be consistent within the carriers' claims.

Capitation Files

All Capitation files are to be submitted on a monthly basis, for all Capitation PAID in the month of the file submitted. The amount to be reported on capitation records must represent any costs associated with providing services which are not reported in claims and encounters. This may come from formal contracts with providers such as HCO/PCPs, or any other financial arrangement or allocation of costs.

The cap_amount field should represent a calculation which includes the earned capitation for the period for each member. Other types of deductions which may be taken out of the provider's payment such as repayment of advances, retentions for reserves should not be included in the calculation.

The gross_cap_amount field should represent a calculation that includes the earned capitation for the period for each member (not the group average).

The net_cap_amount field should represent a calculation which includes the earned capitation for the period for each member (gross_cap_amount) less claims paid amounts, if any, chargeable against the provider risk. Other types of deductions which may be taken out of the provider's payment such as repayment of advances, retentions for reserves should not be included in the calculation.

Capitation records shall be provided for all members enrolled in the PMG's regardless of their risk coverage. The risk coverage type will be identified with a new risk type field.

Capitation Adjustments

There may be circumstances in which capitation payments which have already been reported, need to be adjusted or reversed in a later month. To accomplish this, the Capitation records will behave differently than Claims and Services. The carrier will send a new record

for the provider / member / experience date with the amount(s) to be added or subtracted from the previously reported amount(s), specifically for the following fields: Capitation Amount, Gross Capitation Amount, Net Capitation Amount, Capitation Days and Capitation Percent. If a capitation of $10.00 is to be reversed then the new record should contain the same information as the original but with a new Capitation Date, a Capitation Amount of -$10.00, and the corresponding adjustments to the Gross Capitation Amount, Net Capitation Amount, Capitation Days and Capitation Percent fields as well. Inside MedInsight the capitation for that Provider / Member for that particular date will be the aggregate of all the records and this example will result in $0.00.

Note that, as Capitation net amounts for any particular record may be negative, a reversal in such a case would be a positive amount.

Data Validation and Audit Process

After the files are loaded, Milliman will employ an automated validation process, File Field and Quality Checks (FFQC), to ensure that the format and content of each submitted file is valid and complete. Monthly files that do not pass the reconciliation process and the data audit process will be rejected. Load threshold levels for individual data elements submitted are validated against those pre-established levels defined by ASES and Milliman.

Failure to conform to any of the submission requirements will result in the rejection and return of the applicable data file(s). No records from such a file will be retained in the system and the carrier will be required to re-submit the rejected file in its entirety before the next month's files become due. Such re-submitted files must be carefully named using the sequence number part of the naming convention to ensure the name is distinct from the rejected file and is named in the correct order.

Due to the large amount and complexity of the data processed, it is more efficient to resubmit an entire file rather than to correct data within the file. Partial replacement files or record specific corrections will not be accepted.

Claims, Capitation and Encounter Lag Reports

Carriers are required to submit encounter, claims and capitation payment reports, called lag reports, on a monthly basis. These reports will be used to reconcile the data submitted. Claims and capitation data that do not match the lag reports on paid amount, and/or encounter claims data that do not match the lag reports on record counts within a reasonable percentage will be deemed invalid and must be corrected.

The claims and capitation lag reports submitted by the carrier will be considered to be financially accurate and may be used for other purposes, including negotiations or other financial analyses. Therefore, it is in the carrier's best interests to produce lag reports that are either from another source that the actual files that are submitted, or to verify that the lag reports tie to financial reports.

The required claims lag reports need to be an Excel file with the following characteristics:

1. Claims paid amounts by:
   a. Region code of member as defined by ASES,
   b. Incurred month with deliverable data format YYYYMM,
   c. Paid month with deliverable data format YYYYMM, and
2. Claim type for claims, where can be filled in with one of the following default values: Medical, Pharmacy and Dental.
3. The report must include at least all paid and incurred months going back 2 full years prior to the month the report is run.
4. Naming of the claims lag reports should be as follows:

CLAIMLAG_ccyymms.xls(x)

Where:

Characters 1-9	Always "CLAIMLAG_"		
Characters 10-11	cc	=	Carrier Code (See attachment II)
Characters 12-13	yy	=	Last two digits of year
Characters 14-15	mm	=	Month – last full paid month in the lags.
Character 16	s	=	sequence number of file submission.
Character 17	Always "."		
Characters 18-20(21)	Extension code for excel file, can be xls or xlsx depending on Excel version.		

An example of how the claims lag report data should look for claims is as follows:

Claim Type	Region	Incurred Month	Paid Month	Paid Amount
Medical	East	201801	201801	50,823.43
Medical	South	201801	201802	45,534.00
Medical	North	201801	201803	986,796.36

Pharmacy	East	201801	201801	686.89
Pharmacy	South	201801	201802	2,342.22
Dental	North	201801	201803	780,989.16
…	…	…	…	…

The required capitation lag reports need to be an Excel file with the following characteristics:

1. Capitation paid amounts by:
   a. Region code of member as defined by ASES,
   b. Capitation experience month (period for which the capitation payment applies) with deliverable data format YYYYMM,
2. Paid month with deliverable data format YYYYMM.
3. The report must include at least all paid and experience months going back 2 full years prior to the month the report is run.
4. Naming of the capitation lag reports should be as follows:

CAPLAG_ccyymms.xls(x)

Where:

Characters 1-7	Always "CAPLAG_"		
Characters 8-9	cc	=	Carrier Code (See attachment II)
Characters 10-11	yy	=	Last two digits of year
Characters 12-13	mm	=	Month – last full paid month in the lags.
Character 14	s	=	sequence number of file submission.
Character 15	Always "."		
Characters 16-18(19)	Extension code for excel file, can be xls or xlsx depending on Excel version.		

An example of how the capitation lag report data should look for claims is as follows:

Region	Incurred Month	Paid Month	Capitation Paid Amount
East	201801	201801	5,023.43
South	201801	201802	4,534.00
North	201801	201803	98,796.36
East	201801	201801	66.89

South	201801	201802	242.22
North	201801	201803	70,989.16
…	…	…	…

The required encounter claims lag reports need to be an Excel file with the following characteristics:

1. Count of Claims records representing encounters by:
   a. Region code of member as defined by ASES,
   b. Incurred month with deliverable data format YYYYMM,
   c. Paid month with deliverable data format YYYYMM,
2. Claim type for claims, where can be filled in with one of the following default values: Medical, Pharmacy and Dental.
3. The report must include at least all paid and incurred months going back 2 full years prior to the month the report is run.
4. Naming of the claims lag reports should be as follows:

ENCOUNTERLAG_ccyymms.xls(x)

Where:

Characters 1-13	Always "ENCOUNTERLAG_"		
Characters 14-15	cc	=	Carrier Code (See attachment II)
Characters 16-17	yy	=	Last two digits of year
Characters 18-19	mm	=	Month – last full paid month in the lag.
Character 20	s	=	sequence number of file submission.
Character 21	Always "."		
Characters 22-24(25)	Extension code for excel file, can be xls or xlsx depending on Excel version.		

An example of how the encounter claims lag report data should look for claims is as follows:

Claim Type	Region	Incurred Month	Paid Month	Encounters Count
Medical	East	201801	201801	5,000
Medical	South	201801	201802	24,200
Medical	North	201801	201803	7,654
…	…	…	…	…

Primary Carrier ID

The *Primary Carrier ID* field in the ClaimServices Input File Layout identifies the entity (MBHO, Sub Contractor Entity, or TPA) which provides services to the enrollees throughout a special or capitated financial arrangement. Another field called *Carrier ID* field contains the ID of the carrier directly contracted with ASES and the one generating the ClaimServices Input File. The ClaimServices Input File will contain the same value in the *Carrier ID* and *Primary Carrier ID* fields when the carrier generating the ClaimServices Input File is the carrier providing services to the enrollees. If this entity does not have an assigned carrier ID from ASES, the *Primary Carrier ID* can be filled in with one of the following 4 default values that represents the type of entity:

MH – Mental Health
VS – Vision
DN – Dental
OT – Other/Unknown

General Notes on Field Level Requirements

Date Fields - All date fields in the following data layout are defined to the same size and format as YYYYMMDD. An 8 byte field where YYYY = 4 digit year, MM = 2 digit month and DD = 2 digit day. 1 digit month and day values must always have the leading zero (0). Date fields must contain a valid date with months between 01 and 12 and days between 01 and maximum day in month. July 1, 2006 will be coded as 20060701.

Amount Fields – All amount fields representing money must be numeric and are defined as 9 bytes in the format s9(7)v99 where v represents and implied decimal point. This allows a maximum of 7 digits for dollars plus the last two digits for cents. These numbers are always right justified and zero filled to the left. As examples:

$1.23 will be coded as	000000123
$100.00 will be coded as	000010000

All amount fields are positive and follow the above definition unless clearly specified otherwise.

End of Record Filler – All file layouts have been designed to end with a filler field of 1 byte which must always be coded as an "*" character. This is done to avoid issues between different systems when generating and transferring ASCII files in which ending field may be empty. The fixed End of Record Filler guarantees that all records in a file can be constructed to the fixed length format as defined in the layouts.

Justification and filling of Fields – The layouts have all been specified to provide fixed length fields and fixed length records. While other methods can be used, it is felt that this provides the best common ground for working with multiple entities each of which uses varying systems. To be sure everyone understands the same about the comments on justification and filling the following examples are given to help keep this concept clear.

All numeric fields must be filled completely with numeric digits. If there are exceptions these are clearly spelled out in the documentation of the layouts. Typically, numeric fields are right justified and to keep them numeric must be zero filled. In a field specified as numeric such a s9(7)v99 the following conventions apply:

- `S` - Leading sign
- `9(7)` - 7 decimal digits
- `V` - Implied decimal point
- `99` - 2 digits after the implied decimal point

The following examples illustrate how data will look in the field:

Value	Field
12.50	000001250
101	000010100
1,234.56	000123456
1,000,000	100000000
-1,234.56	-00123456

All alphanumeric fields must be filled completely. If the value of data in the field is less than the width of the field then care must be taken to ensure that the field is filled with blanks. Allowing "NULLS" or other special characters through may cause unexpected results and make reading, loading and validation of the data difficult. Typically, alphanumeric fields are left justified and filled to the right with blanks to complete the field. In a field specified as alphanumeric such a X(20) the following examples illustrate how data will look in the field where the [ ] characters represent the start and end of the field –

Value	**Field**
P.R.	[P.R.]
José Rivera	[José Rivera]
blanks	[ ]
(Metro-North Region)	[(Metro-North Region)]

MPI Number fields – In all files in which MPI Number is required, carriers should code all 9s if the MPI is unknown. This should not be true for any current beneficiary. This exception will continue until such time as ASES determines that the issue of MPI being unavailable has disappeared from historical data. For Government Employee MPI should be filled with Contract Number.

Data File Naming Conventions

All data files to be delivered to ASES by the carriers must be compressed and follow the naming conventions below. Files which do not fit the naming convention will be ignored and the carrier deemed to have failed in delivery of such a file.

File names must adhere strictly to this naming convention as the structure includes information for identification of the carrier, dates and file type. If not named correctly the file cannot be processed properly.

The general format of file names will be –

DccyymmsVnnl.fff.zip

Where:	Character 1	Always "**D**"		
	Characters 2-3	**cc**	=	Carrier Code (See attachment II)
	Character 4-5	**yy**	=	Last two digits of year

Characters 6-7	**mm**	=	Month
Character 8	**s**	=	sequence number of file submission.
	All submission start with s = 0 and continue in numeric if files are re-submitted to 9		
	If files must be re-submitted beyond 9, then alphabetic characters will be used a, b, c …		
Character 9	Always "**V**"		
Characters 10-11	**nn**	=	Numbers identifying the layout version.
Character 12	**l**	=	Letter identifying the layout version.
Character 13	Always "."		
Characters 14-16	Extension code identifying type of file		
CLM for	CLAIMSERVICES		
PRV for	PROVIDERS		
IPA for	IPA		
CAP for	CAPITATIONS		
NET for	NETWORK		
Characters 17-20	.zip	=	Extension code identifying a compressed file

Files are always dated for the month being reported. For example, when sending claims paid in July 2018 the **yymm** part of the file name will be **1807** while the file will be sent to ASES in August.
Examples of completing this naming convention are –

For imaginary carrier 99 in the files for ClaimServices and payments in April 2018 will be named as follows –

ClaimServices	D9918040V51A.CLM.ZIP
Providers	D9918040 V51A.PRV.ZIP
IPA	D9918040 V51A.IPA.ZIP
Capitation	D9918040 V51A.CAP.ZIP
Network	D9918040 V51A.NET.ZIP

When the Capitation file is rejected, the corrected file will be re-submitted as
D9918041V51A.CAP.ZIP

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	**Carrier ID**	Value that identifies carrier which is reporting claims. Must be a valid code. See Carrier Code List in Attachment II	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	region_code	**Region Code**	Region of member as defined by ASES Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West "P" = SPECIAL "X" = All Regions "O" = Outside Puerto Rico	**X**	Required Must be valid ASES Region code For plan type "01", the Region Code must be a valid region code, and the value cannot be "X" or "O". **For plan type "04", "05", "06" and "09" value must be "X".**
3	plan_type	**Plan Type**	ASES defined Plan Type 01 = GHIP 02 = MA-SNP 03 = MA-PD 04 = Law 95 Commercial 05 = Law 95 Advantage 06 = Law 95 ELA-GHP **07 = Commercial non-Law 95** **08 = Advantage non-Law 95** **09= LAW 95 Pensioned Police**	**XX**	Required **Must equal "01", "02", "03", "04", "05", "06", "09"** Value "01" must correspond to a GHIP carrier or to an MBHO, PBM, or other assigned carrier code which is not Medicare Platino. Values of "02" or "03" must correspond to Medicare Platino Carrier ID. Values of "04" or "05" must correspond to Government Employee Carrier ID. Value "06" must correspond to Government Employee Carrier ID for ELA-GHP ("ELA Puros"). **Values of "07" or "08" must correspond to carrier, which is not plan type "01"-"06" or "09".** **Value "09" must correspond to government employee carrier ID for Pensioned Police.**

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
4	contract_type	**Contract Type**	Contract type to distinguish multiple plans within Plan Type. For government employee claims indicates contract type: 1 = Family 2 = Couple 3 = Individual 4 = Optional Dependent	**X**	**Required for Plan Type "04", "05", "06" and "09" (Government Employee)** Not required for Plan Type "01", "02", or "03".
5	claim_id	**Claim ID**	Unique Identification number within Carrier for the claim.	**X(20)**	Required Left justified, blank filled to 20 characters if value is less than 20 characters.
6	sv_line	**Service Line Number**	Number identifying individual service within a given claim.	**XXXXX**	Required Must be a maximum of 5 digits. ID of the Service Line within the Claim ID. Duplicates within Claim ID and Service Line Number on the same submission will be considered errors (the combination of the claim_id plus the service_line_no must be unique within the carrier).
7	bill_type	**Bill Type**	Originating bill type – U=UB-04 / Institutional H=HCFA/CMS1500 / Individual / Professional P=Pharmacy Claim D=Dental Claim	**X**	Required Must equal "U", "H", "P" or "D".
8	ub_bill_type	**UB Type of Bill**	Type of Bill on the UB claim form. The type of bill encodes facility type, bill classification, and description.	**XXX**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be one of the standard three-digit codes as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual.
9	sv_stat	**Claim Line Status**	Indicates payment action on the service represented by this record. P= Paid D=Denied A=Adjustment R=Reversal E=Encounter	**X**	Required Must equal "P", "D", "A", "R" or "E" If value is "E", service will have zero Paid Amount.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
10	adj_code	**Adjustment Reason Code**	Adjustment reason code explaining why a claim payment was adjusted. Codes used are the X12 code list maintained by CMS and NUCC. The code set can be found at the following site: http://www.x12.org/codes/claim-adjustment-reason-codes/	**XXX**	Must be present on claims with a Claim Line Status (sv_stat field) equal to "A". Right justified. For claims without adjustment, this field must be left blank.
11	forced_claim_ind	**Forced Claim Indicator**	This code indicates if the claim was processed by forcing it through a manual override process.	**X**	'Y'- Yes 'N' - No
12	adm_date	**Admit Date**	For UB-04 claims this is the date of admission. For other claims this is the Service From Date of the earliest service.	**YYYYMMDD**	Required Must be a valid date.
13	dis_date	**Discharge Date**	For UB-04 claims this is the date of discharge. For other claims this is the Service To date of the latest service.	**YYYYMMDD**	Required Must be a valid date Must be equal or later than Admit Date
14	from_date	**Service From Date**	Begin date of the treatment.	**YYYYMMDD**	Required Must be a valid date.
15	to_date	**Service To Date**	End date of the treatment.	**YYYYMMDD**	Required Must be a valid date Must be on or after Service From Date
16	paid_date	**Payment Date**	For an Encounter, this will be the date the transaction is processed by the carrier. For non-encounters, this will be the date of payment for paid claims or the process date for denied claims.	**YYYYMMDD**	Required Must be a valid date Must be on or after Service To Date
17	rec_date	**Received Date**	Date when claim was received in carrier in YYYYMMDD format	**YYYYMMDD**	Required Must be a valid date Must be equal or greater than Discharge Date
18	entry_date	**Entry Date**	Date when claim was entered into the carrier's system. YYYYMMDD format.	**YYYYMMDD**	Required Must be a valid date Must be equal or greater than Received Date

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
19	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Claims Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
20	mpi	**MPI Number or Contract Number**	Master Patient Index (MPI) As supplied in ASES Eligibility Data For government employee this will be the contract number	**X(13)**	Required Must be a valid MPI number For government employee only, contract number Must be left justified, blank filled to the right
21	primary_center	**Primary Center**	Identify the Primary Care Center (IPA/HCO) of the member. Code as assigned by the carrier.	**X(10)**	Must be present on all claims of Plan Type "01", except on claims from plan version 970. May be present on claims of other Plan Types When present it indicates the Primary Care Center (IPA/HCO etc.) of the member. Must be left justified and blank filled to complete the field. Must be found on the IPA table matched by Carrier ID and IPA.
22	ssn_mainh	**HOH Social Security**	Social Security number of Head of Household (HOH) of family. This is available from the Family record in ASES eligibility data sent to carriers.	**X(9)**	Required Must be all numeric Must be a full 9 digits, right justified, zero filled
23	ssn	**Patient Social Security**	Social Security Number of member	**X(9)**	Required Must be all numeric Must be a full 9 digits, right justified, zero filled

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
24	member_suffix	**ASES Member Suffix**	Identifies the beneficiary within the family group. For non-governmental employees - Must be the two digit member suffix as supplied in ASES Eligibility data. For governmental employees - Must be one of the following: 01 = Principal - (Main Holder) 02 = Spouse - Direct 03 = Spouse - Joint (Mancomunado) 04 = Children - Direct 05 = Optional - Direct (parents) 06 =Substantial 07 = Co-Habitant 08 = Co-Habitant - Joint (Mancomunado)	**99**	Required Must be ASES Assigned member suffix. All numeric value 01 to 99.
25	patient_name	**Patient Name**	Member Name	**X(30)**	Required Must be left justified, blank filled to the right.
26	household_id	**ASES Household ID**	Household ID as supplied in ASES Eligibility data	**X(11)**	Required ASES / ODSI Household ID. Alphanumeric full 11 characters. For government employee use SSN Main Holder. Must be left justified, blank filled to the right.
27	sex	**Sex Code**	Gender of member M = Male F = Female	**X**	Required Must equal "M" or "F"
28	birth_date	**Birth Date**	Member Date of Birth in YYYYMMDD format	**YYYYMMDD**	Required Must be a valid date Cannot be in later than the Extract Date. Cannot be greater than 150 years ago compared to Extract Date. Must be equal or earlier than Admit Date.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
29	municipality_res	**Municipality Residence**	Municipality of residence of member. See Municipality Codes in Attachment I.	**XXXX**	Required Must be a valid ASES Municipality Code All numeric, right justified, zero filled Must correspond to a municipality within Region Code
30	municipality_code	**Municipality Service**	Municipality in which services are provided based on provider address. See municipality Codes in Attachment I.	**XXXX**	Required Must be a valid ASES Municipality Code All numeric, right justified, zero filled. For outside of Puerto Rico, code 0666 is included in the list of Municipality Codes.
31	drg_code	**DRG Code and Severity of Illness (SOI) at Discharge**	Diagnosis Related Group Code, including severity of illness that is applicable for the type of DRG, extracted from DRG Grouper.	**XXXXX**	The first four digits must be a valid DRG Code. This must be left justified, blank filled to the left. The fifth digit indicates the severity of illness. For example, DRG 139 and SOI 2 would be submitted as "01392". SOI Values: 1: Minor 2: Moderate 3: Major 4: Extreme
32	drg_type	**DRG Type Code**	DRG Type Code, representing the type of DRG Code submitted on the claim.	**X**	Required when DRG is provided. Must be one of the following: 1= MS DRG 2= CMS DRG 3= AP DRG 4= APR DRG
33	drg_outlier_amt	**DRG Outlier Amount**	Additional amount paid by carrier on a claim that is associated with either a cost outlier or length of stay outlier.	**S9(7)v99**	For claims submitted on Uniform Bill (UB) claim form. Must be zero for encounters. Must be zero for Services with Payment Status of "D". On non-UB claims must be blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
34	drg_rel_weight	**Relative DRG Weight**	Indicates the relative weight for the DRG Code submitted on the claim, extracted from DRG Grouper.	**9(6)V9(6)**	If populated, must be a valid weight without any decimal points. This weight should align with the type of DRG submitted. The HSRV weight should be provided for APR DRGs. Blank filled. - A DRG weight of 2.397 should be reported as 000002397000. - A HSRV weight of 1.821173 should be reported as 000001821173
35	drg_version	**DRG Version**	Indicates the DRG version for the DRG on the claim.	**XXXX**	Required when DRG is provided. Must be a valid DRG version without any decimal points. Left justified, blank filled. A DRG version V39.1 should be reported as V391.
36	pre_auth_num	**Pre-Authorization Number**	The number identifying pre-authorization. A unique identification number, that indicates the services provided on this claim have been authorized by the carrier (Also called Prior Authorization)	**X(20)**	Should be supplied when available. Left justified, blank filled to 20 characters if value is less than 20 characters.
37	proc_code	**Procedure Code**	For non-Pharmacy Standard procedure code conforming to HCPCS/CPT or HCSPC/CDT as appropriate	**X(15)**	For claims from CMS1500 / UB-04, when present must be a HCPCS/CPT code. For Dental claims must be a valid dental HCPCS/CDT code. For Pharmacy claims this must be all blanks.
38	cpt_mod_1	**Procedure Modifier Code 1**	Modifier code valid for the Procedure Code	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be valid as a modifier for the Procedure code.
39	cpt_mod_2	**Procedure Modifier Code 2**	Modifier code valid for the Procedure Code	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be valid as a modifier for the Procedure code Must be left blank for encounters

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
40	cpt_mod_3	**Procedure Modifier Code 3**	Modifier code valid for the Procedure Code	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.
41	cpt_mod_4	**Procedure Modifier Code 4**	Modifier code valid for the Procedure Code A series of procedure code modifiers used with the corresponding Procedure Codes. For example, some states use modifiers to indicate assistance in surgery or anesthesia services.	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.
42	cpt_mod_5	**Procedure Modifier Code 5**	Modifier code valid for the Procedure Code A series of procedure code modifiers used with the corresponding Procedure Codes.	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.
43	cpt_mod_6	**Procedure Modifier Code 6**	Modifier code valid for the Procedure Code A series of procedure code modifiers used with the corresponding Procedure Codes.	**XX**	Can only be present when Procedure Code is present and allows a modifier code. Must be left blank for encounters.
44	rev_code	**Revenue Code**	For UB-04 Claims NUBC Revenue Code	**X(4)**	Required for UB-04 claims. When present it must be a valid Revenue code. Must be zero filled to the left.
45	rx_ndc	**National Drug Code**	National Drug Code value for prescribed drug in 5 4 2 format	**X(11)**	Required on Pharmacy claims. For all medical claims, if a drug is administered, NDC is required if the drug is dispensed with NDC. Must be a valid NDC code in 5 4 2 format filling all 11 bytes. For non-NDC claims must be blank.
46	tooth_code	**Tooth Code**	For Dental only ADA standard tooth number as required by CDT code when procedure directly affects a tooth.	**XXX**	Must be present on Dental claims when Procedure code requires Tooth Code. Must be left justified and blank filled to complete the field. For non-Dental claims must be blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
47	surface_code	**Surface Code**	For Dental only ADA standard surface code as required by CDT code when procedure directly affects one or more surfaces.	**X(7)**	Must be present on Dental claims when procedure code requires Surface Code. Must be a valid Surface Code. Must be left justified and blank filled to complete the field. For non-Dental claims must be blank.
48	Icd_diag_01	**Primary ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims. Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
49	Icd_diag_02	**Second ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims. Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
50	Icd_diag_03	**Third ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
51	Icd_diag_04	**Fourth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
52	lcd_diag_05	**Fifth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
53	lcd_diag_06	**Sixth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
54	lcd_diag_07	**Seventh ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
55	lcd_diag_08	**Eighth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
56	lcd_diag_09	**Ninth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
57	lcd_diag_10	**Tenth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
58	lcd_diag_11	**Eleventh ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
59	lcd_diag_12	**Twelfth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
60	lcd_diag_13	**Thirteenth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
61	lcd_diag_14	**Fourteenth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
62	lcd_diag_15	**Fifteenth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
63	lcd_diag_16	**Sixteenth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
64	lcd_diag_17	**Seventeenth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
65	lcd_diag_18	**Eighteenth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
66	lcd_diag_19	**Nineteenth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
67	Icd_diag_20	**Twentieth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
68	Icd_diag_21	**Twenty-First ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
69	Icd_diag_22	**Twenty-Second ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
70	Icd_diag_23	**Twenty-Third ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
71	Icd_diag_24	**Twenty-Fourth ICD Diagnosis code**	Non-Pharmacy/Dental ICD diagnosis code.	**X(8)**	Not required for Pharmacy and Dental claims Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.
72	icd_proc_01	**Primary ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Principal Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
73	icd_proc_02	**Second ICD10 Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
74	icd_proc_03	**Third ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
75	icd_proc_04	**Fourth ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
76	icd_proc_05	**Fifth ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
77	icd_proc_06	**Sixth ICD Procedure code**	Non-Pharmacy/Dental ICD-10 Surgical Procedure Code (Secondary Surgery)	**X(10)**	Not required for Pharmacy and Dental claims. If provided, must be a valid ICD10-CM procedure code without any decimal points.
78	pcp_prov_id	**PCP Provider**	National Provider Identifier (NPI) of the member's PCP.	**X(20)**	Required for Plan Type "01" claims Must be a valid Provider ID found in the provider files. Must be 10-digit numeric NPI
79	att_prov_id	**Attending Provider**	National Provider Identifier (NPI) of the provider delivering the service. If not directly available from the claim it should be filled from the Billing Provider. On pharmacy claims this is the prescribing physician.	**X(20)**	Required Must be a valid Provider ID found in the provider files. Must be 10-digit numeric NPI.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
80	att_taxonomy	**Attending Provider Taxonomy**	Indicates the corresponding provider taxonomy of billing entity/provider, to define provider's type, classification, and area of specialization. The taxonomy code for the institution billing/caring for the beneficiary.	**X(12)**	Required Left justified, blank field to the right.
81	ref_prov_id	**Referring Provider**	National Provider Identifier (NPI) of referring provider, when applicable.	**X(20)**	When present, must be a valid Provider ID found in the provider files. When present, must be a valid NPI number.
82	ref_prov_taxonomy	**Referring Provider Taxonomy**	Indicates the corresponding provider taxonomy of referring provider, to define provider's type, classification, and area of specialization.	**X(12)**	Left justified, blank field to the right.
83	bill_prov_id	**Billing Provider**	National Provider Identifier (NPI) of the provider billing for the service.	**X(20)**	Required Must be a valid Provider ID found in the provider files. Must be 10-digit numeric NPI.
84	network_affiliation	**Network Affiliation**	Indicates if the service provider is in the preferred provider network or not. N – Not a network provider Y – A general network provider P – A Preferred Provider Network (PPN) provider	**X**	Required Must be "N", "P" or "Y".
85	primary_carrier_id	**Primary Carrier ID**	Value that identifies the primary carrier providing service to the patient. May be the same as the carrier_id field or another carrier as a sub-contractor – a MBHO, Vision, or Dental plan. See Carrier ID List in Attachment II	**XX**	Required Must be two (2) digits (alpha-numeric). Must equal a valid Carrier ID as assigned by ASES if one has been assigned. If sub-contracted entity does not have a carrier code assigned by ASES, the following default codes may be used to represent the type of sub-contracted entity is the primary carrier: MB – Mental Health VS – Vision DN – Dental OT – Other/Unknown Carrier Type

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
86	pos_code	**Place of Service**	Place of Service Code identifying the place in which the service is delivered. See POS Code List in Attachment IV	**XX**	Required Must be a valid Place of service Code.
87	cob_code	**COB Code**	Identify if the beneficiary has other Health Insurance for this service. "Y if member has other health insurance, "N" otherwise.	**X**	Required Must be "Y" or "N"
88	amt_billed	**Billed Amount**	Cost of service as billed by the provider.	**S9(7)v99**	Required Must be a number on all records. Cannot be left blank.
89	amt_allowed	**Allowed Amount**	For non-Pharmacy Amount allowed for the service by the carrier.	**S9(7)v99**	Required Must be a number on all records Must be zero for encounters or denied services (Payment Status (sv_stat) = "E" or "D") Cannot be left blank For sv_stat "P" (Payment Status = "paid") this must be greater than zero. For Pharmacy: amt_allowed = ingredient cost + dispensing fee + tax.
90	deduct	**Deductible**	Amount paid by members before payments by the carrier begin for this service	**S9(7)v99**	Required Must be a number on all records Must be zero for encounters Cannot be left blank.
91	copay	**Co-Pay**	Amount paid by member as dollar co-payment for this service	**S9(7)v99**	Required Must be a number on all records Must be zero for encounters Cannot be left blank.
92	cob	**COB Amount**	Amount paid by other Health Insurance attributable to this service.	**S9(7)v99**	Required Must be a number on all records Must be zero for encounters Cannot be left blank.
93	coins	**Coinsurance Amount**	Amount paid by member as percentage of cost for this service	**S9(7)v99**	Required Must be a number on all records Must be zero for encounters Cannot be left blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
94	amt_paid	**Paid Amount**	Amount paid by carrier for this service	**S9(7)v99**	Required Must be zero for encounters Must be zero for Services with Payment Status of "D" For Services with sv_stat = "P" (Payment Status = Paid) one of the following calculations must be valid within a record – For non-Pharmacy: amt_paid = amt_allowed - deduct - copay - cob - coins For Pharmacy: amt_paid = rx_ingr_cost - deduct - copay - cob - coins + rx_disp_fee **For Plan Type "02", "03", "04", "05", "06", "09" only - amt_paid may be zero if the appropriate calculation above results in 0.00.** For Plan Type "01" the amt_paid must be greater than zero.
95	enc_proxy_price	**Encounter Proxy Price**	This field shows the amount that would have been paid for this exact same service if it had been processed as a Fee for Service claim. It does not represent an actual dollar disbursement.	**S9(7)v99**	Required on Encounter claims. On non-encounter claims, it must be blank.
96	rx_disc	**Drug Discount**	For Pharmacy only Amount Discounted at the Pharmacy This is the discount given from AWP to get the Ingredient Cost When drug is paid from a MAC list the discount amount will be Zero (0) This field does not form part of the calculation to get Amount Paid but can be used with Ingredient Cost to work back to AWP.	**S9(7)v99**	Required on Pharmacy claims. On non-Pharmacy claims must be blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
97	rx_ingr_cost	**Ingredient Cost**	For Pharmacy only. Cost of ingredient(s) dispensed for this Service.	**S9(7)v99**	Required on Pharmacy claims. Must be greater than zero. On non-Pharmacy claims must be blank.
98	rx_disp_fee	**Dispensing Fee**	For Pharmacy only. Dispensing fee charged by pharmacy.	**S9(7)v99**	Required on Pharmacy claims. Must be a number On non-Pharmacy claims must be blank.
99	rx_amt_tax	**Tax Amount**	For Pharmacy only. Tax Amount charged by pharmacy.	**S9(7)v99**	Required on Pharmacy claims. Must be a number On non-Pharmacy claims must be blank.
100	rx_total_disp	**Total Quantity Dispensed**	For Pharmacy only. Total metric quantity of drug dispensed by pharmacy.	**S9(7)v99**	Required on Pharmacy claims. For non-Pharmacy claims must be blank. May include decimal point. This field is only applicable when the NDC code billed can be quantified in discrete units. Left justified, blank filled.
101	rx_days_supply	**Prescription Days**	For Pharmacy only. Number of days prescribed and dispensed.	**999**	Required on Pharmacy claims Must be greater than zero On non-Pharmacy claims must be blank.
102	rx_drug_type	**Drug Type Code**	For Pharmacy only. Code identifying type of drug on pharmacy claims. Valid codes are: 01=Generic 02=SSB 03=MSB	**XX**	Required on Pharmacy claims When present it must be one of the valid codes. On non-Pharmacy claims must be blank.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
103	rx_daw	**Dispensed As Written**	For Pharmacy only. Code indicating "Dispense as written" status of the prescription on pharmacy claims	**X(6)**	Required on Pharmacy claims When present it must be one of the valid codes. On non-Pharmacy claims must be blank Valid Codes are – 0 - NO DISPENSE AS WRITTEN 1 - PHYSICIAN writes DISPENSE AS WRITTEN 2 - PATIENT REQUESTED 3 - PHARMACIST SELECTED BRAND 4 - GENERIC NOT IN STOCK 5 - BRAND DISPENSED, PRICED AS GENERIC 6 - OVERRIDE 7 - SUBSTITUTION NOT ALLOWED; BRAND MANDATED BY LAW 8 - GENERIC NOT AVAILABLE 9 - OTHER
104	rx_refill_cnt	**Refill Count**	For Pharmacy only. The number of refills specified by the physician writing the prescription on pharmacy claims.	**9(6)**	Required on Pharmacy claims When present must be a number On non-Pharmacy claims must be blank.
105	rx_par	**Participating Pharmacy Flag**	For Pharmacy only Indicates whether prescription was dispensed by a participating pharmacy on pharmacy claims Valid values – "Y" = participating pharmacy "N" = non-participating pharmacy	**X(7)**	Required on Pharmacy claims Left justified, blank filled Must be "Y" or "N" On non-Pharmacy claims must be blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
106	compound_dosage_form	**Compound Dosage Form**	For Pharmacy only. Indicates the Dosage form of the complete compound mixture. Compound codes are identified as: 01 = Capsule 02 = Ointment 03 = Cream 04 = Suppository 05 = Powder 06 = Emulsion 07 = Liquid 10 = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup 17 = Lozenge 18 = Enema Blank = Not Specified	**XX**	Required on Pharmacy claims On non-Pharmacy claims must be blank. All numeric, right justified, zero filled.
107	compound_drug_ind	**Compound Drug Indicator**	For Pharmacy only. Indicator for whether to specify if the drug is compound or not. Y= Drug is compound N= Drug is not compound	**X**	Required on Pharmacy claims. On non-Pharmacy claims must be blank. Must be "Y" or "N"
108	date_prescribed	**Prescription Date**	For Pharmacy claims, this is the date where a prescription was written for the member individual.	**YYYYMMDD**	Required on Pharmacy claims. Must be a valid date. Must be on or before Service From Date. For non-Pharmacy claims must be blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
109	ndc_unit_type	**NDC Unit of Measure**	A code indicates the basis by which the quantity of the National Drug Code is expressed. Value must be equal to a valid value. Valid Values: "F2" = International Unit – Products described as IU/vial or micrograms "GR" = Gram – Ointments, creams, inhalers, or bulk powder in a jar "ME" = Milligram "ML" = Milliliter – Liquid, solution, or suspension "UN" = Unit – Powder for injection (needs to be reconstituted), pellet, kit, patch, tablet, device. "EA" = Each	**XX**	Required on Pharmacy claims. For non-Pharmacy claims should be supplied when available. Describes the basis of the amount reported on the NDC Quantity-QUANTITY and RX-CLAIM-QUANTITY-ALLOWED Fields.
110	prescription_num	**Prescription ID**	The unique identification number assigned by the pharmacy or supplier to the prescription. This number is used to avoid duplicated Claims, but allows multiple service lines within the same claim.	**X(20)**	Required Left justified, blank filled to 20 characters if value is less than 20 characters.
111	rx_quantity_allowed	**RX quantity allowed**	The maximum allowable quantity of a drug or service that may be dispensed per prescription per date of service or per month.	**X(9)**	Required on Pharmacy claims For non-Pharmacy claims must be blank. Must be without any decimal points May include decimal point. For example, an amount of 30 should be coded as 3000. This field is only applicable when the NDC code being billed can be quantified in discrete units and should be described by the **NDC-UNIT-OF-MEASURE** field. Left justified, blank filled.
112	rebate_eligible_indicator	**Rebate Eligible Indicator**	An indicator to identify claim lines with an NDC that is eligible for the drug rebate program.	**X**	"Y"- Yes "N"- No

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
113	submission_clar_code	**Submission Clarification Code**	Indicates that the drug was purchased through the 340B Drug Pricing Program. See Submission Clarification Codes in Attachment IX	**XX**	Required for pharmacy claims.
114	cost_determination	**Basis of Cost Determination**	Indicates the basis of cost determination in the 340B Drug Pricing Program Values: 05 = Acquisition Cost 08 = Disproportionate	**XX**	Required for 340B claims. On non 340B claim must be blank.
115	ub_dis_stat	**UB Discharge Status Code**	On UB-04 claims, Patient Status Code at discharge.	**XX**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be one of the standard two-digit codes as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual.
116	risk_type	**Risk Type**	Distinguishes for this service whether risk belongs to PCP(/Group) or carrier. If cost should be charged to PCP(/Group) then value = "PCP" Shared risk agreement should be identified as "SHR". Otherwise value = "CAR" (Carrier). Where there is no risk sharing the value should be entered as "CAR". PBM ONLY – when a PBM is submitting this file this field should be coded as "UNK" for Unknown.	**XXX**	Required Must be filled Must be "PCP", "SHR" or "CAR" For PBM only value can be "UNK"
117	stop_loss_flag	**Stop Loss Flag**	When Risk Type is "PCP", set to "Y" if stop loss for PCP(/Group) has been reached for PCP on member Otherwise "N". When Risk Type is "CAR", set to "N" PBM ONLY – set to "N"	**X**	Required Must be filled "Y" or "N"

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
118	applied_cost	**Cost Applied To**	Defines whether service is part of the ASES coverage, the CMS (MA) coverage or both. When filled the valid values are – 1=ASES 2=CMS 3=BOTH (SPLIT)	**X**	Required for Plan Type "01" (GHIP – Dual Eligible Population), "02" and "03" (Medicare Platino) Must be filled and be a valid value. Not Required for Plan Type "04", "05", "06","09"
119	ases_split_amt	**ASES Split Amount**	Indicates the part of the Paid Amount allocated to ASES coverage.	**S9(7)v99**	Required for Plan Type "01" (GHIP – Dual Eligible Population), "02" (Medicare Platino) and "03" (Medicare Platino) Must be filled if Cost Applied To = "1" or "3" Not Required for Plan Type "04", "05", "06" or "09".
120	cms_split_amt	**CMS Split Amount**	Indicates the part of the Paid Amount allocated to CMS (MA) coverage.	**S9(7)v99**	Required for Plan Type "01" (GHIP – Dual Eligible Population), "02" (Medicare Platino) and "03" (Medicare Platino) Must be filled if Cost Applied To = "2" or "3" Not Required for Plan Type "04", "05", "06" or "09"
121	off_island	**Off Island Flag**	Indicator for whether service was located off of the islands of Puerto Rico, Culebra, and Vieques.	**X**	Required Y=Off Island N=On Island
122	plan_version	**Plan Version**	Plan Version to distinguish multiple plans within the Plan Type. Always three numeric characters, e.g. 001 See Plan Version List in Attachment VI	**XXX**	Required Must be a 3-digit Plan Version Code Carrier ID, Plan Type, and Plan Version must validate with a plan definition contracted with ASES. **Required for Plan Type "02", "03" (Medicare Platino), "04", "05", "06" and "09"** Not Required for Plan Type "01"

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
123	sv_units	**Units of Service**	Number of occurrences of service	**S9(7)v99**	Required for medical claims only. May be negative amount if claim is a reversal or adjustment. Could represent number of services provided or dosage amount for medical drugs, ie. Drugs billed with a HCPCS code in a medical setting. When present must be a number.
124	hcpcs_dosage	**HCPCS Code Dosage**	Billable unit for administered drug, according HCPCS. If there is no valid HCPCS code, use "NOC" (Not Otherwise Classified). (e.g. 7.5mg, 15mg)	**X(10)**	When present must be a valid HCPCS Code Dosage with any decimal points. Left justified, blank filled.
125	claim_type	**Claim Type**	Claim Type: I=Inpatient O=Outpatient P=Professional	**X**	Required for all medical claims. For Rx and Dental claims, this field can be left blank. Must equal "I", "O" or "P" if populated.
126	admission_hour	**Admission Hour**	For UB-04 claims, this is the hour of admission. The hour code must be a two-digit code, based on 24-hour clock. See Hour Codes in Attachment VIII	**XX**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual. See attachment VIII for the codes to be used.
127	discharge_hour	**Discharge Hour**	For UB-04 claims this is the hour of discharge. The hour code must be a two-digit code, based on 24-hour clock.	**XX**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual. See Hour Codes in Attachment VIII

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
128	admission_type	**Admit Type**	Admit type code indicates the primary reason (priority) for admission. Admission codes: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma 9 = Information Not Available	**X**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be as described in the National Uniform Bill (UB) data specifications manual.
129	adm_prov_id	**Admitting Provider Id**	National Provider Identifier (NPI) of member's admitting provider.	**X(20)**	When present, must be a valid Provider ID found in the provider files. When present, must be a valid NPI number.
130	adm_prov_taxonomy	**Admitting Provider Taxonomy**	Indicates the corresponding provider taxonomy of admitting provider, to define provider's type, classification, and area of specialization.	**X(12)**	Generally, the provider taxonomy requires 10 bytes. However, two additional bytes have been provided for future expansion. Must be left justified and blank filled to the right
131	check_eff_date	**Check Date**	Check Date is the date when the check or electronic remittance for payment is processed.	**YYYYMMDD**	Must be a valid date. Must be on or after Service To Date. Not required for denied claims.
132	check_num	**Check Number**	Check Number is the check or electronic remittance number for payment.	**X(50)**	Must be left blank for Services with Payment Status of "E". Left justified, blank filled to 50 characters if value is less than 50 characters. Not required for denied claims.
133	claim_rem_code_01	**First Remittance Advice Remark Codes (RARCs)**	Indicates the first RARCs to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.	**XXXX**	Must be left blank for Services with Payment Status of "E". Must be left justified and blank filled.
134	claim_rem_code_02	**Second Remittance Advice Remark Codes (RARCs)**	Indicates the second RARCs to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.	**XXXX**	Must be left blank for Services with Payment Status of "E". Must be left justified and blank filled.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
135	claim_rem_code_03	**Third Remittance Advice Remark Codes (RARCs)**	Indicates the third RARCs to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.	**XXXX**	Must be left blank for Services with Payment Status of "E". Must be left justified and blank filled.
136	claim_rem_code_04	**Fourth Remittance Advice Remark Codes (RARCs)**	Indicates the fourth RARCs to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.	**XXXX**	Must be left blank for Services with Payment Status of "E". Must be left justified and blank filled.
137	poa_ind_1	**First Present on Admission (POA) Indicator**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
138	poa_ind_2	**Second Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
139	poa_ind_3	**Third Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
140	poa_ind_4	**Fourth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
141	poa_ind_5	**Fifth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
142	poa_ind_6	**Sixth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
143	poa_ind_7	**Seventh Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
144	poa_ind_8	**Eighth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
145	poa_ind_9	**Ninth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
146	poa_ind_10	**Tenth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
147	poa_ind_11	**Eleventh Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
148	poa_ind_12	**Twelfth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
149	occurrence_code_01	**First Occurrence Code**	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
150	occurrence_code_02	**Second Occurrence Code**	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
151	occurrence_code_03	**Third Occurrence Code**	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
152	occurrence_code_04	**Fourth Occurrence Code**	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	XXXX	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
153	occurrence_code_05	**Fifth Occurrence Code**	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	XXXX	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
154	occurrence_code_06	**Sixth Occurrence Code**	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	XXXX	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
155	occurrence_code_07	**Seventh Occurrence Code**	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled.	XXXX	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
156	occurrence_code_08	**Eighth Occurrence Code**	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled	XXXX	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
157	occurrence_code_09	**Ninth Occurrence Code**	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes. Must be right justified, zero filled	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
158	occurrence_code_10	**Tenth Occurrence Code**	A code to describe specific event(s) relating to this billing period. These fields can be used for either occurrences or occurrence spans. Must be a valid code. See NUBC manual for specific codes.	**XXXX**	Should be supplied when available for all claims submitted on Uniform Bill (UB) claim. Occurrence codes are two alpha-numeric digits. For claims without occurrence code, this field must be left blank.
159	original_claim_id	**Original Claim ID Number**	For adjustments or reversals, must be the original claim ID reported by the carrier.	**X(20)**	Must be present on claims with a Claim Line Status (sv_stat field) equal to "A" or "R". Right justified. For claims without adjustment or reversal, this field must be left blank. Left justified, blank filled to 20 characters if value is less than 20 characters.
160	birth_weight	**Birth Weight**	Newborn birth weight.	**XXXX**	Newborn's birth weight in grams. Report in whole number with no decimals or commas. Should be supplied when available for all claims submitted on Uniform Bill (UB) claim.
161	admit_diag	**Admitting Diagnosis Code**	ICD code describing the patient's diagnosis at the time of admission.	**X(7)**	Required for all claims involving inpatient admissions. When present, must be as described in the National Uniform Bill (UB) data specifications manual. Must be a valid ICD/DSM IV code without any decimal points. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
162	DRGBaseRate	**DRG Base Rate**	The Base Rate used for calculating claim payment, extracted from DRG Grouper.	**9(7)v9(4)**	Required for all claims involving inpatient admissions. When present must be a number. On claims not involving inpatient admissions, must be blank.
163	DRGBasePayment	**DRG Base Payment**	The portion of the claim total payment paid for a claim qualifying as an inlier, extracted from DRG Grouper.	**9(8)v99**	Required for all claims involving inpatient admissions. When present must be a number. On claims not involving inpatient admissions, must be blank.
164	HACAdjustedDRG	**DRG following HAC Adjusted DRG Processing**	Diagnosis Related Group (DRG) assigned at discharge, calculated using the DRG grouper version submitted, not including any diagnosis codes that were identified as Hospital Acquired Conditions (HACs) using the HAC version submitted, extracted from DRG Grouper. DRG is a one to three character code that represents the disease classification derived from the patient age, claim diagnosis and procedure codes as defined by the DRG classification system.	**XXX**	A valid HAC Version must be submitted. Value should be whatever value was output from the grouper.
165	HACAdjustedSOI	**Severity of Illness (SOI) Following HAC Adjusted DRG Processing**	Severity of Illness (SOI) level assigned at discharge, calculated using the DRG grouper version submitted, not including any diagnosis codes that were identified as Hospital Acquired Conditions (HACs) using the HAC version submitted, extracted from DRG Grouper. When present must be a valid value: 0 - No class specified 1 - Minor 2 - Moderate 3 - Major 4 - Extreme	**X**	A valid HAC Version must be submitted. Value should be whatever value was output from the grouper.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
166	HighLOSPayment	**High LOS Outlier Payment**	The portion of the total payment for the claim that includes reimbursement for care where the length of stay (LOS) is greater than the agency defined high LOS threshold, extracted from DRG Grouper.	**9(7)v99**	For claims involving inpatient admissions. When present must be a number. On claims not involving inpatient admissions must be blank. Value should be whatever value was output from the grouper.
167	HighLOSThreshold	**High LOS Threshold**	The defined length of stay that if the claim LOS is greater, makes the claim eligible for a High LOS outlier payment, extracted from DRG Grouper.	**99999**	For claims involving inpatient admissions. When present must be a number. Must be left justified, blank filled to the right. Value should be whatever value was output from the grouper. On claims not involving inpatient admissions, must be blank.
168	HighOutlierPerDiem	**High Outlier Per Diem Rate**	The dollar amount per day that will be paid for each day that the claim LOS exceeds the High LOS Outlier Threshold, extracted from DRG Grouper.	**9(7)v99**	For claims involving inpatient admissions. When present must be a number. Value should be whatever value was output from the grouper. On claims not involving inpatient admissions, must be blank.
169	LOS	**Los (Length Of Stay)**	Length of stay (LOS) is the number of days the patient was hospitalized, extracted from DRG Grouper.	**9999**	For claims involving inpatient admissions. When present must be a number. Must be left justified, blank filled to the right. Value should be whatever value was output from the grouper. On claims not involving inpatient admissions, must be blank.
170	LowLOSThreshold	**Low LOS Threshold**	The length of stay, specific to each DRG, that if the claim LOS is less than, makes the claim eligible for a low-cost outlier payment, extracted from DRG Grouper.	**99999**	For claims involving inpatient admissions. When present must be a number. Must be left justified, blank filled to the right. Value should be whatever value was output from the grouper. On claims not involving inpatient admissions, must be blank.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
171	LowOutlierPerDiem	**Low Outlier Per Diem Rate**	The dollar amount per day that will be paid for each day of the claim LOS where the claim LOS is less than the low LOS outlier threshold, extracted from DRG Grouper.	**9(7)v99**	For claims involving inpatient admissions. When present must be a number. Value should be whatever value was output from the grouper. On claims not involving inpatient admissions, must be blank.
172	MeanLOS	**Mean LOS**	This field represents the Geometric Mean Length of Stay, specific to the DRG. See Notes for exceptions, extracted from DRG Grouper.	**9(5)v9(4)**	For claims involving inpatient admissions. When present must be a number. Value should be whatever value was output from the grouper. On claims not involving inpatient admissions, must be blank.
173	DRGPaymentStatus	**DRG Status for Payment**	Payment status for the claim, extracted from DRG Grouper. Values: 01 - Standard Payment 02 - Transfer Payment 05 - Long Stay Outlier 07 - Short Stay Outlier 15 - Same-day Stay 87 - No reimbursement, excessive other coverage or member responsibility 98 - No reimbursement calculated, Grouper	**XX**	For claims involving inpatient admissions. When present must be a number. Value should be whatever value was output from the grouper. On claims not involving inpatient admissions, must be blank.
174	DRGShortStayPayment	**DRG Short Stay Payment**	Payment based on the lesser of the facility costs and the Comparable Per Diem Amount, extracted from DRG Grouper.	**9(7)v99**	For claims involving inpatient admissions. When present must be a number. Value should be whatever value was output from the grouper. On claims not involving inpatient admissions, must be blank.
175	DRGTransferPayment	**DRG Transfer Payment**	The portion of the claim total payment due to the claim qualifying as a transfer, extracted from DRG Grouper.	**9(7)v99**	For claims involving inpatient admissions. When present must be a number. Value should be whatever value was output from the grouper. On claims not involving inpatient admissions, must be blank.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
176	DRGTransferPerDiem	**DRG Transfer Per Diem Rate**	The dollar amount paid for each day's stay when the claim qualifies as a transfer, extracted from DRG Grouper.	**9(7)v99**	For claims involving inpatient admissions. When present must be a number. Value should be whatever value was output from the grouper. On claims not involving inpatient admissions, must be blank.
177	ValueCode	**Value Code**	The Value Code and the Value Code Amount are used to relate amounts or values that are necessary to process this claim as qualified by the payer.	**XX**	For claims involving inpatient admissions. On claims not involving inpatient admissions, must be blank. Must be one of the standard codes as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual. Please use value code "54" to indicate birth weight, "80" to indicate covered days, and "81" to indicate non-covered days.
178	ValueCodeAmount	**Value Code Amount**	The Value Code and the Value Code Amount are used to relate amounts or values that are necessary to process this claim as qualified by the payer.	**x(10)**	For claims involving inpatient admissions. On claims not involving inpatient admissions, must be blank. This field contains the amount (for example, birth weight in grams, days, etc.) for the value code field.
179	AdmitSource	**Point of Origin**	Point of Origin indicates the source of the patient's referral for admission.	**X**	Required for all claims submitted on Uniform Bill (UB) claim form. When present, must be one of the standard one-character codes as described in the National Uniform Billing Committee (NUBC) UB-04 data specifications manual.
180	NoncoveredCharges	**Noncovered Charges**	Amount, if any, that is not covered by the primary payer for this service.	**S9(7)v99**	For claims submitted on Uniform Bill (UB) claim form. On claims not involving inpatient admissions, must be blank. May be negative amount if claim is a reversal or adjustment.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
181	poa_ind_13	**Thirteenth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	X	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
182	poa_ind_14	**Fourteenth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	X	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
183	poa_ind_15	**Fifteenth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
184	poa_ind_16	**Sixteenth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
185	poa_ind_17	**Seventeenth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
186	poa_ind_18	**Eighteenth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
187	poa_ind_19	**Nineteenth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
188	poa_ind_20	**Twentieth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
189	poa_ind_21	**Twenty-First Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
190	poa_ind_22	**Twenty-Second Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.

CLAIMSERVICES INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
191	poa_ind_23	**Twenty-Third Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
192	poa_ind_24	**Twenty-Fourth Present on Admission (POA) Indicator Flag**	A code to identify conditions that are present at the time the order for inpatient admission occurs; conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. POA indicator must be reported on each diagnosis code submitted on facility claims, except for "specific" diagnosis codes.	**X**	Required for all claims involving inpatient admissions to general acute care hospitals Must be left blank for Services exempt from POA reporting. Must be a valid value Valid values: "Y" = Diagnosis was present at time of inpatient admission "N" = Diagnosis was not present at time of inpatient admission "U" = Documentation insufficient to determine if condition was present at the time of inpatient admission "W" = Clinically undetermined whether the condition was present at the time of inpatient admission.
193	Filler	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"

RECORD LENGTH	**1258**

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	prov_carrier	**Prov Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	prov_id	**Prov ID**	Must be the NPI, or if none exists, may be the Tax Id.	**X(20)**	Required Must be left justified and blank filled to the right. If NPI is used, must be 10-digit numeric NPI. For all providers found in the CLAIMSERVICES files, must be the NPI.
3	prov_lname	**Prov Lname**	For an individual, Last Names (Apellidos) For an entity (other than an individual), the entity name	**X(50)**	Required Must be left justified, blank filled to the right
4	prov_fname	**Prov Fname**	For an individual, First Name (Nombre)	**X(30)**	Required for Individual providers Must be left justified, blank filled to the right
5	prov_mname	**Prov Mname**	For an individual, Middle Name	**X(30)**	Optional Must be left justified, blank filled to the right
6	prov_name_type	**Prov Name Type Indicator**	Indicator that tells if the provider is an individual or an entity. Valid values are: "I" = Individual "E" = Entity	**X(1)**	Required
7	prov_addr1	**Prov Addr1**	First line of provider's physical address	**X(45)**	Required Must be the physical address and use second and third line as needed. Must be left justified, blank filled to the right
8	prov_addr2	**Prov Addr2**	Second line of provider's physical address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
9	prov_addr3	**Prov Addr3**	Third Line of provider's physical address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
10	prov_city	**Prov City**	Provider's city	**X(45)**	Required Must be left justified, blank filled to the right
11	prov_state	**Prov State**	Provider's state	**X(45)**	Required Must be left justified, blank filled to the right

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
12	prov_zip	**Prov Zip**	Provider's Zip code Either 5 digit or plus 4 format without dashes	**X(9)**	Required Must be left justified, blank filled to the right Significant characters must be numeric and 5 or 9 digits in length
13	prov_country	**Prov Country**	Provider's country	**X(45)**	Required Must be left justified, blank filled to the right
14	prov_tel	**Prov Telephone**	Provider's telephone number. *SEE NOTES – Changes and Additions in Data File Layouts: PROVIDER telephone numbers*	**X(20)**	Required Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
15	prov_ext	**Prov Ext**	Provider's telephone extension	**X(20)**	Optional Must be left justified, blank filled to the right
16	prov_email	**Prov Email**	Provider's e-mail address	**X(40)**	Optional If supplied it must fit e-mail address format rules Must be left justified, blank filled to the right
17	prov_contact	**Prov Contact**	Name of contact person if provider is not an individual	**X(50)**	Optional Must be left justified, blank filled to the right
18	prov_type	**Prov Type**	Type of provider. See Provider Type Codes in Attachment V	**X(20)**	Required Must be left justified, blank filled to the right Must be a valid Provider Type Code
19	taxonomy1	**Taxonomy 1**	Report the NUCC healthcare provider taxonomy code. If not available, see Specialty Code in Attachment III	**X(10)**	Required Must be left justified, blank filled to the right Must be a valid taxonomy Code.
20	spec1	**Specialty Code 1**	Provider Specialty (first). See Specialty Code in Attachment III	**X(20)**	Required Must be left justified, blank filled to the right Must be a valid Specialty Code
21	taxonomy2	**Taxonomy 2**	Report the NUCC healthcare provider taxonomy code. If not available, see Specialty Code in Attachment III	**X(10)**	Optional Must be left justified, blank filled to the right Must be a valid taxonomy Code.
22	spec2	**Specialty Code 2**	Provider Specialty (second). See Specialty Code in Attachment III	**X(20)**	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
23	taxonomy3	**Taxonomy 3**	Report the NUCC healthcare provider taxonomy code. If not available, see Specialty Code in Attachment III	**X(10)**	Optional Must be left justified, blank filled to the right Must be a valid taxonomy Code.
24	spec3	**Specialty Code 3**	Provider Specialty (third). See Specialty Code in Attachment III	**X(20)**	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code
25	taxonomy4	**Taxonomy 4**	Report the NUCC healthcare provider taxonomy code. If not available, see Specialty Code in Attachment III	**X(10)**	Optional Must be left justified, blank filled to the right Must be a valid taxonomy Code.
26	spec4	**Specialty Code 4**	Provider Specialty (fourth). See Specialty Code in Attachment III	**X(20)**	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code
27	network_specialist	**Preferred Network Specialist**	Indicates if the service provider is a participating specialist of the preferred network in the PMG	**X**	Required Must be "Y" or "N"
28	federal_tax_id	**Federal Tax ID**	SSN for individuals, EIN for entities.	**X(20)**	Required Left justified, blank filled to the right Must be 9 digits in significant positions
29	tax_id_indicator	**Federal Tax ID Indicator**	Identifies if the federal tax ID provided in field *federal_tax_id* is a SSN or EIN. Valid values: "SSN" "EIN"	**X(3)**	Required Should be supplied when available
30	licence_number	**License Number**	State License Number	**X(15)**	Should be supplied when available Must be left justified, blank filled to the right
31	npi	**NPI**	National Provider Identifier	**X(10)**	Required Must be 10-digit numeric NPI. For all providers found in the CLAIMSERVICES files, the NPI must be provided. If none exists must be "N/A".

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
32	dea_number	**DEA Number**	DEA number	**X(20)**	Optional Should be supplied when available Must be left justified, blank filled to the right
33	medicare_number	**Medicare Number**	Medicare number	**X(20)**	Optional Must be left justified, blank filled to the right
34	medicaid_number	**Medicaid Number**	Medicaid number	**X(20)**	Optional Should be supplied when available Must be left justified, blank filled to the right.
35	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Provider Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
36	clia_id	**CLIA Number**	Indicates the Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures. CLIA number consists of ten alphanumeric positions.	**X(10)**	Required for providers with specialty code equals to "Clinical Laboratory". Left justified, blank field to the right.
37	accepting_new_pat	**Accepting New Patient Indicator**	Indicates if the provider is accepting new patients (members) or not. Valid values: 0 = No 1 = Yes 8 = N/A – The individual only practices as a member of a group.	**X**	Must be a valid value.
38	dob	**Birth Date**	For an individual, Provider Date of Birth in YYYYMMDD format	**YYYYMMDD**	Required for an individual; left blank for an entity. Must be a valid date Cannot be in later than the Extract Date. Cannot be greater than 150 years ago compared to Extract Date.

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
39	dod	**Death Date**	For an individual Provider, Date of Death in YYYYMMDD format.	**YYYYMMDD**	Optional for an individual; left blank for an entity Should be supplied when available Must be a valid date Cannot be in later than the Extract Date Cannot be greater than 150 years ago compared to Extract Date. Cannot be equal or less than the date of birth. A provider with a date of death before the Extract Date cannot be listed as a provider for an eligible individual.
40	facility_group_ind_code	**Facility Group Indicator Code**	Indicates whether the SUBMITTING-STATE-PROV-ID is assigned to an individual, a group of providers, or a facility.	**XX**	Required Must be a valid value "01" = Facility – The entity identified by the associated SUBMITTING-STATE-PROV-ID is a facility. "02" = Group – The entity identified by the associated SUBMITTING-STATE-PROV-ID is a group of individual practitioners. "03" = Individual – The entity identified by the associated SUBMITTING-STATE-PROV-ID is an individual practitioner. For Pharmacy claims must be blank
41	license_entity	**License Issuing Entity ID**	Indicates the identity of the entity issuing the license or accreditation.	**X(50)**	Required whenever a value is captured in the LICENSE-OR-ACCREDITATION-NUMBER data element. Must be left justified, blank filled to the right (Enter the applicable state code, county code, municipality name, "DEA", professional society's name, or the CLIA accreditation body's name.) If LICENSE-TYPE = 1 (State, county, or municipality professional or business license) and the license-issuing entity is a state, then enter the applicable ANSI state numeric code. If LICENSE-TYPE = 2 (DEA license), then enter the text string "DEA". If LICENSE-TYPE = 3 (Professional society accreditation), then enter the text string identifying the professional society issuing the accreditation. If LICENSE-TYPE = 4 (CLIA accreditation), then enter the text string identifying the CLIA accreditation body's name. If LICENSE-TYPE = 5 (Other accreditation), then enter the text string identifying the entity issuing the accreditation. If LICENSE-TYPE = 9 (Unknown), then enter "Unknown".

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
42	license_type	**License Type**	A code to identify the kind of provider's license. Valid values: "1" = State, county, or municipality professional or business license "2" = DEA license "3" = Professional society accreditation "4" = CLIA accreditation "5" = Other "9" = Unknown	**X**	Required whenever a provider is required by the state's agency requires one in order to be a Medicaid/CHIP provider. Must be a valid value. If a provider has more than one license, please report the one with lowest valid value. Example: for a provider with both "1" = State, county, or municipality professional or business license and "2" = DEA license, report "1" = State, county, or municipality professional or business license.
43	prov_dba	**Provider DBA Name**	The provider's name that is commonly used by the public when the "doing-business-as" (`) name is different from the legal name. DBA is an abbreviation for "doing business as." Registering a DBA is required to operate a business under a name that differs from the company's legal name.	**X(50)**	Leave the field empty when DBA name equals the legal name
44	sex	**Sex Code**	For an individual, indicates the provider's gender. Valid values: M = Male F = Female U = Unknown	**X**	Must be a valid value
45	credential_eff_date	**Credential Effective Date**	The most recent credentialing/recredentialing date of the provider. If the provider does not require credentialing, enter "1/1/1900" in this column.	**YYYYMMDD**	Required

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

#	*Field*	*Field*	*Description*	*Deliverable Data Format*	*Validation Rules*
46	credential_exp_date	**Credential Expiration Date**	The most recent credentialing/recredentialing expiration date of the provider. If the provider does not require credentialing, enter "1/1/1900" in this column.	**YYYYMMDD**	Optional
47	contract_eff_date	**Contract effective date**	The provider's contract effective date.	**YYYYMMDD**	Required for contracted providers. For "Out of Network" providers, please report as '99991231'.
48	contract_term_date	**Contract termination date**	The provider's contract termination date.	**YYYYMMDD**	For providers with an open-ended contract please report as '99991231'. For a provider with an unknown contract termination date, leave blank.
49	Filler	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
RECORD LENGTH					**963**

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

IPA INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	**Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II.	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	**ipa**	**IPA Code**	**Code assigned by carrier to identify IPA/HCO. Maximum of 4 characters.**	**X(10)**	**Required** **IPA/HCO code assigned by Carrier** **Must be left justified, blank filled to the right**
3	ipa_desc	**IPA Description**	Name of IPA/HCO	**X(80)**	Required Must be left justified, blank filled to the right
4	ipa_addr1	**IPA Addr1**	IPA/HCO's first line of address	**X(45)**	Required Must be left justified, blank filled to the right
5	ipa_addr2	**IPA Addr2**	IPA/HCO's second line of address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
6	ipa_addr3	**IPA Addr3**	IPA/HCO's third line of address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
7	ipa_city	**IPA City**	IPA/HCO's city	**X(45)**	Required Must be left justified, blank filled to the right
8	ipa_state	**IPA State**	IPA/HCO's state	**X(45)**	Required Must be left justified, blank filled to the right
9	ipa_zip	**IPA Zip**	IPA/HCO's zip code. Either 5 digit or plus 4 format without dashes	**X(9)**	Required Must be left justified, blank filled to the right Significant characters must be numeric. Must be 5 or 9 digits in length.
10	ipa_country	**IPA Country**	IPA/HCO's country	**X(45)**	Required Must be left justified, blank filled to the right
11	ipa_home_phone	**IPA Home Phone**	Home telephone number of contact person for IPA/HCO	**X(20)**	Optional Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
12	ipa_work_phone	**IPA Work Phone**	Principal work telephone number of IPA/HCO.	**X(20)**	Required Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
13	ipa_ext	**IPA Ext**	Telephone extension at IPA Work Phone for contact person	**X(20)**	Optional Must be left justified, blank filled to the right

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

IPA INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
14	federal_tax_id	**Federal Tax ID**	EIN of IPA	**X(20)**	Required Must be left justified and blank filled to the right Significant characters must be numeric and 9 digits in length
15	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the IPA Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
16	ipa_npi	**IPA NPI**	National Provider Identifier (NPI) of the IPA., where possible.	**X(10)**	Required Left justified, blank field to the right.
17	ipa_adm_lname	**IPA Administrator Lname**	IPA/HCO Administrator Last Names (Apellidos)	**X(50)**	Required Must be left justified, blank filled to the right
18	Ipa_adm_fname	**IPA Administrator Fname**	IPA/HCO Administrator First Name (Nombre)	**X(30)**	Optional Must be left justified, blank filled to the right
19	prov_mname	**IPA Administrator Mname**	IPA/HCO Administrator Middle Name	**X(30)**	Optional Must be left justified, blank filled to the right
20	Filler	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
RECORD LENGTH					**580**

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	**Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II.	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	cap_id	**Capitation ID**	Capitation payment ID must be a unique ID within carrier; except for the adjustments or reversals that must be the unique ID previously reported. This number is used to avoid duplicated Capitation records.	**X(20)**	Required Must be left justified, blank filled to the right Must be a unique ID within Carrier
3	cap_type	**Capitation Type**	Capitation type code defined as: "01"= Admin "02"= Dental "03"= DME … See Attachment VII	**99**	Required Must be two (2) digits (numeric). Must be a valid code. See Capitation Type List in Attachment VII
4	cap_date	**Capitation Date**	Date capitation paid.	**YYYYMMDD**	Required Must be a valid date
5	expr_date	**Experience Date**	Experience date of capitation payment. This is the date for which the capitation payment applies.	**YYYYMMDD**	Required Must be a valid date
6	prov	**Provider ID**	Must be the NPI, or if none exists, may be the Tax Id of the provider to which the capitation payment is made.	**X(20)**	Required Must be a valid Provider ID found in PRV File. Must be left justified and blank filled to the right. If NPI is used, must be 10 digit numeric NPI. If Tax Id is used, must be 9 digits in significant positions.
7	pcp_npi	**Provider NPI**	National Provider Identifier (NPI) of the provider to which the capitation payment is made.	**X(10)**	Required Must be the NPI, or if none exists, must be "N/A". Left justified, blank field to the right.
8	ipa	**IPA ID**	**Carrier assigned ID of IPA/HCO. This must be filled when IPA/HCO is involved (Must always be filled for Plan Type "01" by MCOs/TPAs)**	**X(10)**	**Required If Carrier ID corresponds to Plan Type "01" Must be a valid IPA Code for the Carrier and found in the IPA file. Left justified, blank field to the right.**

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
9	region_code	**Region**	Region of member Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West 'P" = SPECIAL "X" = All Regions "O" = Outside Puerto Rico	**X**	Required Must be valid ASES Region code For plan type "01", the Region Code must be a valid region code, and the value cannot be "X" or "O". **For plan type "04", "05" "06" and "09", value must be "X".**
10	municipality_code	**Municipality**	Municipality of residence of member. See Municipality Code in Attachment I.	**XXXX**	Required Must be ASES Municipality Code All numeric, right justified, zero filled Must correspond to a municipality within Region Code For outside of Puerto Rico, code 0666 is included in the list of Municipality Codes.
11	member_ssn	**Member SSN**	Social Security Number of member	**9(9)**	Required Must be 9 digits (numeric) Right justified, zero filled
12	household_id	**ASES Household ID**	Household ID as supplied in ASES Eligibility data	**X(11)**	Required ASES / ODSI Household ID. Alphanumeric full 11 characters. For government employees use SSN Main Holder. Must be left justified, blank filled to the right.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
13	member_suffix	**Member Suffix**	Identifies the beneficiary within the family group. For non-governmental employees - Must be the two digit member suffix as supplied in ASES Eligibility data. For governmental employees - Must be one of the following: 01 = Principal - (Main Holder) 02 = Spouse - Direct 03 = Spouse - Joint (Mancomunado) 04 = Children - Direct 05 = Optional - Direct (parents) 06 =Substantial 07 = Co-Habitant 08 = Co-Habitant - Joint (Mancomunado)	**99**	Required Must be 2 digits (numeric)
14	cap_amt	**Capitation Amount**	Capitation amount paid to provider MAY BE NEGATIVE *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	**S9(7)v99**	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
15	gross_cap_amt	**Gross Capitation Amount**	Gross Capitation amount paid to provider per MPI for all risk types. **MAY BE NEGATIVE** *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	**S9(7)v99**	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
16	net_cap_amt	**Net Capitation Amount**	Net Capitation amount paid to provider per MPI for all risk types. **MAY BE NEGATIVE** *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	**S9(7)v99**	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
17	risk_type	**MPI Risk Type**	Distinguishes for this service whether risk belongs to PCP(/Group) or carrier. If cost should be charged to PCP(/Group) then value = "PCP" If the risk is shared, then the value =' SHR' Otherwise, value = "CAR" (Carrier). Where there is no risk sharing the value should be entered as "CAR".	**XXX**	Required Must be filled Must be "PCP" , "SHR" or "CAR" For PBM the only value should be "UNK"
18	tier	**Member capitation tier**	Member capitation tier 0001 Medicare A&B Male 0002 Medicare A Male 0006 Medicare A&B Female 0007 Medicare A Female 0008 0-11 Months 0009 12-23 Months 0010 24 Months - 10 Years 0011 11 - 18 Years 0024 19 - 35 Female 0025 19 - 35 Male 0026 36 - 54 Female 0027 36 - 54 Male 0028 55 - 64 Female 0029 55 - 64 Male 0031 65 + Female 0032 65 + Male	**X(4)**	Required
19	days	**Capitation days**	Number of days included in capitation amount.	**S99**	Required Must be a number 3 byte field Signed, may be negative only for adjustments or reversals Sign must appear in leftmost byte, other 2 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
20	mem_percent	**Capitation percentage**	Percentage (days / month days)	**S999**	Required Must be a number 4 byte field Signed, may be negative only for adjustments or reversals Sign must appear in leftmost byte, other 3 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
21	extract_date	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Capitation Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
22	mpi	**MPI Number or Contract Number**	Master Patient Index (MPI) As supplied in ASES Eligibility Data For government employees this will be the contract number	**X(13)**	Required Must be a valid MPI number For government employees only, contract number Must be left justified, blank filled to the right
23	Federal_Tax_ID	**Federal Tax ID (SSN or EIN)**	The federal identification number of the provider to which the capitation payment is made. If the provider does not have a federal identification number, enter '999999999' in this column. SSN for individuals, EIN for entities.	**X(20)**	Required Left justified, blank filled to the right Must be 9 digits in significant positions
24	region_serv	**Region Service**	Region in which services are provided based on provider address. See region codes per municipality in Attachment I. Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West "P" = SPECIAL "X" = All Regions "O" = Outside Puerto Rico	**X**	Required Must be valid ASES Region code **For plan type "04", "05", "06" and "09" value must be "X".**

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
25	filler	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
RECORD LENGTH					**194**

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier	**Carrier ID**	ASES assigned carrier code. Must be (2) digits (numeric)	**99**	Required Must be two (2) digit s (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	provider_type	**Provider Type**	PCP, Specialist, Dentist, X-Ray, Ancillary Services, Special Case, Laboratory, Other Facility, Hospital	**X(20)**	Required Must be left justified, blank filled to the right
3	month	**Month**	Date field with the first day of month. Ex: 5/1/2014	**YYYYMMDD**	Required Must be a valid date.
4	region	**Region**	The ASES region code. (If the provider has multiple locations specify the Region for current address) Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West "P" = SPECIAL "O" = Outside Puerto Rico	**X**	Required
5	**pmg**	**IPA Code**	**The identification number of the primary medical group. If not applicable enter "N/A".** **Code assigned by carrier to identify IPA/HCO. Maximum of 4 characters**	**X(10)**	**Required** **IPA/HCO code assigned by Carrier** **Must be left justified, blank filled to the right**
6	pmg_name	**PMG Name**	The name or title of the primary medical group. If not applicable enter "N/A"	**X(80)**	Required
7	npi	**NPI**	The national provider identification number. All providers are required to have an NPI number.	**X(10)**	Required

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
8	provider_duplicate_entry	**Provider Duplicate Entry**	Indicate if the provider is entered multiple times in the list. A provider may be entered multiple times if the provider has more than one office location providing services. Enter a "**0**" for the first entry of the provider in the list. Enter an "**X**" for any duplicate entries of the same provider in the list.	**X**	Required
9	assigned_lives	**Assigned lives**	The number of assigned lives to the provider as of the last day of the reporting period. If the provider has multiple office locations, the number of assigned lives must be entered for the first entry (not a duplicated entry) for the provider. This number should include the sum of all office locations of the provider. If the provider does not have or require assigned lives, enter "0" in this column.	**9999**	Required
10	credential	**Credential**	Identify if the provider is up to date with all credentialing requirements as of the last day of the reporting period. Enter "Yes" for a fully credentialed/recredentialed provider, enter "No" if the provider requires credentialing/recredentialing. If the provider is not required to submit credentialing/recredentialing, enter "N/A" in this column.	**XXX**	Required
11	credential_eff_date	**Credential Effective Date**	The most recent credentialing/recredentialing date of the provider. If the provider does not require credentialing, enter "1/1/1900" in this column.	**YYYYMMDD**	Required
12	credential_exp_date	**Credential Expiration Date**	The most recent credentialing/recredentialing expiration date of the provider. If the provider does not require credentialing, enter "1/1/1900" in this column.	**YYYYMMDD**	Optional
13	federal_tax_id	**Provider SSN or EIN**	The federal identification number of the provider. SSN for individuals, EIN for entities.	**X(20)**	Required Left justified, blank filled to the right Must be 9 digits in significant positions

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
14	prov_id	**Provider ID**	Must be the NPI, or if none exists, may be the Tax Id.	**X(20)**	Required Must be left justified and blank filled to the right If NPI is used, must be 10 digit numeric NPI.
15	ccn	**CCN**	CMS Certification Number formerly known as the Medicare Provider Number.	**X(20)**	Optional
16	contract_eff_date	**Contract effective date**	The provider's contract effective date.	**YYYYMMDD**	Required For "Out of Network" providers, please report as '99991231'.
17	contract_term_date	**Contract termination date**	The provider's contract termination date.	**YYYYMMDD**	Required For providers with an open-ended contract please report as '99991231'. For a provider with an unknown contract termination date, leave blank.
18	**specialty**	**Specialty**	**Provider Specialty (first). See Specialty Code description in Attachment III**	**X(40)**	**Optional**
19	**specialty_code**	**Specialty Code**	**Provider Specialty (first). See Specialty Code in Attachment III**	**XX**	**Required** **Must be left justified, blank filled to the right** **Must be a valid Specialty Code**
20	name	**Name**	The full name of the provider.	**X(80)**	Optional Must be left justified, blank filled to the right
21	last_name1	**Last Name 1**	For an individual, the last name of the provider. If the provider has two last names, this should be the first name. For an entity (other than an individual), the entity name	**X(30)**	Required Must be left justified, blank filled to the right
22	last_name2	**Last Name 2**	For an individual, the last name of the provider. If the provider has two last names, this should be the second name.	**X(30)**	Optional Must be left justified, blank filled to the right
23	first_name	**First Name**	For an individual, the first name of the provider.	**X(50)**	Required Must be left justified, blank filled to the right
24	mi	**MI**	For an individual, the middle name of the provider.	**X(30)**	Optional Must be left justified, blank filled to the right
25	addr1	**Address Line 1**	The first line of the physical address of the provider.	**X(45)**	Required Must be the physical address and use second line as needed. Must be left justified, blank filled to the right
26	addr2	**Address Line 2**	The second line of the physical address of the provider.	**X(45)**	Must be left justified, blank filled to the right

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
27	city	**City**	The city of the provider.	**X(45)**	Optional Must be left justified, blank filled to the right
28	zip	**Zip code**	Provider's Zip code Either 5 digit or plus 4 format without dashes	**X(9)**	Required Must be left justified, blank filled to the right Significant characters must be numeric and 5 or 9 digits in length
29	phone	**Phone**	Provider's telephone number. *SEE NOTES – Changes and Additions in Data File Layouts: PROVIDER telephone numbers*	**X(20)**	Required Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
30	fax	**Fax**	The primary fax number of the provider. *SEE NOTES – Changes and Additions in Data File Layouts: PROVIDER telephone numbers*	**X(20)**	Optional Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
31	sunday	**Sunday working hours**	The Sunday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
32	monday	**Monday working hours**	The Monday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
33	tuesday	**Tuesday working hours**	The Tuesday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
34	wednesday	**Wednesday working hours**	The Wednesday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
35	thursday	**Thursday working hours**	The Thursday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
36	friday	**Friday working hours**	The Friday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional
37	saturday	**Saturday working hours**	The Saturday open office hours of the provider in 12hr format. (i.e. 8:00am - 5:00pm)	**X(20)**	Optional

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

NETWORK INPUT FILE LAYOUT

#	*Field*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
38	ncpdp_id	**NCPDP ID**	The National Council for Prescription Drugs ID	**X(10)**	Optional
39	state	**State**	The provider's address state.	**X(45)**	Optional Must be left justified, blank filled to the right
40	license_number	**License number**	The Provider's license number.	**X(10)**	Required Should be supplied when available Must be left justified, blank filled to the right
41	contact_person	**Contact person**	The provider's contact person.	**X(80)**	Optional
RECORD LENGTH					**962**

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENTS

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	REGION	CODE
Adjuntas	S	0004
Aguada	Z	0008
Aguadilla	Z	0012
Aguas Buenas	E	0016
Aibonito	G	0020
Añasco	Z	0024
Arecibo	A	0028
Arroyo	G	0032
Barceloneta	A	0036
Barranquitas	G	0040
Bayamón	B	0044
Cabo Rojo	Z	0048
Caguas	E	0052
Camuy	A	0056
Canovanas	F	0060
Carolina	F	0064
Cataño	B	0068
Cayey	E	0072
Ceiba	F	0076
Ciales	A	0080
Cidra	E	0084
Coamo	G	0088
Comerio	B	0092
Corozal	B	0096
Culebra	F	0100

Ordered By Code		
CODE	MUNICIPALITY	REGION
0004	Adjuntas	S
0008	Aguada	Z
0012	Aguadilla	Z
0016	Aguas Buenas	E
0020	Aibonito	G
0024	Añasco	Z
0028	Arecibo	A
0032	Arroyo	G
0036	Barceloneta	A
0040	Barranquitas	G
0044	Bayamón	B
0048	Cabo Rojo	Z
0052	Caguas	E
0056	Camuy	A
0060	Canovanas	F
0064	Carolina	F
0068	Cataño	B
0072	Cayey	E
0076	Ceiba	F
0080	Ciales	A
0084	Cidra	E
0088	Coamo	G
0092	Comerio	B
0096	Corozal	B
0100	Culebra	F

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	REGION	CODE
Dorado	B	0104
Fajardo	F	0108
Florida	A	0112
Guanica	S	0116
Guayama	G	0120
Guayanilla	S	0124
Guaynabo	B	0128
Gurabo	E	0132
Hatillo	A	0136
Hormigueros	Z	0140
Humacao	E	0144
Isabela	Z	0148
Jayuya	S	0152
Juana Diaz	G	0156
Juncos	E	0160
Lajas	Z	0164
Lares	A	0168
Las Marias	Z	0172
Las Piedras	E	0176
Loiza	F	0180
Luquillo	F	0184
Manatí	A	0188
Maricao	Z	0192
Maunabo	G	0196
Mayagüez	Z	0200

Ordered By Code		
CODE	MUNICIPALITY	REGION
0104	Dorado	B
0108	Fajardo	F
0112	Florida	A
0116	Guanica	S
0120	Guayama	G
0124	Guayanilla	S
0128	Guaynabo	B
0132	Gurabo	E
0136	Hatillo	A
0140	Hormigueros	Z
0144	Humacao	E
0148	Isabela	Z
0152	Jayuya	S
0156	Juana Diaz	G
0160	Juncos	E
0164	Lajas	Z
0168	Lares	A
0172	Las Marias	Z
0176	Las Piedras	E
0180	Loiza	F
0184	Luquillo	F
0188	Manatí	A
0192	Maricao	Z
0196	Maunabo	G
0200	Mayagüez	Z

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	REGION	CODE
Moca	Z	0204
Morovis	A	0208
Naguabo	E	0212
Naranjito	B	0216
Orocovis	G	0220
Patillas	G	0224
Peñuelas	S	0228
Ponce	S	0232
Puerta de Tierra	J	0264
Puerto Nuevo	J	0270
Quebradillas	A	0236
Rincon	Z	0240
Rio Grande	F	0244
Rio Piedras	J	0272
Sabana Grande	Z	0248
Salinas	G	0252
San German	Z	0256
San José	J	0274
San Juan	J	0266
San Lorenzo	E	0276
San Sebastian	Z	0280
Santa Isabel	G	0284
Toa Alta	B	0288
Toa Baja	B	0292
Trujillo Alto	F	0296

Ordered By Code		
CODE	MUNICIPALITY	REGION
0204	Moca	Z
0208	Morovis	A
0212	Naguabo	E
0216	Naranjito	B
0220	Orocovis	G
0224	Patillas	G
0228	Peñuelas	S
0232	Ponce	S
0236	Quebradillas	A
0240	Rincon	Z
0244	Rio Grande	F
0248	Sabana Grande	Z
0252	Salinas	G
0256	San German	Z
0264	Puerta de Tierra	J
0266	San Juan	J
0270	Puerto Nuevo	J
0272	Rio Piedras	J
0274	San José	J
0276	San Lorenzo	E
0280	San Sebastian	Z
0284	Santa Isabel	G
0288	Toa Alta	B
0292	Toa Baja	B
0296	Trujillo Alto	F

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	**REGION**	**CODE**
Utuado	A	0300
Vega Alta	B	0304
Vega Baja	A	0308
Vieques	F	0312
Villalba	G	0316
Yabucoa	E	0320
Yauco	S	0324
Outside Puerto Rico	O	0666

Ordered By Code		
CODE	**MUNICIPALITY**	**REGION**
0300	Utuado	A
0304	Vega Alta	B
0308	Vega Baja	A
0312	Vieques	F
0316	Villalba	G
0320	Yabucoa	E
0324	Yauco	S
0666	Outside Puerto Rico	O

* 0666 is valid only for use with Municipality Service on CLAIMSERVICES Input File and/or Municipality on CAPITATION Input File.

NOTE: Any municipality code may appear in region SPECIAL.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
01	(discontinued) Triple-S Salud, Inc.	MCO
02	(discontinued) Humana	MCO
03	(discontinued) Triple-S Salud, Inc.	TPA
04	(discontinued) First Medical Health Plan, Inc.	MCO
05	(discontinued) PMC Medicare Choice, LLC	MCO
06	(discontinued) Triple-S Salud, Inc.	MCO
07	(discontinued) Molina Healthcare of Puerto Rico, Inc.	MCO
08	(discontinued) MMM Multi Health, LLC	MCO
09	First Medicaid Health Plan, Inc. (NHM)	MCO
10	MMM Multi Health, LLC (NHM)	MCO
11	(discontinued) Molina Healthcare of Puerto Rico, Inc. (NHM)	MCO
12	Plan de Salud Menonita (NHM)	MCO
13	Triple-S Salud, Inc. (NHM)	MCO
17	(discontinued) MCS	MCO
25	(discontinued) La Cruz Azul de P.R.	MCO
27	(discontinued) MCS Life	Medicare Platino
28	(discontinued) Red Medica	Medicare Platino
29	MMM Healthcare, INC	Medicare Platino
31	(discontinued) Triple-S Salud, Inc.	Medicare Platino
33	Preferred Medicare Choice	Medicare Platino
34	MCS Advantage	Medicare Platino
35	(discontinued) COSVIMed	Medicare Platino
37	(discontinued) Salud Dorada con Medicare	Medicare Platino

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
39	(discontinued) MAPFRE	Medicare Platino
41	(discontinued) Health Medicare Ultra	Medicare Platino
42	Humana	Medicare Platino
44	(discontinued) Auxilio Platino	Medicare Platino
45	(discontinued) Constellation Health, LLC	Medicare Platino
46	Triple-S Advantage	Medicare Platino
47	(discontinued) American Health	Medicare Platino
48	(discontinued) MMM-First Plus	Medicare Platino
49	(discontinued) First Medical Health Plan, Inc.	Medicare Platino
51	(discontinued) Triple-S Salud, Inc.	TPA – Direct Contract
52	(discontinued) Humana	TPA – Direct Contract
53	(discontinued) MCS	TPA – Direct Contract
54	(discontinued) Triple-S Salud, Inc.	TPA – Direct Contract
55	(discontinued) COSVI	TPA – Direct Contract
60	(discontinued) Caremark	PBM
62	ABARCA	PBM
64	MC-21	PBM
70	(discontinued) ASSMCA	Mental Health Pilot
71	Plan de Salud Hospital Menonita	Government Employee
72	MMM Healthcare, INC	Government Employee
73	(discontinued) National Life Insurance Company	Government Employee
74	(discontinued) Ryder Health Plan, Inc.	Government Employee
75	Triple-S Salud Inc.	Government Employee

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
76	(discontinued) BHP	MBHO
77	Humana Health Plan of Puerto Rico, Inc.	Government Employee
78	(discontinued) MAPFRE	Government Employee
79	MCS Life Insurance Company	Government Employee
80	PROSSAM	Government Employee
81	Asociacion de Maestros de Puerto Rico	Government Employee
82	First Medical Health Plan, Inc.	Government Employee
83	(discontinued) APS	MBHO
84	(discontinued) APS	Government Employee
85	PMC Medicare Choice, LLC	Government Employee
86	(discontinued) Molina Healthcare of Puerto Rico, Inc.	Government Employee
87	Triple-S Advantage	Government Employee
88	(discontinued) MMM-First Plus	Government Employee
89	(discontinued) Panamerican Life Insurance Group (PALIG)	Government Employee
90	(discontinued) Delta Dental	Government Employee
91	MMM Multi Health, LLC	Government Employee
92	AUXILIO MUTUO PLUS	Government Employee
95	(discontinued) FHC	MBHO
96	(discontinued) American Health Medicare	Government Employee

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan	
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
15	Speech Language Pathologist in Private Practice
16	Obstetrics / Gynecology
17	Hospice and palliative care
18	Ophthalmology
19	Oral Surgery
20	Orthopedic Surgery
21	Cardiac electrophysiology

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
22	Pathology
23	Sports medicine
24	Plastic and Reconstructive Surgery
25	Physical Medicine / Rehabilitation
26	Psychiatry
27	Geriatric psychiatry
28	Colorectal Surgery (Formerly Proctology)
29	Pulmonary Diseases
30	Diagnostic Radiology
31	Intensive cardiac rehabilitation
32	Anesthesiologist Assistant
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
42	Certified Nurse Midwife
43	Certified Registered Nurse Assistant (CRNA)
44	Infectious Disease

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
45	Mammography Screening Center
46	Endocrinology
47	Independent Diagnostics Testing Facility
48	Podiatry
49	Ambulatory Surgical Center
50	Nurse Practitioner
51	Medical Supply Company with Orthotist
52	Medical Supply Company with Prosthetist
53	Medical Supply Company with Orthotist-Prosthetist
54	Other Medical Supply Company
55	Individual Certified Orthotist
56	Individual Certified Prosthetist
57	Individual Certified Orthotist-Prosthetist
58	Medical Supply Company with pharmacist
59	Ambulance Service Provider
60	Public Health and Welfare Agency
61	Voluntary Health or Charitable Agency
62	Psychologist
63	Portable X-ray Supplier
64	Audiologist
65	Physical Therapist
66	Rheumatology
67	Occupational Therapy

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
68	Clinical Psychologist
69	Clinical Laboratory
70	Multi-Specialty Clinic or Group Practice
71	Registered Dietician / Nutritional Professional
72	Pain Management
73	Mass Immunization Roster Billers
74	Radiation Therapy Center
75	Slide Preparation Facilities
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
80	Licensed Clinical Social Worker
81	Critical Care (Intensivists)
82	Hematology
83	Hematology / Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
87	All Other Suppliers
88	Unknown Supplier / Provider Specialty
89	Certified Clinical Nurse Specialist
90	Medical Oncology

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Intervention Radiology
96	Optician
97	Physician Assistant
98	Gynecological Oncology
99	Unknown Physician Specialty
A1	Skilled Nursing Facility
A2	Intermediate Care Nursing Facility
A3	Other Nursing Facility
A4	Home Health Agency
A5	Pharmacy
A6	Medical Supply Company with Respiratory Therapist
A7	Department Store
A8	Grocery Store
BB	Blood Bank
CV	Cardiac Catheterization Facility
DC	Detox Center
DD	Dentist
DF	Dialysis Facility
EC	Emergency Care Facility
EN	Endodontist

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
G1	Geneticist
HE	Health Educator
HN	Home Health Nurse
HV	HIV Ambulatory Antibiotic Facility
IC	Intensive Care Unit
IT	Infusion Therapy
LI	Lithotripsy
N1	Neonatology
NI	Neonatal ICU
O1	Occupational Medicine
OP	Optical
P1	Perinatology
P2	Pediatric Surgery
PC	Clinic – Primary Level
PE	Periodontist
PH	Private Hospital
PP	Private Psychiatric Hospital
PS	Psychiatric Partial Hospital
RT	Respiratory Therapist
SH	State Hospital
SP	State Psychiatric Hospital
ST	Short Term Intervention Center (Behavioral Health-Stabilization Unit)
XR	X-ray Facility

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
Y2	Psych/Mental Health Facility
Z4	Cardiovascular Surgery Program

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan		
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	**Telehealth Provided Other than in Patient's Home**	**The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.**
03	School	A facility whose primary purpose is education.
04	**Homeless Shelter**	**A facility or location whose primary purpose is to provide temporary housing to homeless individuals. (e.g., emergency shelters, individual or family shelters).**
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
09	Prison / Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	**Telehealth Provided in Patient's Home**	**The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.**
11	Office	Location, other than a hospital, Skilled Nursing Facility (SNF), military treatment facility, community health center, State or local public health clinic, or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services.
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short term accommodation such as a hotel, campground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18	Place of Employment- Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus- Outpatient Hospital	A portion of a hospital, which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room - Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility, which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: • Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility. • 24 hour a day emergency cares services. • Day treatment, other partial hospitalization services, or psychosocial rehabilitation services. • Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission. • Consultation and education services.
54	Intermediate Care Facility/ Individuals with Intellectual Disabilities	A facility which primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who, does not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care, which provides a total 24-hour therapeutically, planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58	**Non-residential Opioid Treatment Facility**	**A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT).**
59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility, which is located in a rural medically, underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other service facilities not specified above.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT V - PROVIDER TYPE CODES

CODE	Description
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan	
AM	Ambulance
AS	Ambulatory Surgical Center
BB	Blood Bank
CL	Clinical Facility
DE	Dentist
DM	Durable Medical Equipment (DME)
EM	Emergency Facility
HH	Home Health Agency
HO	Hospital
HS	Hospice
LA	Laboratory
MD	Medical Doctor (Physician)
RX	Pharmacy
SN	Skilled Nursing Facility (SNF)
UF	Urgent Care facility
XR	Radiology Facility
ZZ	Other

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VI – PLAN VERSION LIST

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
01	09	100				Plan Vital
01	09	110				Plan Vital
01	09	120				Plan Vital
01	09	130				Plan Vital
01	09	220				Plan Vital
01	09	230				Plan Vital
01	09	300				Plan Vital
01	09	310				Plan Vital
01	09	320				Plan Vital
01	09	330				Plan Vital
01	09	970				Encarcelados
01	10	100				Plan Vital
01	10	110				Plan Vital
01	10	120				Plan Vital
01	10	130				Plan Vital
01	10	220				Plan Vital
01	10	230				Plan Vital
01	10	300				Plan Vital
01	10	310				Plan Vital
01	10	320				Plan Vital
01	10	330				Plan Vital
01	10	970				Encarcelados
01	12	100				Plan Vital
01	12	110				Plan Vital
01	12	120				Plan Vital
01	12	130				Plan Vital
01	12	220				Plan Vital
01	12	230				Plan Vital
01	12	300				Plan Vital
01	12	310				Plan Vital
01	12	320				Plan Vital

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
01	12	330				Plan Vital
01	12	970				Encarcelados
01	13	100				Plan Vital
01	13	110				Plan Vital
01	13	120				Plan Vital
01	13	130				Plan Vital
01	13	220				Plan Vital
01	13	230				Plan Vital
01	13	300				Plan Vital
01	13	310				Plan Vital
01	13	320				Plan Vital
01	13	330				Plan Vital
01	13	970				Encarcelados
02	29	004				Medicare Platino - MA-SNP
02	29	005				Medicare Platino - MA-SNP
02	29	014				Medicare Platino - MA-SNP
02	29	015				Medicare Platino - MA-SNP
02	29	017				Medicare Platino - MA-SNP
02	29	018				Medicare Platino - MA-SNP
02	29	019				Medicare Platino - MA-SNP
02	29	020				Medicare Platino - MA-SNP
02	29	023				Medicare Platino - MA-SNP
02	29	024				Medicare Platino - MA-SNP
02	29	025				Medicare Platino - MA-SNP
02	29	026				Medicare Platino - MA-SNP
02	29	031				Medicare Platino - MA-SNP
02	29	032				Medicare Platino - MA-SNP
02	29	033				Medicare Platino - MA-SNP
02	29	034				Medicare Platino - MA-SNP
02	33	005				Medicare Platino - MA-SNP
02	33	006				Medicare Platino - MA-SNP
02	33	007				Medicare Platino - MA-SNP

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
02	33	008				Medicare Platino - MA-SNP
02	33	009				Medicare Platino - MA-SNP
02	33	010				Medicare Platino - MA-SNP
02	33	015				Medicare Platino - MA-SNP
02	33	016				Medicare Platino - MA-SNP
02	33	017				Medicare Platino - MA-SNP
02	33	018				Medicare Platino - MA-SNP
02	33	019				Medicare Platino - MA-SNP
02	33	020				Medicare Platino - MA-SNP
02	33	025				Medicare Platino - MA-SNP
02	33	026				Medicare Platino - MA-SNP
02	33	027				Medicare Platino - MA-SNP
02	33	028				Medicare Platino - MA-SNP
02	33	029				Medicare Platino - MA-SNP
02	33	030				Medicare Platino - MA-SNP
02	33	031				Medicare Platino - MA-SNP
02	33	032				Medicare Platino - MA-SNP
02	34	003				Medicare Platino - MA-SNP
02	34	004				Medicare Platino - MA-SNP
02	34	011				Medicare Platino - MA-SNP
02	34	012				Medicare Platino - MA-SNP
02	34	029				Medicare Platino - MA-SNP
02	34	030				Medicare Platino - MA-SNP
02	34	031				Medicare Platino - MA-SNP
02	34	032				Medicare Platino - MA-SNP
02	34	035				Medicare Platino - MA-SNP
02	34	036				Medicare Platino - MA-SNP
02	34	043				Medicare Platino - MA-SNP
02	34	044				Medicare Platino - MA-SNP
02	34	045				Medicare Platino - MA-SNP
02	34	046				Medicare Platino - MA-SNP
02	34	047				Medicare Platino - MA-SNP

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
02	34	048				Medicare Platino - MA-SNP
02	34	049				Medicare Platino - MA-SNP
02	34	050				Medicare Platino - MA-SNP
02	34	051				Medicare Platino - MA-SNP
02	34	052				Medicare Platino - MA-SNP
02	34	053				Medicare Platino - MA-SNP
02	34	054				Medicare Platino - MA-SNP
02	34	055				Medicare Platino - MA-SNP
02	34	056				Medicare Platino - MA-SNP
02	34	057				Medicare Platino - MA-SNP
02	34	058				Medicare Platino - MA-SNP
02	34	059				Medicare Platino - MA-SNP
02	34	060				Medicare Platino - MA-SNP
02	34	061				Medicare Platino - MA-SNP
02	34	062				Medicare Platino - MA-SNP
02	34	063				Medicare Platino - MA-SNP
02	34	064				Medicare Platino - MA-SNP
02	34	065				Medicare Platino - MA-SNP
02	34	066				Medicare Platino - MA-SNP
02	34	067				Medicare Platino - MA-SNP
02	34	068				Medicare Platino - MA-SNP
02	34	070				Medicare Platino - MA-SNP
02	34	071				Medicare Platino - MA-SNP
02	34	072				Medicare Platino - MA-SNP
02	34	073				Medicare Platino - MA-SNP
02	42	005				Medicare Platino - MA-SNP
02	42	006				Medicare Platino - MA-SNP
02	42	007				Medicare Platino - MA-SNP
02	42	008				Medicare Platino - MA-SNP
02	42	013				Medicare Platino - MA-SNP
02	42	014				Medicare Platino - MA-SNP
02	42	015				Medicare Platino - MA-SNP

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
02	42	016				Medicare Platino - MA-SNP
02	42	017				Medicare Platino - MA-SNP
02	42	018				Medicare Platino - MA-SNP
02	42	019				Medicare Platino - MA-SNP
02	42	020				Medicare Platino - MA-SNP
02	42	021				Medicare Platino - MA-SNP
02	42	022				Medicare Platino - MA-SNP
02	42	023				Medicare Platino - MA-SNP
02	42	024				Medicare Platino - MA-SNP
02	46	003				Medicare Platino - MA-SNP
02	46	004				Medicare Platino - MA-SNP
02	46	005				Medicare Platino - MA-SNP
02	46	006				Medicare Platino - MA-SNP
02	46	007				Medicare Platino - MA-SNP
02	46	008				Medicare Platino - MA-SNP
02	46	011				Medicare Platino - MA-SNP
02	46	012				Medicare Platino - MA-SNP
02	46	013				Medicare Platino - MA-SNP
02	46	014				Medicare Platino - MA-SNP
02	46	015				Medicare Platino - MA-SNP
02	46	016				Medicare Platino - MA-SNP
02	46	017				Medicare Platino - MA-SNP
02	46	018				Medicare Platino - MA-SNP
02	46	019				Medicare Platino - MA-SNP
02	46	020				Medicare Platino - MA-SNP
02	46	025				Medicare Platino - MA-SNP
02	46	026				Medicare Platino - MA-SNP
02	46	027				Medicare Platino - MA-SNP
02	46	028				Medicare Platino - MA-SNP
02	46	037				Medicare Platino - MA-SNP
02	46	038				Medicare Platino - MA-SNP
02	46	039				Medicare Platino - MA-SNP

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
02	46	040				Medicare Platino - MA-SNP
02	46	041				Medicare Platino - MA-SNP
02	46	042				Medicare Platino - MA-SNP
02	46	043				Medicare Platino - MA-SNP
02	46	044				Medicare Platino - MA-SNP
02	46	045				Medicare Platino - MA-SNP
02	46	046				Medicare Platino - MA-SNP
02	46	047				Medicare Platino - MA-SNP
02	46	048				Medicare Platino - MA-SNP
04	71	401	Oro	Regular	MCO	
04	71	402	Plata	Regular	MCO	
04	71	402	Altenativa 1 Plata	Regular	MCO	Law 95 Commercial
04	71	404	Alternativa 2 Rubi	Regular	MCO	Law 95 Commercial
04	71	405	Diamante	Regular	MCO	
04	71	407	Mandatoria	Regular	MCO	Law 95 Commercial
04	71	408	Alterno 1	Regular	MCO	
04	71	409	Alterno 2	Regular	MCO	
06	71	400	Coverage 400 (ELA)	Regular	MCO	Law 95 - ELA-Puro (Cubierta ASES)
09	71	400	Coverage 400 (ELA)	Retired Policemen	HMO	
05	72	501	Oro	Regular	HMO	
05	72	502	Plata	Regular	HMO	
05	72	503	Bronce	Regular	HMO	
05	72	504	Rubi	Regular	HMO	
05	72	505	ELA Flex	Auto-Enrollment	HMO POS	
05	72	506	ELA Relax	Auto-Enrollment	HMO POS	
05	72	507	MMM ELA Relax (HMO-POS)	Auto-Enrollment	HMO	
05	72	508	MMM ELA Premium (HMO-POS)	Auto-Enrollment	HMO	
05	72	509	MMM ELA Advantage	Auto-Enrollment	HMO	
05	72	510	ELA CASH	Regular	HMO	
05	72	511	ELA GRANDE	Regular	HMO	
05	72	512	ELA DINAMICO	Regular	HMO	
04	75	401	Oro	Regular	MCO	

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
04	75	402	Plata	Regular	MCO	
04	75	403	Bronce	Regular	MCO	
04	75	404	Rubi	Regular	MCO	
04	75	405	Diamante	Regular	MCO	
04	75	406	Complementaria de Medicare	Regular	MCO	
04	75	407	Mandatoria Universal	Regular	MCO	
04	75	408	Alterna 1 Equilibrio	Regular	MCO	
04	75	409	Care Plus Medigap		MCO	Law 95 Commercial
06	75	400	Coverage 400 (ELA)	Regular	MCO	Law 95 - ELA-Puro (Cubierta ASES)
09	75	400	Coverage 400 (ELA)	Retired Policemen	HMO	
05	77	501	Oro	Regular	HMO	
05	77	502	Plata	Regular	HMO	
05	77	503	Bronce	Regular	HMO	
05	77	504	Rubi	Regular	HMO	
05	77	505	PR I	Auto-Enrollment	HMO	
05	77	506	PR II	Auto-Enrollment	HMO	
05	77	507	PR III	Auto-Enrollment	PPO	
05	77	508	US Acess Only	Auto-Enrollment	HMO	
05	77	509	HMO FL	Auto-Enrollment	HMO	
05	77	510	ELA Rubí MAX	Auto-Enrollment	HMO	
05	77	511	ELA HMO Bronce	Auto-Enrollment	HMO	
05	77	512	ZAFIRO		HMO	
05	77	513	Basic Deluxe		HMO	
04	78	401	Oro	Regular	MCO	
04	78	402	Plata	Regular	MCO	
04	78	403	Bronce	Regular	MCO	
04	78	404	Rubi	Regular	MCO	
04	78	405	Diamante	Regular	MCO	
04	78	406	Complementaria de Medicare	Regular	MCO	
04	78	407	Mandatoria	Regular	MCO	
04	78	408	Alterno 1	Regular	MCO	
04	78	409	Alterno 2	Regular	MCO	

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
05	79	501	Oro	Regular	HMO	
05	79	502	Plata	Regular	HMO	
05	79	503	Bronce	Regular	HMO	
05	79	504	Rubi	Regular	HMO	
05	79	505	ELA Crédito	Auto-Enrollment	HMO	
05	79	506	ELA Ahorro	Auto-Enrollment	HMO	
05	79	507	ELA Crédito Rubí	Auto-Enrollment	HMO	
05	79	508	ELA ENLACE ACERO OSS-PDS	Auto-Enrollment	HMO	
05	79	509	Gobierno Ahorro	Auto-Enrollment	HMO	
05	79	510	ELA TE AYUDA OSS-PDS	Regular	HMO	
05	79	511	ELA MAXIMO OSS-PDS	Regular	HMO	
05	79	512	ELA Gobierno Extra	Regular	HMO	
05	79	513	ELA Solido			
04	80	401	Oro	Regular	MCO	
04	80	402	Plata	Regular	MCO	
04	80	403	Bronce	Regular	MCO	
04	80	404	Rubi	Regular	MCO	
04	80	405	Diamante	Regular	MCO	
04	80	406	Complementaria de Medicare	Regular	MCO	
04	80	407	Mandatoria	Regular	MCO	
04	80	408	Alterno 1	Regular	MCO	
04	80	409	Alterno 2	Regular	MCO	
04	80	410	Mandatorio ULTRA	Regular	MCO	Law 95 Commercial
04	80	411	Alternativa 1 MAX	Regular	MCO	Law 95 Commercial
04	80	412	Alternativa 2 FIT	Regular	MCO	Law 95 Commercial
04	82	400	Coverage 400 (ELA)		MCO	Law 95 - ELA-Puro (Cubierta ASES)
04	82	403	Bronce	Regular	MCO	
04	82	404	Alternativa 1 Premium ELA RUBI	Regular	MCO	Law 95 Commercial
04	82	405	Diamante	Regular	MCO	
04	82	406	Complementaria de Medicare	Regular	MCO	
04	82	407	Alternativa 2 Classic ELA RUBI	Regular	MCO	Law 95 Commercial
04	82	408	Alterno 1	Regular	MCO	

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

Plan Type	Carrier Id	Plan Version	Plan Version Description	Plan_ACT	Plan Version Access	Plan Detail
04	82	409	Alterno 2	Regular	MCO	
04	82	410	Cubierta Mandatoria ORO		MCO	Law 95 Commercial
06	82	400	Coverage 400 (ELA)	Regular	HMO	
09	82	400	Coverage 400 (ELA)	Retired Policemen	HMO	
05	87	501	Oro	Regular	HMO	
05	87	502	Plata	Regular	HMO	
05	87	503	Bronce	Regular	PPO	
05	87	504	Rubi	Regular	HMO	
05	87	505	ELA Royal	Auto-Enrollment	HMO	
05	87	506	ELA Óptimo	Auto-Enrollment	HMO	
05	87	507	ELA Royal Plus	Auto-Enrollment	HMO	
05	87	508	ELA Titán	Auto-Enrollment	HMO	
05	87	509	ELA Óptimo Plus	Auto-Enrollment	HMO	
05	87	510	ELA Royal Max			
05	88	501	MMM ELA Advantage	Regular	PPO	
05	88	502	Plata	Regular	PPO	
05	88	503	Bronce	Regular	PPO	
05	88	504	Rubi	Regular	PPO	
05	88	505	Premium	Auto-Enrollment	PPO	
05	88	506	Premium 2	Auto-Enrollment	PPO	
05	88	507	Plus	Auto-Enrollment	PPO	
06	91	400	Coverage 400 (ELA)	Regular	MCO	Law 95 - ELA-Puro (Cubierta ASES)
09	91	400	Coverage 400 (ELA)	Retired Policemen	HMO	
04	92	401	Cubierta Mandatoria		MCO	Law 95 Commercial
04	92	402	Plata		MCO	Law 95 Commercial
04	92	403	Rubí		MCO	Law 95 Commercial

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VII – CAPITATION TYPE LIST

Cap type code	Cap type description
01	Admin
02	Dental
03	DME
04	Emergency Room
05	Extended Hours Services
06	Glasses and Contact Lenses
07	Home Health Care
08	Hospital
09	Lab/Medical Imaging
10	Medical Transportation
11	Mental Health
12	Mental Health Facility
13	Occupational/Physical/Speech Therapy
14	On Call Services
15	Pharmacy
16	Preventative
17	Primary Care Physician
18	Primary Medical Group
19	Prosthetics and Orthotics
20	RAF
21	Specialist
22	Other

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VIII - HOUR CODES

CODE	Description
Codes included in this table are designed for completeness of fields that require providing the hour using a two-digit code, based on 24-hour clock.	
01	1:00 a.m.
02	2:00 a.m.
03	3:00 a.m.
04	4:00 a.m.
05	5:00 a.m.
06	6:00 a.m.
07	7:00 a.m.
08	8:00 a.m.
09	9:00 a.m.
10	10:00 a.m.
11	11:00 a.m.
12	12:00 noon
13	1:00 p.m.
14	2:00 p.m.
15	3:00 p.m.
16	4:00 p.m.
17	5:00 p.m.
18	6:00 p.m.
19	7:00 p.m.
20	8:00 p.m.
21	9:00 p.m.
22	10:00 p.m.
23	11:00 p.m.
00	12:00 a.m.

ATTACHMENT IX - SUBMISSION CLARIFICATION CODES

CODE	Description
03	Vacation Supply: The pharmacist is indicating that the cardholder has requested a vacation supply of the medicine
04	Lost/Damaged Prescription: The pharmacist is indicating that the cardholder has requested a replacement of medication that has been damaged or lost
05	Therapy Change: The pharmacist is indicating that the physician has determined that a change in therapy was required; either the medication was used faster than expected or a different dosage form is needed
06	Starter Dose: The pharmacist is indicating that the previous medication was a starter dose and now additional medication is needed to continue treatment
07	Medically Necessary: The pharmacist is indicating that this medication has been determined by the physician to be medically necessary
08	Process compound for approved ingredients
12	DME Replacement Indicator: Indicator that this certification is for a DME item replacing a previously purchased DME item
13	Payer-Recognized Emergency/Disaster Assistance Request: The pharmacist is indicating that an override is needed based on an emergency/disaster situation recognized by the payer
19	Split Billing: Indicates that the quantity dispensed is the remainder billed to a subsequent payer when Medicare Part A no longer applies. Used only in long-term care settings
20	340B: Indicates that, prior to providing service, the pharmacy has determined that the product being billed is purchased pursuant to rights available under Section 340B of the Public Health Act of 1992 including sub-ceiling purchases authorized by Section 340B (a)(10) and those made through the Prime Vendor Program (Section 340B(a)(8))
21	LTC Dispensing: 14 days or less not applicable. CMS exclusion and/or manufacturer packaging may not be broken or special dispensing methodology (i.e., vacation supply, leave of absence, e-box, splitter dose). Medication quantities are dispensed as billed
22	LTC Dispensing: 7 days – Pharmacy dispenses medication in 7 day supplies
23	LTC Dispensing: 4 days – Pharmacy dispenses medication in 4 day supplies
24	LTC Dispensing: 3 days – Pharmacy dispenses medication in 3 day supplies
25	LTC Dispensing: 2 days – Pharmacy dispenses medication in 2 day supplies
26	LTC Dispensing: 1 day – Pharmacy or remote (multiple shifts) dispenses medication in 1 day supplies
34	LTC Dispensing: 14 days – Pharmacy dispenses in 14 day supplies
35	LTC Dispensing: 8-14 day dispensing not listed above – 8-14 day dispensing cycle not otherwise represented
36	LTC Dispensing: Dispensed outside of short-cycle – Medicare Part D coverage was determined post-dispensing
99	Other

ADDENDUM 8

EFT Folder Organization
Insurance Carrier

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 0 0 0 0 2

NÚMERO DE CONTRATO

GOVERNMENT OF PUERTO RICO
PUERTO RICO HEALTH INSURANCE ADMINISTRATION
ASES

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 00002

NÚMERO DE CONTRATO

Puerto Rico Medicaid Enterprise - Health Insurance Plans

ASES Enterprise File Transfer (EFT) Folder Organization Insurance Carrier

Version 1.1
Effective May 01, 2023

Table of Contents

Table of Contents 2

Document Information 3

Revision History 4

Preface 5

ASES EFT Location 6

Reporting Guidelines Folder 7

Folder Organization 7

Folder Categories 7

Container Folders 7

Data Exchange Folders 7

"General Use" Folder 8

"Benefit Enrollment and Maintenance" Folder 8

"Premium Payment" Folder 8

Encounter Data Folder 9

Reporting Package Folders 10

Other Guidelines 12

Document Information

Required Information	Description
Owner:	ASES
Date:	03/16/2023

Revision History

Version	Date	Description of Change
1.0	10/01/2022	Initial Folder Structure
1.1	03/16/2023	Criteria to consider for law 95

Preface

The purpose of this document is to describe how the folders are organized in the ASES Enterprise File Transfer (EFT) solution for the Data Exchange between ASES and the Insurance Carriers.

ASES EFT solution is also known as *"ASES Secure FTP"* and it's currently contracted with CITRIX which uses a secure FTP protocol.

ASES EFT Location

The location for the ASES EFT solution (ASES Secure FTP) is in the following URL:

https://asessecurevdr.sharefile.com/

Reporting Guidelines Folder

ASES publishes all reporting and data exchange guidelines in the following folder:

Reporting_Guidelines

Folder Organization

Here are how the files are organized for Insurance Carriers.

Folder Categories

Container Folders

[Environment Root Folder]

This is the primary access for the Data Exchange for a specific environment.

[Environment Root Folder] can be one of the following:

Production: ASES_FTP
Test: ASES_FTP_TEST

[Insurance Carrier Root Folder]

This is the Root Folder for an Insurance Carrier within the environment [Insurance Carrier Root Folder] will be replaced with the corresponding FTP_CarrierName assigned to the Insurance Carrier.

Regular Folder

This Folder contains files for ad-hoc for manual business processes.

Automated Processing Folder

This Folder contains files for automated business processes.

Data Exchange Folders

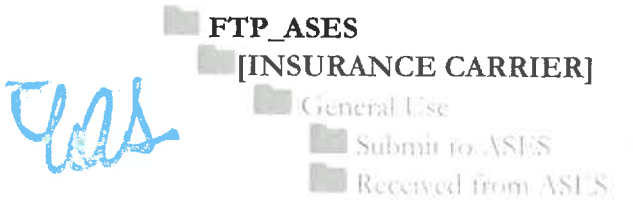
Within container folders there are Data Exchange Folders that identify the direction of the information been shared

Received From ASES:
These folders contain all data exchange the Insurance Carrier **receives from ASES**.

Received From ASES:
These folders contain all data exchange the Insurance Carrier **submits from ASES**.

"General Use" Folder

This folder is used for manual sharing of information that is not automated in any of the other folders. The "General Use" folder is located under the following path:

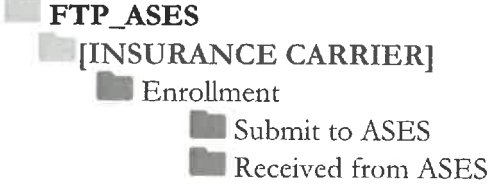


"Benefit Enrollment and Maintenance" Folder

This folder is used for sharing data associated with the Benefit Enrollment and Maintenance business processes.

- Received From ASES:
  - Enrollment Export Files (.EXP, .CNCL, .ALL)
- Submit to ASES:
  - Enrollment Effectuation Files (.SUS)
  - FAM95/MEM95
  - Coordination of Benefits (.COB)

The "Benefit Enrollment and Maintenance Folder" folder is located under the following path:



"Premium Payment" Folder

This folder is used for sharing data associated with the Premium Payment business processes.

- Received From ASES:
  - 820 Files
- Submit to ASES:
  - OTP Files

The "Benefit Enrollment and Maintenance Folder" folder is located under the following path:

FTP_ASES
[INSURANCE CARRIER]
Premium Payment
Submit to ASES
Received from ASES

Encounter Data Folder

FTP_ASES
[INSURANCE CARRIER]
Encounter Data (Report 12)
CLM
Submit to ASES
Received from ASES
CAP
Submit to ASES
Received from ASES
PRV
Submit to ASES
Received from ASES
NET
Submit to ASES
Received from ASES
IPA
Submit to ASES
Received from ASES

Reporting Package Folders

This folder is used for sharing information associated with the Reporting Package business processes as it is stated in the Reporting Guide.

An Example for the Compliance business process data exchange is as follows:

- **FTP_ASES**
  - **[INSURANCE CARRIER]**
    - **Reporting_Package**
      - Compliance
        - 1-Weekly
          - Submit to ASES
          - Received from ASES
        - 1.5-Bi-Weekly
          - Submit to ASES
          - Received from ASES
        - 2-Monthly
          - Submit to ASES
          - Received from ASES
        - 3-Quarterly
          - Submit to ASES
          - Received from ASES
        - 4-Semi annually
          - Submit to ASES
          - Received from ASES
        - 5-Annually
          - Submit to ASES
          - Received from ASES
        - 6-Ad Hoc
          - Submit to ASES
          - Received from ASES

The other Reporting Packages business processes share the same structure:

- **FTP_ASES**
  - **[INSURANCE CARRIER]**
    - **Reporting_Package**
      - Customer Service
        - [Note: Contents same as Compliance]
      - Finance
        - [Note: Contents same as Compliance]
      - Legal
        - [Note: Contents same as Compliance]
      - Clinical Operations Area
        - [Note: Contents same as Compliance]
      - Systems
        - [Note: Contents same as Compliance]
      - Program Integrity
        - [Note: Contents same as Compliance]

All contents for the *"Reporting_Package"* folders, are explained in the following guides shared by ASES:

- Plan Vital Reporting Guide
- Medicare Platino Reporting Guide
- Law 95 Reporting Guide

Example for Insurance Carrier submission (MCOs/MAOs):

Quarterly submission for report 03 "Fraud, Waste and Abuse": RP_13_03_2022030.xml. (Production Environment)

Example of Use Starting December 01, 2022

- **FTP_ASES**
  - **FTP_CARRIER_NAME**
    - **Reporting_Package**
      - Compliance
        - 3-Quarterly
          - Submit to ASES
            - *RP_13_03_2022030.xml*

Some Insurance Carriers used a different folder organization in the past. Please note that this will no longer be supported:

Example of Use Before December 01, 2022
Directorio para Reportes CARRIER_NAME Compliance 3-Quarterly *RP_13_03_2022030.xml*

Other Guidelines

- No Entity other than ASES should create folders or subfolders without the written authorization of ASES, as they will be deleted without prior notice and files placed in a folder not authorized by ASES will not be considered received.

- For Test environments the folder structure will be the same as the Production Environment, except that the root folder will be as follows:
  - For QA Tests the root folder is:
    - FTP_ASES_TEST
  - For other required tests that are used in parallel, a specific structure can be created using a number after the word TEST, this environment will be created on demand. Example of root folders:
    - FTP_ASES_TEST01
    - FTP_ASES_TEST02

ADDENDUM 9

Electronic Data Interchange (EDI) Process

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 0 0 0 0 2

NÚMERO DE CONTRATO

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 00002

NÚMERO DE CONTRATO

Puerto Rico Medicaid Management Information System (PRMMIS)

Electronic Data Interchange (EDI) Process

DEPARTAMENTO DE SALUD

GOBIERNO DE PUERTO RICO

EDI Responsabilities

- Ensures that incoming and outgoing transactions are in compliance with Health Insurance Portability and Accountability Act (HIPAA) standards
- Provides connectivity support to external entities by providing the necessary protocol required to transmit files (such as claims) electronically
- Provides support for trading partners via EDI Helpdesk (by phone and by email) and researches issues related to EDI transmissions as they arise
- Tracks incoming and outgoing referrals for assistance with EDI problems, using the Call Center Management System (CCMS) interface

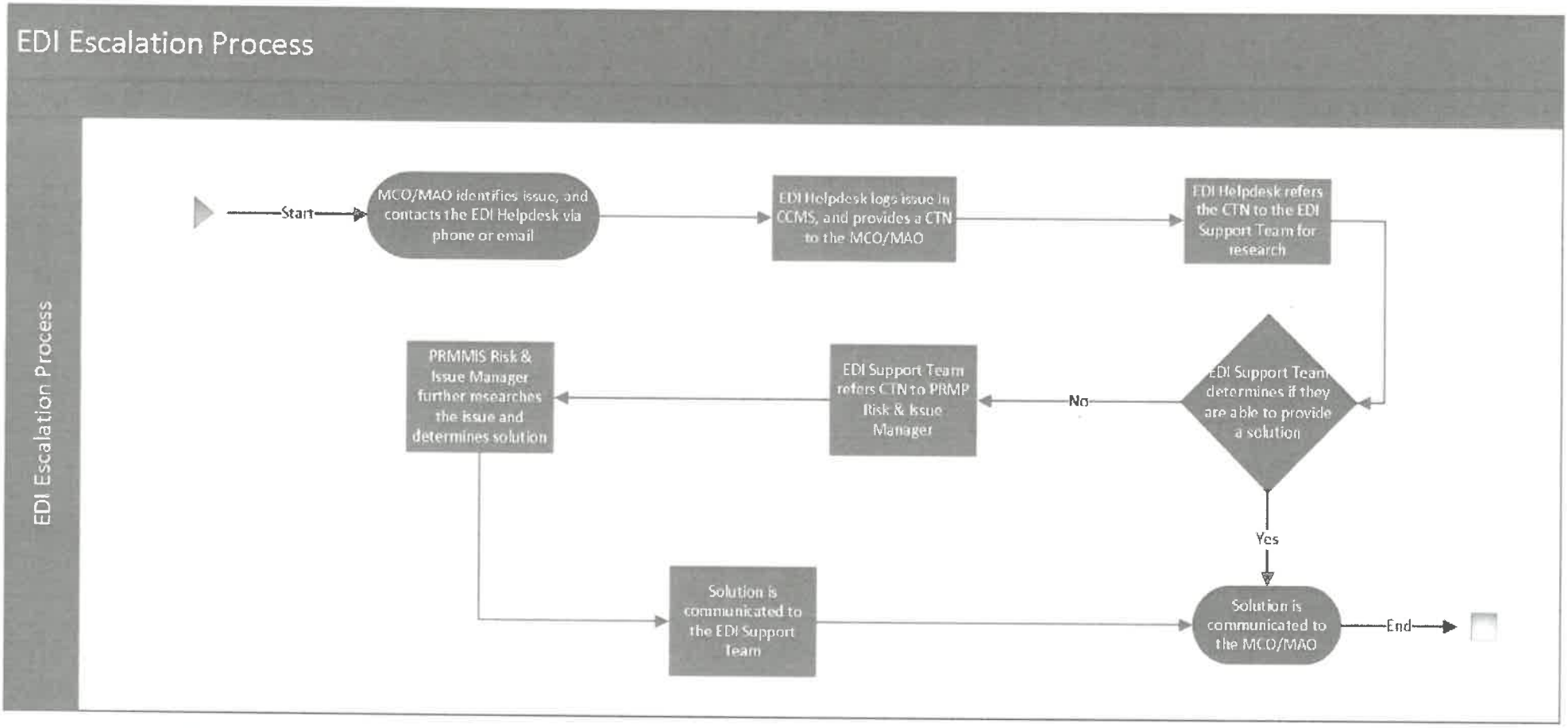
DEPARTAMENTO DE SALUD

EDI Help Desk

- Answers calls received via phone and respond to EDI related emails
- Provides technical assistance to users who are experiencing transmission difficulties, related documents and requests
- Assists MCO/MAO's with electronic 5010 X12 HIPAA batches and real-time transactions
- Verifies receipt of electronic transmissions
- Escalate PRMMIS and E&E (Eligibility & Enrollment) related issues
- Account support (password reset & login fail)

DEPARTAMENTO DE SALUD

EDI Escalation Process



DEPARTAMENTO DE SALUD

EDI Contact Information

- Via Phone: (833) 209-8326
- Via Email: prmmis_edi_support@gainwelltechnologies.com
- EDI Operation hours: 8:00am – 5:00pm M-F

DEPARTAMENTO DE SALUD

ADDENDUM 10

Query and Response file
270 & 271 Companion Guide

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 0 0 0 0 2

NÚMERO DE CONTRATO

Puerto Rico Medicaid Management Information System Services (PRMMIS)

HIPAA Transaction Standard Companion Guide

Refers to the Technical Report Type 3 (TR3) Implementation Guides Based on ASC X12 Version 005010X279A1

270/271 Eligibility & Benefit Inquiry and Response

Companion Guide Version Number: 1.3

August 2023

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 00002

NÚMERO DE CONTRATO

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The communications/connectivity component is included in the Companion Guide when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The transaction instruction component is included in the Companion Guide when the publishing entity wants to clarify the implementation guide instructions for submission of specific electronic transactions. The transaction instruction component content is limited by ASC X12's copyrights and Fair Use statement.





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Preface

This Companion Guide to the v5010 ASC X12N Technical Report Type 3 (TR3) adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) clarifies and specifies the data content when exchanging transactions electronically with PRMMIS. Transmissions based on this Companion Guide, used in tandem with the TR3, also called the 270/271 Health Care Eligibility and Benefit Inquiry and Response (270/271) ASC X12N (version 005010X279A1), are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N TR3 adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

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Table of Contents

1 INTRODUCTION 7

1.1 Scope 8
1.2 Overview 8
1.3 References 9
1.4 Additional Information 9
1.5 National Provider Identifier 9
1.6 Acceptable Characters 10
1.7 Acknowledgements 10

2 GETTING STARTED 10

2.1 Working with PRMMIS 10

3 CONNECTIVITY WITH PRMMIS / COMMUNICATIONS 10

3.1 Batch Eligibility Benefit Inquiry and Response 10
3.2 Transmission Administrative Procedures 11
3.3 Re-transmission Procedure 12
3.4 Communication Protocol Specifications 12
3.5 Passwords 12

4 CONTACT INFORMATION 12

4.1 Electronic Data Interchange Helpdesk 12
4.2 Electronic Data Interchange Technical Assistance 12
4.3 Trading Partner ID 13
4.4 Applicable Web Sites 13

5 CONTROL SEGMENTS / ENVELOPES 15

5.1 ISA-IEA 15
5.2 GS-GE 16
5.3 ST-SE 17
5.4 File Delimiters 18

6 PRMMIS-SPECIFIC BUSINESS RULES AND LIMITATIONS 18

6.1 Terminology 18
6.2 Member Limit 18
6.3 271 Interpretation Guidelines 19
6.4 Notes on 270 Search Hierarchy 19
6.5 270 Request 20
6.6 271 Response 20
6.7 File Naming Convention 21

6.8 Scheduled Maintenance 21

7 ACKNOWLEDGEMENTS AND/OR REPORTS 22

7.1 TA1 — Transaction Acknowledgement 22
7.2 999 — Functional Acknowledgement 22
7.3 Report Inventory 22

8 TRANSACTION-SPECIFIC INFORMATION 22

8.1 005010X279A1 — 270 Health Care Eligibility Benefit Inquiry 22
8.2 005010X279A1 — 271 Health Care Eligibility Benefit Response 26

APPENDICES 30

1. Implementation Checklist 30
2. Business Scenarios 30
3. Transmission Examples 32
4. Frequently Asked Questions 38
5. Change Summary 39

1 INTRODUCTION

This section describes how TR3, also called 270/271 ASC X12N (version 005010X279A1), adopted under HIPAA, will be detailed with the use of a table. The tables contain a Notes/Comments column for each segment that PRMMIS has information additional to the TR3. That information can:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the implementation guide's internal code listings.
4. Clarify the use of loops, segments, composite, and simple data elements.
5. Provide any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with PRMMIS.

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

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set Companion Guides. The table contains a Notes/Comments column to provide additional information from PRMMIS for specific segments provided by the TR3. The following is just an example of the type of information that would be spelled out or elaborated on in Section 9: Transaction Specific Information.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10 percent and notes or comments about the segment itself go in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by PRMMIS.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 Scope

This Companion Guide is intended for trading partner use in conjunction with the TR3 HIPAA 5010 270/271 (referred to as Eligibility and Benefit in the rest of this document) for the purpose of submitting eligibility and benefit inquiries electronically. This Companion Guide is not intended to replace the TR3. The TR3s define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of this Companion Guide is to provide trading partners with a guide to communicate PRMMIS-specific information required to successfully exchange transactions electronically with PRMMIS interChange. The instructions in this Companion Guide are not intended to be stand-alone requirements documents. This Companion Guide conforms to all the requirements of any associated ASC X12 Implementation Guide and is in conformance with ASC X12's Fair Use and Copyright statements.

The information contained in this Companion Guide applies to PRMMIS, which includes the following programs: TXIX or CHIP or CWLTH and Medicaid managed care programs. All of these programs use PRMMIS interChange for processing.

PRMMIS interChange will accept and process any HIPAA-compliant transaction; however, a compliant transaction that does not contain PRMMIS-specific information, though processed, may be denied. For example, a compliant 270 inquiry (270) created with an invalid PRMMIS member identification number will be processed by PRMMIS but will be denied.

Refer to this Companion Guide first if there is a question about how PRMMIS processes a HIPAA transaction. For further information, contact the PRMMIS Electronic Data Interchange (EDI) Department at (833) 209-8326. This guide is intended as a resource to assist carriers with PRMMIS interChange in successfully conducting EDI of administrative health care transactions. This document provides instructions for enrolling as a PRMMIS interChange carrier, obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information. This document does not provide detailed data specifications, which are published separately by the industry committees responsible for their creation and maintenance.

1.2 Overview

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

The HIPAA requirements serve to:
Create better access to health insurance.
Limit fraud and abuse.
Reduce administrative costs.

This guide is designed to help those responsible for testing and setting up electronic eligibility transactions. Specifically, it documents and clarifies when situational data elements and segments must be used for reporting and identifies codes and data elements that do not apply to PRMMIS interChange. This guide supplements (but does not contradict) requirements in the ASC X12N 270/271 (version 005010X279A1) implementation. This information should be given to the carrier's business area to ensure that eligibility responses are interpreted correctly. This guide provides communications-related information a trading partner needs to enroll as a trading partner, obtain support, format the interchange control header (ISA) and functional group header (GS) envelopes, and exchange test and production transactions with PRMMIS interChange.

This Companion Guide must be used in conjunction with the TR3 instructions. The Companion Guide is intended to assist trading partners in implementing electronic 270/271 transactions that meet PRMMIS interChange processing standards by identifying pertinent structural and data-related requirements and recommendations. Updates to this Companion Guide will occur periodically and new documents will be posted on PRMMIS LMS Puerto Rico LMS - Home.

1.3 References

For more information regarding the ASC X12 Standards for Electronic Data Interchange 270/271 Health Care Eligibility and Benefit Inquiry and Response (version 005010X279A1) and to purchase copies of the TR3 documents, consult the Washington Publishing Company Web site at *www.wpc-edi.com/*.

The implementation guide specifies in detail the required formats for transactions exchanged electronically with an insurance company, health care payer, or government agency. The implementation guide contains requirements for the use of specific segments and specific data elements within those segments and applies to all health care providers and their trading partners. It is critical that the provider's information technology (IT) staff or software vendor review this document in its entirety and follow the stated requirements to exchange HIPAA-compliant files with PRMMIS interChange.

1.4 Additional Information

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

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

1.5 National Provider Identifier

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

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

PRMMIS has determined that all providers, except for personal care only providers, specialized medical vehicle providers, and blood banks, are health care providers (per the definitions within the NPI Final Rule) and, therefore, are required to obtain and use an NPI. PRMMIS requires all health care providers to submit their NPI on electronic transactions.

1.6 Acceptable Characters

The HIPAA transactions must not contain any carriage returns nor line feeds; the data must be received in one, continuous stream. PRMMIS accepts the extended character set. Uppercase characters are recommended.

1.7 Acknowledgements

An accepted 999 Implementation Acknowledgement, rejected 999 Implementation Acknowledgement (with HTML file), or rejected TA1 InterChange Acknowledgement will be generated in response to all submitted files. Trading partners are responsible for retrieving acknowledgments from the PRMMIS Portal to determine the status of their files.

2 GETTING STARTED

2.1 Working with PRMMIS

This section describes how to interact with PRMMIS's EDI Department.

Before PRMMIS can process transactions, the submitter is required to obtain a trading partner ID, create a Portal user account, and complete Production Authorization testing. Additional information is provided in the next section of this Companion Guide. Trading partners should exchange electronic health care transactions with PRMMIS interChange via MoveIT. Each trading partner must successfully complete testing. Upon successful completion of testing, production transactions may be exchanged.

Reminder: Testers are responsible for the preservation, privacy, and security of data in their possession. While using production data that contains personal health information (PHI) to conduct testing, the data must be guarded and disposed of appropriately.

3 CONNECTIVITY WITH PRMMIS / COMMUNICATIONS

This section describes the process to interactively submit HIPAA 270 transactions, along with various submission methods, security requirements, and exception handling procedures.

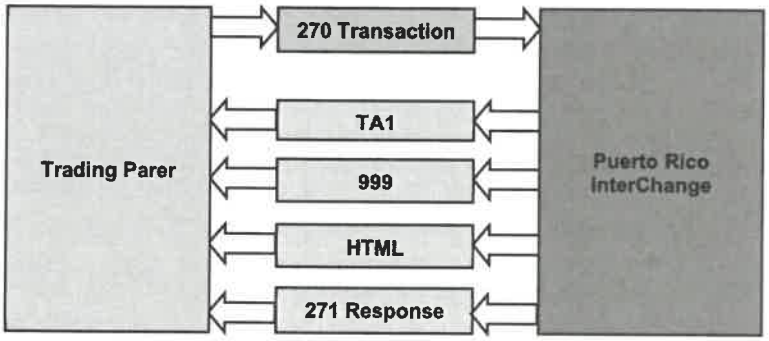
3.1 Batch Eligibility Benefit Inquiry and Response

The response to a batch eligibility transaction will consist of the following:

- First-level response — TA1 will be generated when errors occur within the outer envelope (no 999 or 271 will be generated).
- Second-level response — 999 will be generated — "Rejected" 999 (AK901 = R) when errors occur during 270 compliance validation (no 271 will be generated) or "Accepted" 999 (AK901 = A) if no errors are detected during the compliance validation.
- Third-level response — 271 will be generated indicating either the eligibility and benefits **or** AAA errors within request validation.

Each transaction is validated to ensure that the 270 complies with the 005010X279A1 TR3.

Transactions that fail this compliance check will generate a "Rejected" 999 file back to the sender with an error message indicating the compliance error (AK901 = R). Transactions that pass this compliance check will generate an "Accepted" 999 (AK901 = A) file back to the sender with AK9*A to indicate that the file passed compliance. Transactions with multiple ST/SE loops that fail this compliance check in some of the ST/SE loops will generate a "Partial" 999 (AK901 = P) file back to the sender with an error message indicating the compliance error (all inquiries in the ST/SE envelopes that pass compliance will be processed and a 271 will be generated without the ST/SE loop(s) that failed compliance). Files that have a compliance error will generate a proprietary HTML file that identifies the compliance error in a "human" readable format. Transactions that pass compliance checks, but failed to process (e.g., due to member not being found) will generate a 271 response transaction, including an AAA segment indicating the nature of the error. Transactions that pass compliance checks and have not failed to process (e.g., the member was found with enrollment within the requested dates) do not generate AAA segments but will create a 271 using the information in our eligibility and benefit system.



3.2 Transmission Administrative Procedures

This section provides PRMMIS's specific transmission administrative procedures.

The trading partner must determine if the transmission being sent is Test or Production and is using the appropriate indicator. For details about available PRMMIS Access Methods, refer to the Communication Protocol Specifications section.

PRMMIS is available only to authorized users. Submitters must be PRMMIS trading partners. A submitter is authenticated using a username and password assigned by the trading partner.

3.3 Re-transmission Procedure

This section provides PRMMIS's specific procedures for re-transmissions.

The instructions within the 271 AAA data segment provide information on whether resubmission is allowed or what data corrections need to be made in order for a successful response.

In the event of an interrupted communications session, the trading partner only has to reconnect and initiate the file transfer as he or she normally does.

If a file fails compliance, errors must be corrected before re-transmission. Because PRMMIS does not allow duplicate files, before resubmiting a file it is required that a new file name, Interchange Group (ISA), and Transaction Control Numbers be changed.

3.4 Communication Protocol Specifications

This section describes PRMMIS's communication protocol(s).

The communication method currently available to get a member's Eligibility and Benefits from PRMMIS is MoveIT (SFTP) – see "MoveIT/SFTP guide" & "How to use MoveIt Guide" posted on PRMMIS LMS Puerto Rico LMS - Home.

3.5 Passwords

This section describes PRMMIS's use of passwords.

The Portal password must be reset every 60 days. The passwords are maintained by the external user. If a general user needs a password reset, he or she must contact the EDI Helpdesk at (833) 209-8326.

Reminder: Strong security precautions should be taken with passwords. For example, password complexity should be used. Passwords must not be shared or written down where persons other than the authorized party can access them.

4 CONTACT INFORMATION

If the trading partner has questions beyond what is explained in this Companion Guide, refer to the contact information below to reach the appropriate PRMMIS support area.

4.1 Electronic Data Interchange Helpdesk

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

For questions related to PRMMIS's Eligibility and Benefits Request and Response, contact the EDI Helpdesk at (833) 209-8326.

4.2 Electronic Data Interchange Technical Assistance

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

Electronic Data Interchange Customer Service can help with connectivity issues or transaction formatting issues at (833) 209-8326 (Monday – Friday, 8:30 a.m. – 4:30 p.m. Central Standard Time (CST).

4.3 Trading Partner ID

The assigned trading partner ID is PRMMIS's key to accessing a provider's trading partner information. Have this number available each time the EDI Helpdesk is contacted.

4.4 Applicable Web Sites

This section contains detailed information about useful Web sites and e-mail addresses.

Additional information is available on the following Web sites:

Accredited Standards Committee (ASC X12) develops and maintains standards for inter-industry electronic interchange of business transactions: *www.x12.org/*.

Accredited Standards Committee (ASC X12N) develops and maintains X12 EDI and XML standards, standards interpretations, and guidelines as they relate to all aspects of insurance and insurance-related business processes: *www.x12.org/*.

American Hospital Association (AHA) Central Office on *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) is a resource for the ICD-9-CM codes used in medical transcription and billing, and for Level I Healthcare Common Procedure Coding System (HCPCS) procedure codes: *www.ahacentraloffice.org/*.

American Medical Association (AMA) is a resource for the *Current Procedural Terminology* (CPT) procedure codes. The AMA copyrights the CPT codes: *www.ama-assn.org/*.

- Centers for Medicare & Medicaid Services (CMS) is the unit within HHS that administers the Medicare and Medicaid programs. The CMS provides the Electronic Health-Care Transactions and Code Sets Model Compliance Plan at *www.cms.hhs.gov/HIPAAGenInfo/*.
- The CMS is the resource for information related to HCPCS procedure codes: *www.cms.hhs.gov/HCPCSReleaseCodeSets/*.
- The CMS is the resource for Medicaid HIPAA information related to the Administrative Simplification provision: *www.cms.gov/medicaid/hipaa/adminsim/*.
- The CORE is a multi-phase initiative of CAQH; CORE is a committee of more than 100 industry leaders who help create and promulgate a set of voluntary business rules focused on improving physician and hospital access to electronic patient insurance information at or before the time of care: *www.caqh.org/CORE_overview.php/*.
- The CAQH is a nonprofit alliance of health plans and trade associations, working to simplify health care administration through industry collaboration on public-private initiatives. Through two initiatives — the CORE and Universal Provider Datasource (UPD); CAQH aims to reduce administrative burden for providers and health plans: *www.caqh.org/*.
- Designated Standard Maintenance Organizations (DSMO) is a resource for information about the standard-setting organizations and transaction change request system: *www.hipaa-dsmo.org/*.

- Healthcare Information and Management Systems (HIMSS) is an organization exclusively focused on providing global leadership for the optimal use of IT and management systems for the betterment of health care: *www.himss.org/*.
- Medicaid HIPAA-Compliant Concept Model (MHCCM) presents the Medicaid HIPAA Compliance Concept Model, information, and a toolkit: *www.mhccm.org/*.
- National Committee on Vital and Health Statistics (NCVHS) was established by Congress to serve as an advisory body to the HHS on health data, statistics, and national health information policy: *www.ncvhs.hhs.gov/*.
- National Council of Prescription Drug Programs (NCPDP) is the standards and codes development organization for pharmacy: *www.ncpdp.org/*.
- National Uniform Billing Committee (NUBC) is affiliated with the AHA and develops standards for institutional claims: *www.nubc.org/*.
- National Uniform Claim Committee (NUCC) is affiliated with the AMA. It develops and maintains a standardized data set for use by the non-institutional health care organizations to transmit claims and encounter information. The NUCC maintains the national provider taxonomy: *www.nucc.org/*.
- Office for Civil Rights (OCR) is the office within the HHS responsible for enforcing the Privacy Rule under HIPAA: *www.hhs.gov/ocr/hipaa/*.
- The federal HHS is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA: *www.aspe.hhs.gov/admnsimp/*.
- Washington Publishing Company (WPC) is a resource for HIPAA-required transaction implementation guides and code sets: *http://www.wpc-edi.com/*.
- Workgroup for Electronic Data Interchange (WEDI) is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA: *www.wedi.org/*.
- The registry for the NPI is the National Plan and Provider Enumeration System (NPPES): *https://nppes.cms.hhs.gov/NPPES/Welcome.do*.
- Other resources pertaining to the NPI: *www.cms.hhs.gov/NationalProvIdentStand/*.
- Implementation guides and non-medical code sets: *store.x12.org/*.
- The HIPAA statute, Final Rules, and related Notices of Proposed Rulemaking (NPRMS): *www.cms.hhs.gov/HIPAAGenInfo/* or *aspe.hhs.gov/datacncl/adminsim.shtml*.
- Information from CMS about ICD-9 and ICD-10 codes: *www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage* or *https://www.cms.gov/ICD10/*.
- Quarterly updates to the HCPCS code set are available from CMS: *www.cms.hhs.gov/HCPCSReleaseCodeSets/*. (CPT-4, or Level 1 HCPCS, is maintained and licensed by the AMA and is available for purchase in various hardcopy and softcopy formats from of variety of vendors.)

- Information at the federal level about Medicaid can be found at www.cms.hhs.gov/home/medicaid.asp.
- The CMS online manuals system and Internet-only manuals (IOM) system, including Transmittals and Program Memoranda, at www.cms.hhs.gov/Manuals/.
- Place of service codes are listed in the Medicare Claims Processing Manual and are maintained by the CMS at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf.

5 CONTROL SEGMENTS / ENVELOPES

5.1 ISA-IEA

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

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

- The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled in with spaces.
- Each trading partner is assigned a six-digit trading partner ID.
- All dates are in the CCYYMMDD format.
- All dates/times are in the CCYYMMDDHHMM format.
- Batch responses are not returned until all inquiries are processed. Limiting the number of total inquiries per ISA-IEA will produce faster results.
- Each Payer ID must be in its own file.
- No more than 99 inquiries per Transaction Set (ST-SE).
- Utilize BHT Segment for Transaction Set Inquiry Response association.
- Utilize TRN Segments for Subscriber Inquiry Response association.
- Only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Transactions transmitted as a batch are identified by an ISA and trailer segment (IEA), which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
C.3	None	ISA	Interchange Control Header		
C.4		ISA01	Authorization Information Qualifier	00	Use "00" to indicate no Authorization Information Present.
C.4		ISA02	Authorization Information		Leave blank
C.4		ISA03	Security Information Qualifier	00	Use "00" to indicate no Security Information Present.
C.4		ISA04	Security Information		Leave blank
C.4		ISA05	Interchange ID (Sender) Qualifier	ZZ	Enter the value "ZZ
C.5		ISA06	Interchange Sender ID		Enter the six-digit numeric trading partner identification number assigned by PRMMIS interChange.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
C.5		ISA07	Interchange ID (Receiver) Qualifier	ZZ	Enter the value "ZZ'
C.5		ISA08	Interchange Receiver ID		"PRMMIS"
C.5		ISA09	Interchange Date		The date format is YYMMDD.
C.5		ISA10	Interchange Time		The time format is HHMM.
C.5		ISA11	Repetition Separator	^	A Caret "^" is recommended.
C.5		ISA12	Interchange Control Version Number	00501	Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003
C.5		ISA13	Interchange Control Number		The interchange control number assigned in ISA13 must be identical to the value in IEA02.
C.6		ISA14	Acknowledgement Requested	0	0 = Only generate interchange acknowledgment (TA1) if error in envelope.
C.6		ISA15	Usage Identifier	P, T	Code indicating whether the data enclosed is production or test.
			Production Data	P	Enter value "P" to indicate that the file contains production data
			Test Data	T	Enter value "T" to indicate that the file contains test data.
C.6		ISA16	Component Element Separator	:	A colon ":" is recommended.

5.2 GS-GE

This section describes PRMMIS's use of the functional group control segments.

It includes a description of expected application sender and receiver codes.

The table below represents only those fields in which PRMMIS requires a specific value or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction — the TR3 should be reviewed for that information.

Note: Puerto Rico only accepts files with one GS/GE loop per file.

GS – Functional Group Header

This section describes the use of the functional group control segments. It includes a description of expected application sender and receiver codes.

The table below shows the fields that PRMMIS will be sending.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
C.7	None	GS	Functional Group Header		

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
C.7		GS01	Functional ID Code	HS	Eligibility, Coverage or Benefit Information (270).
C.7		GS02	Application Sender's Code		Carrier's Trading Partner ID
C.7		GS03	Application Receiver's Code		"PRMMIS"
C.7		GS04	Date		The date format is CCYYMMDD.
C.8		GS05	Time		The time format is HHMM.
C.8		GS06	Group Control Number		Group Control Number – Must be identical to GE02.
C.8		GS07	Responsible Agency Code	X	"X" Responsible Agency Code
C.8		GS08	Version/ Release/Industry Identifier Code	005010X279A1	Version/ Release/ Industry Identifier Code

GE – Functional Group Trailer

The table below shows the fields that Puerto Rico Medicaid will be sending.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
C.9	None	GE	Functional Group Trailer		
C.9		GE01	Number of Transaction Sets Included		Total number of transaction sets
C.9		GE02	Group Control Number		Must be identical to the value in GS06

5.3 ST-SE

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

PRMMIS recommends that trading partners follow the guidelines set forth in the TR3 — start the first ST02 in the first file with 000000001 and increment from there. The TR3 should be reviewed for how to create compliant transaction set control segments.

ST – Transaction Set Header

The TR3 should be reviewed for specific information.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
70	None	ST	Transaction Set Header		
70		ST01	Transaction Set Identifier Code	270	270 Health Care Benefit & Enrollment Maintenance

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
70		ST02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA).
70		ST03	Implementation Guide Version Name	005010X279A1	This field contains the same value as GS08.

SE – Transaction Set Trailer

The TR3 should be reviewed for specific information.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
496	None	SE	TRANSACTION SET TRAILER		
496		SE01	Transaction Segment Count		Total number of segments included in a transaction set including the ST and SE segments
496		SE02	Transaction Set Control Number		The Transaction Set Control Number in ST02 and SE02 must be identical.

5.4 File Delimiters

PRMMIS requests that you use the following delimiters on your 270 file. If used as delimiters, these characters (* : ~ ^) must not be submitted within the data content of the transaction sets. Contact the EDI Helpdesk at (833) 209-8326 if there is a need to use a delimiter other than the following.

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

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

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

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

6 PRMMIS-SPECIFIC BUSINESS RULES AND LIMITATIONS

6.1 Terminology

The term "subscriber" will be used as a generic term throughout the Companion Guide.

6.2 Member Limit

File Size is restricted to 5,000 member inquiries per 270 transaction file.

6.3 271 Interpretation Guidelines

The following two types of eligibility and benefit information can be returned in a PRMMIS interChange 271 eligibility response:

- Puerto Rico Medicaid Program eligibility.
- Medicare coverage.

It is important that all aspects of a subscriber's eligibility and benefits are considered when reading an eligibility response. The simple fact that a subscriber is eligible in a health program does not always indicate that the health program should be billed for services rendered. If a subscriber has coverage through private insurance, Medicare, or Medicaid managed care, services should be billed accordingly.

All eligibility and benefit information is accompanied by effective dates. It is important that effective dates are considered in combination with the dates of service (DOS) submitted in the inquiry. If eligibility information is requested for a range of dates, it is possible that the subscriber's coverage may vary at times throughout the range of service dates.

Disclaimer: Information provided in a 271 response is not a guarantee of payment or coverage in any specific amount. Actual benefits depend on various factors, including compliance with applicable administrative protocols, Date Of Service rendered, and benefit plan terms and conditions. It is a provider's responsibility to validate whether or not an authorization is required prior to administering the service to the member.

6.4 Notes on 270 Search Hierarchy

1. If a Medicaid ID (MID) is present, a search is made for a match on the member ID. If no member is found, an error is returned and the 270 should be resubmitted with other criteria.

2. If last name, first name and Social Security number (SSN) are present in the 270, a search of the database is made for the name and SSN match. If no member is found or last name, first name, and SSN are not present;

3. If SSN and DOB are present, a search is made for a match on the SSN and DOB. If no member is found, a AAA segment with a value of 75 (Subscriber not found) in AAA03 is returned.

4. If none of the above information is available to try any of the above searches, a AAA segment with a value of 15 (Required application data missing) in AAA03 is returned.

5. All members are enrolled in either the TXIX or CHIP or CWLTH programs. Members are defined as "subscribers." All requests should be submitted at the subscriber level. Any requests submitted at the dependent level that result in an error (Not Found) will be returned at the dependent level. If the member is a *subscriber* in PRMMIS's membership tables but was submitted in the Dependent loop on the 270 request (2100D), the member will be returned in the Subscriber loop on the 271 response (2100C).

6. If the search for a subscriber is successful, the subscriber's identifying information contained in the 271 response will be taken from the applicable eligibility table.
Note: The INS segment is not used by PRMMIS.

7. If the search for a subscriber is unsuccessful, the subscriber's identifying information contained in the incoming 270 will be returned in the 271 response.

6.5 270 Request

No dependent level (Loop 2100D) data should be sent within a 270 Eligibility Inquiry file. All PRMMIS members can be uniquely identified by their subscriber ID number.

If no Date Of Service is sent with the 270 Eligibility Inquiry file, the current date will be used for processing.

PRMMIS does not currently support an explicit service type code (EQ01) other than "30" (Health Benefit Plan Coverage).

PRMMIS interChange does not support 270 requests submitted with multiple EQ segments or repeating of the EQ01 element. If submitted, PRMMIS interChange will process as if EQ01 value of "30" was submitted.

PRMMIS interChange does not support 270 requests submitted with procedure codes or diagnosis pointers (to the HI segment) in the EQ segment. If a procedure code or diagnosis pointer is submitted, PRMMIS interChange will return a 271 response with the "Standard" Service Type (30).

Eligibility requests for a date range will return all plans for the member that are identified by the search criteria submitted. Any plans that had/have coverage during the date range will be returned.

Parameters for requesting past and future eligibility:

- A request can be for any date in the past.
- A date range can be for any 12-month (366-day) period in the past.
- A 271 AAA value of 62 or 63 will be returned if the date range validation fails.

When sending in single date inquiries, if an active plan is not found for the member, a subsequent request with a different date will need to be submitted.

6.6 271 Response

Disclaimer: Information provided in a 271 response is not a guarantee of payment or coverage in any specific amount. Actual benefits depend on various factors, including compliance with applicable administrative protocols, Date Of Service rendered, and benefit plan terms and conditions. It is a provider's responsibility to validate whether or not an authorization is required prior to administering the service to the member.

The 271 response may not be at the same level that was received in the 270 request. All eligibility and benefit responses will be at the subscriber 2100C level.

PRMMIS interChange returns Medicare information, identified by EB01 = "R" (Other or Additional Payor) and EB04 = "MA" or "MB" or "OT". PRMMIS interChange returns the Medicare effective date and the member's Medicare ID.

If the Eligibility check is unsuccessful, PRMMIS interChange will return a 271 response containing a AAA segment noting the reason a match could not be made. If indicated (AAA04 = "C"), correct and resubmit your request.

If the Eligibility check identifies a PRMMIS member who is inactive on the service date requested, PRMMIS will return a 271 response containing EB01 = "6". The 271 response will contain data from the PRMMIS's membership files.

6.7 File Naming Convention

270 Inbound from Carriers

Example:
Submission Date: 06/01/2023
Total Number of members: 9,500 (we recommend limiting each file to 5,000 members)

20230601_ABRV_270_###.dat

Date file was created (**YYYYMMDD format)**
underscore
2 to 4 character abbreviation of Carrier's (MCO/MAO) name
underscore
Type of file – use **270**
underscore
= Sequence number of each file submitted during the day (start with 001 and increment by one)
Use **.dat** or **.txt** for every file

The standards above will avoid accidently overwriting files.
Files submitted with the same name will be rejected as a duplicate.

Example:

20230601_ABRV_270_001.dat	**first 5,000 members**
20230601_ABRV_270_002.dat	**remaining 4,500 members**

271 Outbound to Carriers

SAKID_SAKID_20230601_ABRV_271001.x12

SAKIDs are the Gainwell unique identifiers for this file.

6.8 Scheduled Maintenance

PRMMIS schedules regular maintenance every Sunday from 00:00 a.m. to 04:00 a.m. CST.

7 ACKNOWLEDGEMENTS AND/OR REPORTS

7.1 TA1 — Transaction Acknowledgement

PRMMIS interChange will only respond with a TA1 when the batch X12 contains Envelope errors. If a TA1 is produced then neither a 999 nor 271 response will be sent. The submitted 270 will need to be corrected and resubmitted.

7.2 999 — Functional Acknowledgement

This file informs the submitter that the transaction arrived and provides information about the syntactical quality of the Functional Groups in a batch X12 file. PRMMIS interChange will always respond with a 999 for a batch X12 file. If a "rejected" 999 is produced then the 271 response will not be sent. The submitted 270 will need to be corrected and resubmitted.

7.3 Report Inventory

There are no acknowledgement reports at this time.

8 TRANSACTION-SPECIFIC INFORMATION



This section describes how ASC X12N implementation guides adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that PRMMIS has something additional, over and above, the information in the implementation guides. That information can do the following:

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



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

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set Companion Guides. The table contains a row for each segment that PRMMIS has something additional, over and above, the information in the TR3s.

8.1 005010X279A1 — 270 Health Care Eligibility Benefit Inquiry

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
63	None	BHT	Beginning of Hierarchical Transaction		
63	None	BHT01	Hierarchical Structure Code	0022	Specify the sequence of hierarchical levels that may appear in the transaction set.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
64	None	BHT02	Transaction Set Purpose Code	13	PRMMIS interChange validates only Code 13 (Request).
64	None	BHT04	Transaction Set Creation Date	CCYYMMDD	Date the transaction was created
69	2100A	NM1	Information Source Name		
69	2100A	NM101	Entity Identifier Code	PR	Enter "PR" to indicate payer.
70	2100A	NM102	Entity Type Qualifier	2	Enter "2" to indicate a non-person entity
70	2100A	NM103	Information Source Last or Organization Name	PRMMIS	Enter "PRMMIS"
71	2100A	NM108	Identification Code Qualifier	PI	Enter "PI" to indicate payer identification.
71	2100A	NM109	Information Source Primary Identifier	PRMP	Enter "PRMP"
75	2100B	NM1	Information Receiver Name		
75	2100B	NM101	Entity Identifier Code	P5	Plan Sponsor
75	2100B	NM102	Entity Type Qualifier	2	Enter "2" to indicate a non-person entity
75	2100B	NM103	Information Source Last or Organization Name		Enter Carrier's Name
77	2100B	NM108	Identification Code Qualifier	SV	Service Provider Number
78	2100B	NM109	Information Receiver Identification Number		Enter the Provider Medicaid ID, 9 chars, leading 0's required
79	2100B	REF	Information Receiver Additional ID		Any data submitted in this segment will not be used in processing the inquiry.
81	2100B	N3	Information Receiver Address		Any data submitted in this segment will not be used in processing the inquiry.
82	2100B	N4	Information Receiver Address		Any data submitted in this segment will not be used in processing the inquiry.
84	2100B	PRV	Information Receiver Provider Information		Any data submitted in this segment will not be used in processing the inquiry.
90	2000C	TRN	Subscriber Trace Number		This segment may be used to assign a trace number to a transaction. 271 responses will contain as many TRN segments as were present on the received 270 inquiry as well as an additional segment originated by the information source.
90	2000C	TRN01	Trace Type Code		Enter 1 = Current Transaction Trace Number

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
91	2000C	TRN02	Trace Number		Use this field to assign a unique trace or reference number for this transaction.
91	2000C	TRN03	Trace Assigning Entity Identifier		Use this field for an identification number of the entity that originated the reference identification in TRN02. *Note: The first position must be either a "1" if an EIN is used, a "3" if a DUNS is used or a "9" if a user assigned identifier is used.*
91	2000C	TRN04	Trace Assigning Entity Additional Identifier		Enter your Trading Partner ID with leading zeros
92	2100C	NM1	Subscriber Name		Note: See section 6.6 for rules on search hierarchy.
92	2100C	NM101	Entity Identifier Code	IL	Enter IL = Subscriber
93	2100C	NM102	Entity Type Qualifier	1	Enter 1 = Person
93	2100C	NM103	Subscriber Last Name		Enter the subscriber's last name.
93	2100C	NM104	Subscriber First Name		Enter the subscriber's first name.
95	2100C	NM108	Identification Code Qualifier	MI	MI = Member ID.
96	2100C	NM109	Subscriber Primary Identifier		Enter the subscriber's member ID.
97	2100C	REF	Subscriber Additional Information		Note: See section 6.4 for rules on search hierarchy.
98	2100C	REF01	Reference Identification Qualifier	SY	Enter SY - Social Security number (SSN)
99	2100C	REF02	Subscriber Supplemental Identifier		Enter SSN as qualified by field REF01.
100	2100C	N3	Subscriber Address		Any data submitted in this segment will not be used in processing the inquiry.
101	2100C	N4	Subscriber City, State, ZIP Code		Any data submitted in this segment will not be used in processing the inquiry.
103	2100C	PRV	Provider Information		Any data submitted in this segment will not be used in processing the inquiry.
107	2100C	DMG	Subscriber Demographic Information		The DMG segment should only be used if the subscriber's date of birth (DOB) is to be provided.
108	2100C	DMG01	Date Time Period Format Qualifier	D8	Date Expressed in Format CCYYMMDD
108	2100C	DMG02	Subscriber Birth Date		
110	2100C	INS	Multiple Birth Sequence Number		Any data submitted in this segment will not be used in processing the inquiry.
113	2100C	HI	Subscriber Health Care Diagnosis Code		Any data submitted in this segment will not be used in processing the inquiry.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
122	2100C	DTP	Subscriber Date		The DTP segment can be used to specify a date or range of dates for which eligibility will be verified. If no DTP segment is present, the member's eligibility will be provided for the date the transaction is processed.
123	2100C	DTP01	Date Time Qualifier	291	291 = Eligibility
123	2100C	DTP02	Date Time Period Qualifier	D8 RD8	
			Single Date	D8	
			Range of Dates	RD8	
123	2100C	DTP03	Date Time Period		Enter the date(s) of inquiry for the subscriber's benefits in the format CCYYMMDD or CCYYMMDD-CCYYMMDD.
124	2110C	EQ	Subscriber Eligibility or Benefit Inquiry		
124	2110C	EQ01	Service Type Code	30	PRMP only supports service type code "30" (Health Benefit Plan Coverage).
136	2110C	AMT	Subscriber Spend Down Amount		Any data submitted in this segment will not be used in processing the inquiry.
136	2110C	AMT	Subscriber Spend Down Total Billed Amount		Any data submitted in this segment will not be used in processing the inquiry.
138	2110C	III	Subscriber Eligibility or Benefit Additional Inquiry Information		Any data submitted in this segment will not be used in processing the inquiry.
142	2110C	REF	Subscriber Additional Information		Any data submitted in this segment will not be used in processing the inquiry.
144	2110C	DTP	Subscriber Eligibility / Benefit Date		Any data submitted in this segment will not be used in processing the inquiry.
146	2000D		Dependent Level		Because each subscriber and each of his/her dependents is assigned a unique identification number, dependents are treated as subscribers in the PRMMIS interChange system. Any data submitted at the dependent level will be processed as a subscriber.



8.2 005010X279A1 — 271 Health Care Eligibility Benefit Response

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
211		BHT	Beginning of Hierarchical Transaction		
211	2000A	BHT01	Hierarchical Structure Code	0022	Specify the sequence of hierarchical levels that may appear in the transaction set.
211	2000A	BHT02	Transaction Set Purpose Code	11	PRMMIS interChange returns Code 11 (Response).
211	2000A	BHT03	Submitter Transaction Identifier		The value in this field will be identical to the unique transaction identifier received in the BHT03 field of the 270 inquiry.
215	2000A	AAA	Request Validation		This segment will be used in the response if the PRMMIS interChange eligibility tables are unavailable at the time of processing.
215	2000A	AAA01	Valid Request Indicator	N Y	
			Indicate that the request or an element in the request is not valid.	N	
			request is valid, however the transaction has been rejected as identified by the code in AAA03.	Y	
215	2000A	AAA03	Reject Reason Code	42	This field will contain "42" to indicate that PRMMIS interChange is unable to respond at the current time.
215	2000A	AAA04	Follow-up Action Code	P	This field will contain a "P" to indicate that the inquiry must be resubmitted.
218	2100A	NM1	Information Source Name		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
221	2100A	PER	Information Source Additional Information		This segment will contain PRMMIS helpdesk information.
226	2100A	AAA	Request Validation		This segment will be returned if an error was detected in the 2100A loop of the 270 inquiry.
226	2100A	AAA03	Reject Reason Code	04 41 42 79	This field will contain "79" to indicate that invalid participant identification has been entered in loop 2100A, field NM109 of the 270 inquiry.
			Authorized Quantity Exceeded	04	Transaction exceeds the number of patient requests allowed.
			Authorization/Access Restrictions	41	Entity identified in GS02 is not authorized to submit 270 transactions.
			Unable to Respond at Current Time	42	Entity identified in either ISA08 or GS03 is unable to process the transaction at the current time.
			Invalid Participant Identification	79	Value in either GS02 or GS03 is invalid.
226	2100A	AAA04	Follow-up Action Code	C	This field will contain "C" to indicate that there was a problem with the inquiry. The inquiry must be corrected and resubmitted.
232	2100B	NM1	Information Receiver Name		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
236	2100B	REF	Information Receiver Additional Identification		This segment will not be returned.
E-44	2100B	N3	Information Receiver Address		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
E-45	2100B	N4	Information Receiver City, State, ZIP Code		The values returned to the receiver in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
238	2100B	AAA	Information Receiver Request Validation		This segment will be returned if there was a problem with the 2100B loop, NM1 receiver name segment of the 270 inquiry.
238	2100B	AAA03	Reject Reason Code	41 43 51 79	
			Authorization/Access Restrictions	41	
			Invalid/Missing Provider Identification	43	
			Provider Not on File	51	
			Invalid Participant Identification	79	
238	2100B	AAA04	Follow-up Action Code	C	This field will contain "C" to indicate that there was a problem with the inquiry. The inquiry must be corrected and resubmitted.
241	2100B	PRV	Information Receiver Provider Information		This segment will not be returned.
246	2000C	TRN	Subscriber Trace Number		This segment will be used to return the trace number received in the associated subscriber loop of the inquiry (TRN01 = 2).
246	2000C	TRN	Subscriber Trace Number		This segment will be used to assign a unique PRMMIS interChange trace number (TRN01 = 1).
249	2100C	NM1	Subscriber Name		If the member is found the values returned to the receiver in this segment will be from our membership database. If the member is not found the data in this segment will be identical to the values sent by the information receiver in the 270 inquiry.
253	2100C	REF	Subscriber Additional Identification		The member's SSN will be returned if the member was found in the PRMMIS interChange database.
253	2100C	REF01	Reference Identification Qualifier	SY	"SY" = Social Security Number
253	2100C	REF02	Subscriber Supplemental Identifier		This field will contain SSN.
257	2100C	N3	Subscriber Address		This segment will be used to indicate a subscriber's street address. The address will appear as it is contained in the information source's files, regardless of what is sent in the inquiry.
259	2100C	N4	Subscriber City, State, ZIP Code		This segment will be used to indicate a subscriber's additional address information. The information will appear as it is contained in the information source's files, regardless of what is sent in the inquiry.
262	2100C	AAA	Subscriber Request Validation		This segment will be used to report any errors detected in the associated 2100C loop of the inquiry.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
262	2100C	AAA03	Reject Reason Code	15 42 43 48 51 52 57 58 60 61 62 63 72 73 75 76	
			Required application data missing	15	
			Unable to respond at current time	42	
			Invalid/missing provider identification	43	
			Invalid/missing referring provider identification	48	
			Provider not on file	51	
			Service dates not within provider plan enrollment	52	
			Invalid/missing dates of service	57	
			Invalid date of birth	58	
			Date of birth follows date(s) of service	60	
			Date of death precedes date(s) of service	61	
			Date of service not within allowable inquiry period	62	
			Dates of service not within the same calendar month	63	
			Invalid subscriber ID	72	
			Invalid/missing subscriber name	73	
			Subscriber not found	75	
			Duplicate Subscriber/Insured ID Number	76	
262	2100C	AAA04	Follow-up Action Code	C	This field will contain "C" to indicate that there was a problem with the inquiry. The inquiry must be corrected and resubmitted.
265	2100C	PRV	Provider Information		This segment will not be returned.
268	2100C	DMG	Subscriber Demographic Information		This segment will be used to indicate a subscriber's DOB. If the member is found the DOB will appear as it is contained in the information source's files. If the member is not found and the DMG segment was in the inquiry this segment will contain the information as it was sent in the inquiry.
271	2100C	INS	Subscriber Relationship		This segment will not be returned.
274	2100C	HI	Subscriber Health Care Diagnosis Code		This segment will not be returned.
283	2100C	DTP	Subscriber Date		This segment will contain the requested eligibility date in the format CCYYMMDD.

TR3 Page #	LOOP ID	Reference	NAME	CODES	Notes/Comments
285	2100C	MPI	Subscriber Military Personnel Information		This segment will not be returned.
289	2110C	EB	Subscriber Eligibility or Benefit Information		
291	2110C	EB01	Eligibility or Benefit Information	1 6	PRMMIS interChange returns these codes.
			Active Coverage	1	
			Inactive	6	
292	2110C	EB02	Benefit Coverage Level Code	IND	Health Benefit Plan Coverage
293	2110C	EB03	Service Type Code	30	
298	2110C	EB04	Insurance Type Code	MA MB MC OT	
			Medicare Part A	MA	Indicates Medicare Part A Coverage.
			Medicare Part B	MB	Indicates Medicare Part B Coverage.
			Medicaid	MC	PRMMIS is the coverage being referenced.
			Other	OT	Indicates Medicare Part D (Prescription Drug) Coverage or Other Insurance Coverage.
299	2110C	EB05	Plan Coverage Description		This field will contain the benefit plan name and associated coverage and group codes, separated by pipe delimiter. For example, TXIX|110|MPM
309	2110C	HSD	Health Care Services Delivery		This segment will not be returned.
314	2110C	REF	Subscriber Additional Information		The REF segment will occur at this level of the response in association with Medicare coverage(EB01 = R) to provide the health insurance claim (HIC) number (MBI).
317	2110C	DTP	Subscriber Eligibility/Benefit Date		
317	2110C	DTP01	Date Time Qualifier	307	This field will contain "307" to indicate eligibility.
317	2110C	DTP03	Eligibility or Benefit Date Time Period		This field will contain the date or dates related to the eligibility or benefit information in the 2110C loop.
319	2110C	AAA	Subscriber Request Validation		This segment will not be returned.
322	2110C	MSG	Message Text		Contains the member's municipality code. Format of the message is: "Municipality - 123" where 123 is the code.
324	2110C	III	Subscriber Eligibility or Benefit Additional Information		This segment will not be returned.
328	2110C	LS	Loop Header		This segment will not be returned.
329	2120C	NM1	Subscriber Benefit Related Entity Name		This segment will not be returned.
335	2120C	N3	Subscriber Benefit Related Entity Address		This segment will not be returned.
336	2120C	N4	Subscriber Benefit Related City, State, ZIP Code		This segment will not be returned.
339	2120C	PER	Subscriber Benefit Related Contact Information		This segment will not be returned.
344	2120C	PRV	Subscriber Benefit Related Provider Information		This segment will not be returned.
329	2120C	NM1	Subscriber Benefit Related Entity Name		This segment will not be returned.
346	2120C	LE	Loop Trailer		This segment will not be returned.

APPENDICES

1. Implementation Checklist

Contact the EDI Helpdesk at (833) 209-8326 or via e-mail using the Contact link at the bottom of the Portal home page with any questions.

2. Business Scenarios

Terminology

The term "subscriber" will be used as a generic term throughout the Companion Guide. This term could refer to any one of the programs for which the 270/271 Health Care Eligibility/Benefit Inquiry and Information Response (270/271) transaction is being processed:

Member Limit

File Size is restricted to 5,000 member inquiries per 270 transaction file. Up to 99 members can be placed in each ST/SE segment.

271 Interpretation Guidelines

PRMP eligibility and benefit information will be returned in a PRMMIS 5010 standard X12 271 eligibility response transaction.

All eligibility and benefit information is accompanied by effective dates. It is important that effective dates are considered in combination with the dates of service submitted in the inquiry. If eligibility information is requested for a range of dates, it is possible that the subscriber's coverage may vary at times throughout the range of service dates.

270/271 Eligibility, Benefit, or Coverage Inquiry and Response Notes

The EB segment of the 2110C loop in the 271 eligibility response can contain many different types of information relating to the subscriber and can repeat several times. The following grids show the different types of information that can be returned in the EB segment.

PRMMIS Eligibility

Loop	Element	Name	Instructions
2110C	EB01	Eligibility or Benefit Information	This field will contain one of the following values: • "1" — Indicates active coverage. • "6" — Indicates inactive coverage.
2110C	EB02	Coverage Level Code	This field will contain the value "IND" to indicate individual.
2110C	EB03	Service Type Code	If active coverage is indicated in EB01, this field will contain a value of 30
2110C	EB04	Insurance Type Code	This field will contain the value "MC" to indicate that PRMMIS is the coverage being referenced.
2110C	EB05	Plan Coverage Description	This field will contain the benefit plan name, concatenated with coverage code and group code For example, TXIX|110|MPM.

Medicare

Loop	Element	Name	Instructions
2110C	EB01	Eligibility or Benefit Information	This field will contain the value "R" to indicate other or additional payer.
2110C	EB02	Coverage Level Code	This field will contain the value "IND" to indicate individual.

2110C	EB03	Service Type Code	This field will not be populated as PRMMIS is not the true information source.
2110C	EB04	Insurance Type Code	This field will contain one of the following values: • "MA" — Indicates that Medicare Part A is the coverage being referenced. • "MB" — Indicates that Medicare Part B is the coverage being referenced. • "OT" — Indicates Medicare Part D (Prescription Drug) coverage.

3. Transmission Examples – one file containing multiple members/examples. Each query is bounded by STSE with the specifics enclosed in a box. Orange highlights the first statement of the query. Yellow highlights errors.

INBOUND 270	OUTBOUND 271	
ISA*00* *00* *ZZ*B000001 *ZZ*PRMMIS *230131*0800*^*00501*222222222*0*T*:~	ISA*00* *00* *ZZ*PRMMIS *ZZ*B000001 *230816*1518*^*00501*200000015*0*T*:~	
GS*HB*B000001*PRMMIS*20230710*0800*338*X*005010X279A1~	GS*HB*PRMMIS*B000001*20230816*151858*200000015*X*005010X279A1~	
ST*270*0001*005010X279A1~	ST*271*0001*005010X279A1~	
BHT*0022*13*108*20230710*0800~	BHT*0022*11*108*20230816*1518~	
HL*1**20*1~	HL*1**20*1~	
NM1*PR*2*MID*****PI*PRMP~	NM1*PR*2*MID*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*2*1*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*3*2*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*2322800100*PRMMIS ~	added by 271 process
NM1*IL*1******MI*12313115545~	TRN*2*123456789*8391128616*690150~	
DTP*291*RD8*20230501-20230509~	NM1*IL*1*LUZ|COLON*BURGOS*M***MI*12313115545~	last name | last name 2
EQ*30~	N3*HC 2 BOX 13970~	postal address line 1 only
SE*12*0001~	N4*GURABO*PR*007789617~	
	DMG*D8*19500416*F~	birth date, sex
	DTP*291*RD8*20230501-20230509~	dates of service
	EB*1*IND*30*MC*Title 19 TXIX|130|NAM~	Medicaid benefit plan
	DTP*307*RD8*20230501-20240430~	Medicaid elig dates
	MSG*Municipality - 132~	new
	EB*R*IND**MA~	Medicare Part A
	REF*F6*9G05AP1HK57~	MBI
	DTP*307*RD8*20011201-22991231~	Medicare Part A elig dates
	EB*R*IND**MB~	Medicare Part B
	REF*F6*9G05AP1HK57~	MBI
	DTP*307*RD8*20020301-22991231~	Medicare Part B elig dates

	EB*R*IND**OT~	Medicare Part D
	REF*F6*9G05AP1HK57~	MBI
	DTP*307*RD8*20211201-22991231~	Medicare Part D elig dates

ST*270*0002*005010X279A1~
BHT*0022*13*108*20230705*0800~

HL*1**20*1~	HL*4**20*1~	
NM1*PR*2*NAME-SSN*****PI*PRMP~	NM1*PR*2*NAME-SSN*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*5*4*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*6*5*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*2322800101*PRMMIS ~	added by 271 process
NM1*IL*1*BHARAJ*ALEXZAVIER~	TRN*2*123456789*8391128616*690150~	
REF*SY*637138718~	NM1*IL*1*BHARAJ*ALEXZAVIER~	
DTP*291*RD8*20230401-20230409~	REF*SY*637138718~	
EQ*30~	AAA*N**58*C~	member not found
SE*13*0002~	DTP*291*RD8*20230401-20230409~	
	HL*7**20*1~	

ST*270*0003*005010X279A1~
BHT*0022*13*108*20230710*0800~

HL*1**20*1~	HL*7**20*1~	
NM1*PR*2*NAME-DOB*****PI*PRMP~	NM1*PR*2*NAME-DOB*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*8*7*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*9*8*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*23192000C8*PRMMIS ~	
NM1*IL*1*BHARAJ*ALEXZAVIER~	TRN*2*123456789*8391128616*690150~	
DMG*D8*19571007~	NM1*IL*1*BHARAJ*ALEXZAVIER****MI*55779235742~	last name only, no last name 2
DTP*291*RD8*20230501-20230509~	N3*1979 27 CALLE 25 DE JULIO APT 4 APT 3~	
EQ*30~	N4*MAUNABO*PR*007077465~	
SE*13*0003~	DMG*D8*19571007*F~	
	DTP*291*RD8*20230501-20230509~	

	EB*6*IND*30*MC~	no Medicaid eligibility
	DTP*307*RD8*20230501-20230509~	dates of service

ST*270*0004*005010X279A1~
BHT*0022*13*108*20230710*0800~

HL*1**20*1~	HL*10**20*1~	
NM1*PR*2*SSN-DOB*****PI*PRMP~	NM1*PR*2*SSN-DOB*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*11*10*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*12*11*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*23192000C9*PRMMIS ~	
NM1*IL*1*ADDED*SEGMENT~	TRN*2*123456789*8391128616*690150~	
REF*SY*637138718~	NM1*IL*1*ADDED*SEGMENT~	required segment
DMG*D8*19571007~	REF*SY*637138718~	
DTP*291*RD8*20230501-20230509~	AAA*N**75*C~	no match found
EQ*30~	DMG*D8*19571007~	
SE*14*0004~	DTP*291*RD8*20230501-20230509~	dates of service

ST*270*0005*005010X279A1~
BHT*0022*13*108*20230710*0800~

HL*1**20*1~	HL*13**20*1~	
NM1*PR*2*AFTER DEATH*****PI*PRMP~	NM1*PR*2*AFTER DEATH*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*14*13*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*15*14*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*23192000CB*PRMMIS ~	
NM1*IL*1******MI*91103729271~	TRN*2*123456789*8391128616*690150~	
DTP*291*RD8*20230601-20230603~	NM1*IL*1******MI*91103729271~	
EQ*30~	AAA*N**61*C~	date of death before dates of service
SE*12*0005~	DTP*291*RD8*20230601-20230603~	dates of service

ST*270*0006*005010X279A1~
BHT*0022*13*108*20230710*0800~

HL*1**20*1~	HL*16**20*1~	
NM1*PR*2*BEFORE BIRTH*****PI*PRMP~	NM1*PR*2*BEFORE BIRTH*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*17*16*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*18*17*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*23192000CC*PRMMIS ~	
NM1*IL*1******MI*91170268899~	TRN*2*123456789*8391128616*690150~	
DTP*291*RD8*20230503-20230504~	NM1*IL*1******MI*91170268899~	
EQ*30~	AAA*N**60*C~	birth date after dates of service
SE*12*0006~	DTP*291*RD8*20230503-20230504~	dates of service

ST*270*0007*005010X279A1~
BHT*0022*13*108*20230710*0800~

HL*1**20*1~	HL*19**20*1~	
NM1*PR*2*DUP-INACTIVE*****PI*PRMP~	NM1*PR*2*DUP-INACTIVE*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*20*19*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*21*20*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*23192000CD*PRMMIS ~	
NM1*IL*1******MI*13001766552~	TRN*2*123456789*8391128616*690150~	
DMG*D8*20031003~	NM1*IL*1*FRANQUI|DERECK*RIVERA****MI*12302564264~	
DTP*291*RD8*20230501-20230509~	N3*PO BOX 320~	
EQ*30~	N4*TOA BAJA*PR*009510320~	
SE*13*0007~	DMG*D8*19980903*M~	
	DTP*291*RD8*20230501-20230509~	
	EB*6*IND*30*MC~	not eligible for Medicaid
	DTP*307*RD8*20230501-20230509~	
	EB*R*IND**MA~	Medicare Part A
	REF*F6*4DD5RR5MU75~	
	DTP*307*RD8*20171101-22991231~	
	EB*R*IND**MB~	Medicare Part B
	REF*F6*4DD5RR5MU75~	
	DTP*307*RD8*20191101-22991231~	

ST*270*0008*005010X279A1~

BHT*0022*13*108*20230710*0800~

HL*1**20*1~	HL*22**20*1~	
NM1*PR*2*DUP-NAME-DOB*****PI*PRMP~	NM1*PR*2*DUP-NAME-DOB*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*23*22*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*24*23*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*23192000CF*PRMMIS ~	
NM1*IL*1*BURGOS*LIZ~	TRN*2*123456789*8391128616*690150~	
DMG*D8*19500416~	NM1*IL*1*BURGOS*LIZ~	
DTP*291*RD8*20230501-20230509~	AAA*N**75*C~	no match found
EQ*30~	DMG*D8*19500416~	
SE*13*0008~	DTP*291*RD8*20230501-20230509~	

ST*270*0009*005010X279A1~

BHT*0022*13*108*20230710*0800~

HL*1**20*1~	HL*25**20*1~	
NM1*PR*2*INELIGIBLE*****PI*PRMP~	NM1*PR*2*INELIGIBLE*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*26*25*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*27*26*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*23192000CG*PRMMIS ~	
NM1*IL*1******MI*55779235742~	TRN*2*123456789*8391128616*690150~	
DTP*291*RD8*20230501-20230509~	NM1*IL*1*BHARAJ*ALEXZAVIER****MI*55779235742~	
EQ*30~	N3*1979 27 CALLE 25 DE JULIO APT 4 APT 3~	
SE*12*0009~	N4*MAUNABO*PR*007077465~	
	DMG*D8*19571007*F~	
	DTP*291*RD8*20230501-20230509~	
	EB*6*IND*30*MC~	not eligible for Medicaid
	DTP*307*RD8*20230501-20230509~	

ST*270*0010*005010X279A1~

BHT*0022*13*108*20230710*0800~

HL*1**20*1~	HL*31**20*1~	
NM1*PR*2*FUTURE DATE*****PI*PRMP~	NM1*PR*2*FUTURE DATE*****PI*PRMP~	reference, not required
HL*2*1*21*1~	HL*32*31*21*1~	
NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	NM1*1P*2*FIRST MEDICAL HEALTH PLAN, INC.*****SV*000001900~	
HL*3*2*22*0~	HL*33*32*22*0~	
TRN*1*123456789*8391128616*690150~	TRN*1*232280010B*PRMMIS ~	
NM1*IL*1******MI*12313115545~	TRN*2*123456789*8391128616*690150~	
DTP*291*D8*20230901~	NM1*IL*1*LUZ|COLON*BURGOS*M***MI*12313115545~	
EQ*30~	N3*HC 2 BOX 13970~	
SE*12*0010~	N4*GURABO*PR*007789617~	
	DMG*D8*19500416*F~	
	DTP*291*RD8*20230901-20230901~	
	EB*1*IND*30*MC*Title 19 TXIX|130|NAM~	
	DTP*307*RD8*20230501-20240430~	
	MSG*Municipality - 132~	
	EB*R*IND**MA~	
	REF*F6*9G05AP1HK57~	
	DTP*307*RD8*20011201-22991231~	
	EB*R*IND**MB~	
	REF*F6*9G05AP1HK57~	

	SE*154*0001~
GE*10*338~	GE*1*200000015~
IEA*1*222222222~	IEA*1*200000015~





4. Frequently Asked Questions

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

Q: What are the main differences between a 271 and a 999?
A: 271 is the response to a 270 and contains eligibility information. 999 is an acknowledgement transaction that indicates if a 270 file was accepted or rejected. 999 does not contain any eligibility information.

Q: Is there a limit to the number of inquiries I can submit at once?
A: We recommend you follow HIPAA requirements for a maximum of 5,000 inquiries per file. Also, only one interchange (ISA/IEA) loop and one functional (GS/GE) loop is allowed per file.

Q: What information is returned on the 271?
A: All available information about the member will be returned. This may include:

- Member address.
- Member ID, SSN, and/or other agency ID.
- PRMMIS Medicaid benefit plan.
- Medicare Part A, B, D if available.

Q: Will I get back different information if I check by member ID vs. name?
A: The information sent is specific to the member and the complete details are sent, regardless of inquiry by member ID or name.

Q: Are any fields case sensitive?
A: PRMMIS accepts the extended character set. Uppercase characters are recommended.

Q: When can we send 270s and expect to receive 271s?
A: The run schedule for the 270/271 cycle is twice a day, at noon AST and after the 834 cycle is complete, expected to be around 10pm AST. Files will be immediately processed and results available for pickup the same day.

Q: What are the parameters for requesting past and future eligibility?
A:

- Any date in past allowed
- Any date in future allowed
- From Date of Service must be less than To Date of Service (otherwise error 57)
- To and From Date of Service must be in the same month (otherwise error 62)

5. Change Summary

Version 1.3 Revision Log
Companion Document: 270/271 Health Care Eligibility Benefit Inquiry and Response
Modified by Gainwell

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	18	GS08	Version/ Release/Industry Identifier Code		Corrected value
			FAQs		Dates of service
	21		File naming standard		Change to 20230601_ABRV_270_001.dat
2110C	29	MSG	Municipality Code		Contains the member's municipality code. Format of the message is: "Municipality - 123" where 123 is the code.
	19		6.4 Notes on 270 Search Hierarchy		If no member is found, an error is returned and the 270 should be resubmitted with other criteria.
	32		Transmission Example		Updated with FUTURE DATE example and all successful queries show "Municipality"

Version 1.2 Revision Log
Companion Document: 270/271 Health Care Eligibility Benefit Inquiry and Response
Modified by Gainwell

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	16	ISA08			Comments/Notes changed to: "PRMMIS"
	17	GSA02			Comments/Notes changed to : Carrier's Trading Partner ID
	17	GSA03			Comments/Notes changed to: "PRMMIS"
	33		Transmission Example		Minor change HS to HB
	33		Transmission Example		Minor change EB*I* to EB*1*
	39		FAQs		Added run cycle information
2000C	23	TRN TRN01			Corrected Loop to be 2000C

	17	GS01		HS	Corrected value Eligibility, Coverage or Benefit Information (270).

Version 1.1 Revision Log
Companion Document: 270/271 Health Care Eligibility Benefit Inquiry and Response
Modified by Gainwell

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	21		File Naming Convention		Added 271 outbound file name example
2100B	23	NM108	Identification Code Qualifier	SV	Changed to this code
2100B	23	NM109	Provider Medicaid ID		Changed to this value
2100C	27-28	AAA03	Reject Reason Code	76	Added this code. "Duplicate Subscriber/Insured ID Number"
2000C	23	TRN04	Trace Assigning Entity Additional Identifier		Added this Reference.
	30	Business Scenarios	Member Limit		Added this sentence: Up to 99 members can be placed in each ST/SE segment.
	31		Transmission Examples		Added example 270 and 271 X12

Version 1.0 Revision Log
Companion Document: 270/271 Health Care Eligibility Benefit Inquiry and Response
Approved: 06/2023
Modified by: WJ2

Loop ID	Page(s) Revised	Reference	Name	Codes	Text Revised
	ALL PAGES				270/271 transaction is new to Puerto Rico's PRMMIS.