ADDENDUM 2

Eligibility and Enrollment Record Layout

834 format – PRMMIS
V2_00_PRMMIS_834_Companion_Guide_20240201

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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: 7.0

June 2020

Puerto Rico Medicaid Management Information System Services Project

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Disclosure Statement

Companion guides may contain two types of data, instructions for electronic communications with the publishing entity (communications/connectivity instructions), and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 implementation guide (transaction instructions). Either the communications/connectivity component or the transaction instruction component must be included in every companion guide. The components may be published as separate documents or as a single document.

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 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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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
183	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.

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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@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 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

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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.

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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).

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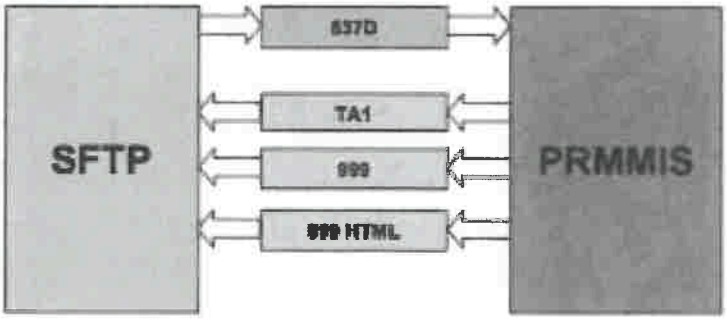
2 CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS

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."



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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.

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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.8		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.

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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 (~).

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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

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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.

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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
65	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.
99	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.
115	2010BA	NM104	Subscriber First Name		Enter the member's first name.

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
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 is a replacement/void of a previously

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					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	Payor 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
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 there is Third Party Liability (TPL), the TPL is primary and the MCO is

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					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		PRIMMIS 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

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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
318	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
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. ENCOUNTER –

TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
					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.

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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

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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.

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					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.

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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

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					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 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
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	19	NM1	Pay-To Address Name		Modify text.

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					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: Electronic adjustments are subject to the same requirements as paper adjustments and therefore

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					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.
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 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	Adjustment Reason Code &		Delete rows.

		CAS18	Adjustment Amount		
N/A	34		Section 7 – Appendix A		Remove Section 7

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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, PRIMMIS 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 – PRIMMIS 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 – PRIMMIS 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

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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.

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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

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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..

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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

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					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

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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

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Disclosure Statement

Companion guides may contain two types of data, instructions for electronic communications with the publishing entity (communications/connectivity instructions), and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 implementation guide (transaction instructions). Either the communications/connectivity component or the transaction instruction component must be included in every companion guide. The components may be published as separate documents or as a single document.

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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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.
216	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.

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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.

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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).

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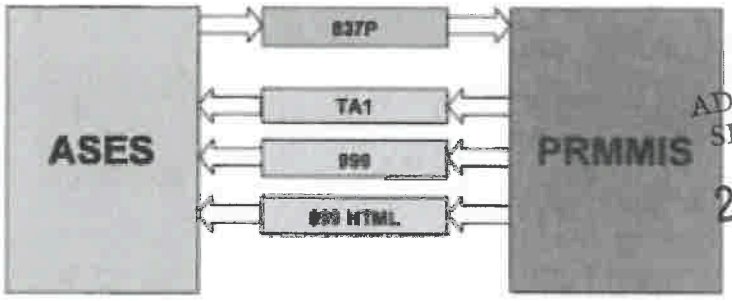
2 CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS

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 Carat "^" 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

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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 (~).

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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

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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.

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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.

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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

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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 4.8 – 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.
162	2300	PWK	Claim Supplemental Information		Puerto Rico Department of Health's PRMMIS does not use this segment for processing of the claim/encounter.
166	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.
166	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.
166	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.

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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 4.8 – 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.

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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

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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.

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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 "99999" 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.

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
425	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		

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TR3 Page #	Loop ID	Reference	Name	Codes	Notes/Comments
488	2430	CAS02	Adjustment Reason Code	A1	ENCOUNTER – "A1" – MCO Denied detail
488	2430	CAS03	Adjustment Amount		

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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

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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 text: 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

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					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

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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.

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A.4 Change Summary

Version 3.1 Revision Log
Companion Document: 837P Health Care Professional Claims & Encounters
Modified by:
Name: WI 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

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					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

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					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 text. 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.**

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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
23108	26	REF01	Reference Identification Qualifier		Remove text: Note: This is not required for nursing homes.
2320	26	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

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					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.

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Contrato Número

A.6 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.

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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

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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: _____

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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.

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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.

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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

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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.**

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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

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Disclosure Statement

Companion guides may contain two types of data, instructions for electronic communications with the publishing entity (communications/connectivity instructions), and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 implementation guide (transaction instructions). Either the communications/connectivity component or the transaction instruction component must be included in every companion guide. The components may be published as separate documents or as a single document.

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 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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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.

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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.

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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.

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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).

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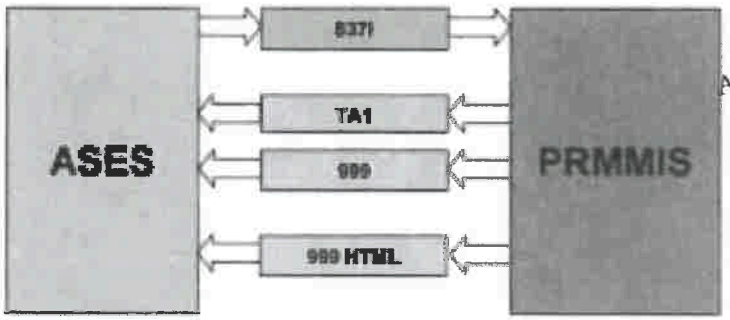
2 CONNECTIVITY WITH PUERTO RICO DEPARTMENT OF HEALTH / COMMUNICATIONS

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."



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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)

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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.

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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 (~).

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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

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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.

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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 ISA08 '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 – The 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.

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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

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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.
146	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		

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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		

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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).
165	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)
165	2300	REF01	Reference Identification Qualifier	FB	"FB" – Original Reference Number
165	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
348	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		

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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		PRIMMIS 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

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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

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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		

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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

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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

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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.

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					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.

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A.4 Change Summary

Version 3.1 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Joelyn 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

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					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:

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					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

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					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

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					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 the 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

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					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

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					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

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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

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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	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~~	**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)

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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.

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A.8 Change History

Version 7.0 Revision Log
Companion Document: 837I Health Care Institutional Claims & Encounters
Modified by:
Name: Wil Josbyn 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.**

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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
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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	28	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.**

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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

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