Driscoll Health Plan

HIPAA Transaction Standard Companion Guide

837 Healthcare Claims

277CA Healthcare Claims Acknowledgments

Refers to the Implementation Guides
Based on ASC X12 version 005010
Batch Claims Submissions and Acknowledgments
June 26, 2025
v2.3

Disclosure Statement

Disclaimer

This information is provided by DHP for education and awareness use only. Even though all information in this document is believed to be correct at the time of writing, this document does not purport to provide legal advice. The information provided here is for reference use only and does not constitute the rendering of legal, financial, or other professional advice or recommendations by DHP.

Preface

This Companion Guide to the v5010 ASC X12N Implementation Guide and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Driscoll Health Plan (DHP) and its contracted agents, Availity and Optum. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASCX12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

NOTE: DHP receives the majority of electronic medical and behavioral health claims via Availity and Optum through a daily batch job. Therefore, connectivity and registration, if required, for the service is between the submitter (which in some cases is another clearinghouse) and Availity or Optum. See the Availity Companion Guides here: https://www.availity.com. DHP offers a Claims Portal, free of charge to registered provider, through Availity. This software does not integrate with practice management software, its sole purpose is data entry and submission of claims files. For more information, contact your DHP Provider Relations Representative.

DHP also receives a small amount of medical and behavioral health claims via Texas Medicaid & Healthcare Partnership (TMHP). Claims can be generated from vendor software, be transmitted through a clearinghouse, or be generated from TMHP's software, TexMedConnect. Claims are routed to DHP based of client eligibility on the date of service.

Although DHP will update this Companion Guide for medical/behavioral health periodically, it is advised for submitters to use guides published by Availity, Optum and TMHP as appropriate.

Vision claims for DHP members are processed by Envolve/Opticare. Dental claims for ***CHIP Perinate*** members are processed by DentaQuest, using ASC X12N/005010X224A3. Dental claims for most DHP members are processed by one of several DMOs, using ASC X12N/005010X224A3. All Drug claims are processed by Navitus, using the NCPDP format. They also offer Point of Sale (POS) options.

Contact these entities for their Companion Guides.

Table of Contents

1. INTRODUCTION

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that DHP has something additional, over and above, the information in the IGs. 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 IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Driscoll Health Plan

In addition to the row for each segment, one or more additional rows are used to describe DHP'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. **NOTE:** This table is only sample data and may not be relevant to the Healthcare Claim transactions.

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% and notes or comments about the segment itself goes in this cell.
195	2100C	NM109	Subscriber Primary Identifier		9	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 DHP.
			Plan Network Identification Number	N6	Makes it clear that the code value belongs to the row immediately above it	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 3 columns makes it clear that the code value belongs to the row immediately above it.

1.1 Scope

Under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Secretary of the Department of Health and Human Services (HHS) is directed to adopt standards to support the electronic exchange of administrative and financial healthcare transactions. The purpose of the Administrative Simplification portion of HIPAA is to enable health information to be exchanged electronically and to adopt standards for those transactions.

This Companion Guide is intended for Trading Partners submitting ASC/X12N 005010 837 Claim files. Trading partners include vendors, clearinghouses, Providers and billing agents

This guide is intended to supplement information from the ASC X12 Technical Reports Type 3 (TR3s)

1.2 Overview

In accordance with the Council for Affordable Quality Healthcare and Committee on Operating Rules for Information Exchange (CAQH/CORE), this guide is composed of the following sections:

- Section 1: Introduction, Scope, Overview and related references.
- Section 2: Getting Started: How to interact with the Availity Implementation Team, how to register as a trading partner and complete payer enrollment, and an overview of testing and certification
- Section 3: Testing
- Section 4: Connectivity
- Section 5: Contact Information: How to get help.
- Section 6: Control Segments/Envelopes: ISA/IEA, GS/GE, and ST/SE values
- Section 7: Payer Specific Business Rules and Limitations:
- Section 8: Acknowledgments and Reports
- Section 9: Trading Partner Agreements
- Section 10: Transaction Specific Information

The purpose of this document is to assist the provider with DHP-particular data sets for information specified in the National Electronic Data Interchange Transaction Set Implementation Guide for the file type. The federal government has set standards to simplify Electronic Data Interchange (EDI). To comply with the standard, DHP has updated the data sets for EDI files to be in accordance with HIPAA and is utilizing the ASC X12 nomenclatures.

The instructions in this companion guide are not intended to be stand-alone requirements documents, and must be used in conjunction with the associated ANSI ASC X12N National Implementation Guide. 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.

1.3 References

ASC X12N/005010222 and Errata A2 Healthcare Claim Professional (837P), ASC X12N/005010223 and Errata A3 Healthcare Claim Institutional (837I), herein referred to as the TR3s.

You are expected to comply with the requirements set forth in the TR3s. You can purchase these guides from the ASC X12 store at http://store.x12.org/ or from Washington Publishing Company http://www.wpc-edi.com. The TR3s are copyrighted.

1.4 Additional Information

Security and Privacy Statement
Covered entities were required to implement HIPAA Privacy Regulations no later than April 14, 2003. A covered entity is defined as a health plan, a healthcare clearinghouse, or a healthcare provider who transmits any health information in electronic form in connection with a HIPAA transaction. Providers that conduct certain electronic transmissions are responsible for ensuring these privacy regulations are implemented in their business practices. Health and Human Services Commission (HHSC) is a HIPAA Covered Entity. Accordingly, Texas Medicaid is operating as a HIPAA Business Associate of HHSC as defined by the federally mandated rules of HIPAA. A Business Associate is defined as a person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce.

The privacy regulation has three major purposes:

- To protect and enhance the rights of consumers by providing them access to their health information and controlling the appropriate use of that information;
- To improve the quality of healthcare in the United States by restoring trust in the healthcare system among consumers, healthcare professionals and the many organizations and individuals committed to the delivery of healthcare; and
- To improve the efficiency and effectiveness of healthcare delivery by creating a national framework for health privacy and protection.

2. GETTING STARTED

Interested parties should primarily contact their software vendor/Clearinghouse, as many of them already directly submit or contract with providers who submit electronic claims through Availity or Optum. The change on the submitter end will merely be a change to adding or activating the DHP Payer ID within the provider software. If the software vendor is not already established with Availity, see section 5 for contacting them. Your organization will be provided with a submitter ID and password, Payer IDs for testing and certification, enrollment forms as needed, production interchange sender IDs and passwords, once assigned.

Once the vendor/Clearinghouse has been established with Availity or Optum, they will be provided with Payer specific instructions for specific field values.

If using TMHP as a gateway or using TexMedConnect, the necessary forms and instructions are available at: http://www.tmhp.com/Pages/EDI/EDI Forms.aspx.

3. Testing

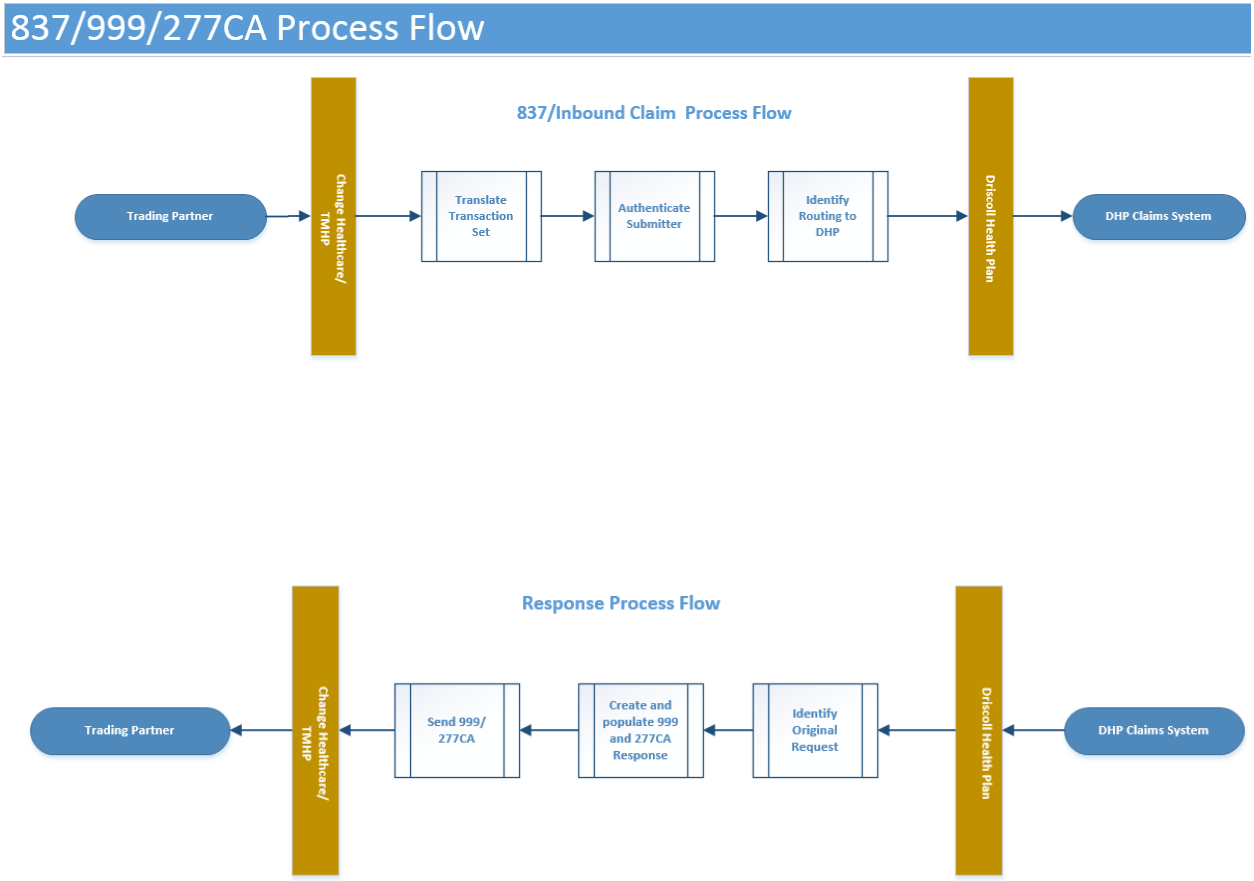
Testing for new submitters to the Availity or Optum Clearinghouses is required; refer to their Companion Guides, Connectivity Guides, and other resources, www.availity.com.

If the Provider or Billing Agent utilizes a Clearinghouse to submit the electronic claims, the entity connecting with Texas Medicaid must have successfully completed the testing process prior to claim submission.

Texas Medicaid provides a self-testing tool through Edifecs. Testing and Certification instructions, along with setup information can be found in Section 9.1 of the Texas Medicaid EDI Connectivity Guide found at: http://www.tmhp.com/TMHP_File_Library/EDI/TMHP%20EDI%20Connectivity%20Guide.pdf.

4. Connectivity

Connectivity starts through Availity, Optum or TMHP, however, the data flow reaches the DHP Claims system to provide response files:



NOTE: additional clearinghouses may be present between the submitting provider/entity and the Availity and/or Optum Clearinghouses and/or TMHP.

4.1 Transmission Administrative Procedures

Availity, Optum and TMHP may have schedules downtimes for maintenance; check their websites/documentation for scheduled maintenance times. DHP may invoke short periods of maintenance that may affect connectivity. Maintenance is usually scheduled outside of business hours to reduce provider/trading partner impact.

4.2 Submission Error Messages

The following are standard HTTP status messages:

- HTTP/1.0 200 OK - The transaction was submitted to the data center and a response was returned to Warp.
- HTTP/1.0 400 Bad Request - There was a problem with the request or the protocol-specific wrapper in which it was sent (corresponds to proprietary error SS0039).
- HTTP/1.0 403 Forbidden - The submitted terminal ID and/or password were invalid.
- HTTP/1.0 500 Internal Server Error - Warp experienced an internal problem. Please submit the transaction again (corresponds to proprietary error SS0042).
- HTTP/1.0 503 Service Unavailable - Warp is unable to process the request, for one of several reasons (corresponds to proprietary errors SS0037, SS0038, and SS0040).
- HTTP/1.0 504 Gateway Timeout - Warp failed to receive a response within the timeout period configured for the connection (corresponds to proprietary errors SS0034 and SS0036).

4.2 Retransmission Procedures

Neither Availity, Optum or TMHP perform re-transmissions. It is the Trading Partner's responsibility to resubmit in the event of a transmission failure.

4.3 Communication Protocol Specifications

Availity, Optum and TMHP have provided connectivity that complies with the CORE Safe Harbor principle (§5 Safe Harbor) according to the CORE Connectivity. Information receivers can submit claims via Safe Harbor. Availity, Optum and TMHP use security protocols based on Username/Password. Obtain them from the appropriate entity.

5. Contact Information

5.1 Phone Support

Technical assistance with Availity is available via phone during regular business hours at 1-866-742-4355.

To reach the Texas Medicaid EDI Help Desk, call: 1-888-863-3638, option 3 (or 1-512-514-4150, option 3)

5.2 Applicable Websites/E-Mail

www.availity.com

www.tmhp.com/Pages/EDI/EDI Technical Info.aspx

6. Control Segments/Envelopes

6.1 DHP Inbound Control Envelopes

837 ISA/IEA

Element	Value	Additional Notes and Conditions
ISA		
ISA01	00	
ISA02		Space fill, must be 15 digits/spaces
ISA03	00	
ISA04	Submitter ID	Left justify, space fill, assigned by Availity, Optum or TMHP to provider/vendor/clearinghouse
ISA05	ZZ	
ISA06	Receiver ID	Left Justify, space fill. Availity: 030240928 Optum: 133052274 TMHP: Production: 617591011C21P/617591011CMSP Test: 617591011C21T/617591011CMST
ISA07	ZZ	
ISA08		Left Justify, space fill
ISA11	>, :, or |	Either for Availity/Optum, but TMHP requires |
ISA13	See TR3	
ISA14	0, 1	Can submit either 0 or 1; however, acknowledgement request is only honored for approved dual-port submitters TMHP requires 0, no TA1 acknowledgment will be provided on accepted files
IEA		
IEA01	1	It is advisable to submit only one Functional Group per Interchange.

837 GS/GE -

Element	Value	Additional Notes and Conditions
GS		
GS02	Submitter	Assigned by Availity/TMHP
GS03	Receiver	Same as ISA06
GE		
GE01	1	It is advisable to submit only one Functional Group per Interchange.

837 ST/SE –

Element	Value	Additional Notes and Conditions
ST		
ST01	837 = Healthcare Claim	
ST02		Assigned by originator
ST03		Must match GS08
SE		
SE02		Must match ST02

6.2 DHP Outbound Control Envelopes

277CA ISA/IEA

Element	Value	Additional Notes and Conditions
ISA		
ISA01	00	
ISA02		Space filled, 15 digits/spaces
ISA03	00	
ISA04	Security Information	Space filled, 10 digits/spaces.
ISA05	ZZ	
ISA06	Sender ID	Left Justify, space fill. Availity: 030240928 Optum: 133052274 TMHP: Production: 617591011C21P/617591011CMSP Test: 617591011C21T/617591011CMST
ISA07	ZZ	
ISA08	Receiver ID	Provider/clearinghouse ID
ISA11	>, :, or |	Either for Availity/Optum, but TMHP requires |
ISA13	See TR3	

Element	Value	Additional Notes and Conditions
ISA		
ISA14	0, 1	Can submit either 0 or 1; however, acknowledgement request is only honored for approved dual-port submitters TMHP requires 0, no TA1 acknowledgment will be provided on accepted files
ISA15	Production indicator	P=Production
ISA15	Component Element Separator	: Colon
IEA		
IEA01	1	Count of GS/GE Functional Groups

277CA GS/GE

Element	Value	Additional Notes and Conditions
GS		
GS01	Functional Identifier Code	"HN"
GS02	Application's Sender Code	ISA06
GS03	Applications Receiver Code	ISA08
GS08	Version/Release/Industry ID Code	005010X214
GE		
GE01	1	Total number of ST/SE Transaction Sets
GE02	Group Control Number	GS06

277CA ST/SE

Element	Value	Additional Notes and Conditions
ST		
ST01	277	
ST02	Assigned by Change/TMHP	Assigned by originator
ST03	005010X214	Must match GS08
SE		
SE01		Number of included segments
SE02		ST02

7. Payer Specific Business Rules and Limitations

Availity, Optum and TMHP impose very few business rules and limitations on the front end. If the inbound 837 is a compliant X12 file, the file will generally be accepted and will be passed it onto the DHP

Claims system. Vendor software or TexMedConnect may have edits up entry to ensure an acceptable claim format and structurally necessary fields.

8. ACKNOWLEDGMENT AND/OR REPORTS

Availity, Optum and TMHP support the exchange of the 837 claims file and respond with reports and acknowledgments that should be used by the Trading Partner for reconciliation purposes

Report/Response File	Entity	Description
TA1 Transaction	Availity TMHP	Availity will send a TA1 if ISA14 in the originating 837 file is a 0 or 1 TMHP will send a *failed* TA1 (as they require ISA14 in the originating 837 file to be 1) if the submitter ID is not known or if the file received was structurally incorrect.
BID Document	TMHP	Batch ID Report This is an acknowledgment of file receipt and matched the *submitted* file name to the TMHP named file. It is a zero byte file and the format is xxxxxxxxx.yyyyyyyy.zzzzzzzzz.txt.BID where: Xxxxxxxxx = submitter ID Yyyyyyyy = TMHP assigned batch ID Zzzzzzzzz = original submitted file name Txt/DAT = file type BID = extension
999	Availity TMHP	Implementation Acknowledgment – high level transaction set response details for the 837 received. It does not contain transaction (claim) level responses. If a TA1 *failed* response is received, a 999 will not be returned.
277CA	Availity TMHP	Healthcare Claim Acknowledgment – includes claim level acknowledgments including acceptance/rejection information. If a TA1 or 999 *failed* response is received, a 277CA will not be returned.

NOTE: Availity provides an online dashboard of submitted/rejected claims at the clearinghouse. Contact them for details regarding access, training and resolution procedures. TMHP's software, TexMedConnect integrates the response into the original claim submission. Contact them for details regarding training and resolution procedures. In the case where other clearinghouses or data validation services are between the provider and Availity or TMHP, contact that entity for access to reports provided to/through Availity or TMHP.

9. TRADING PARTNER AGREEMENTS

Trading Partner agreements are not required for DHP Submitters.

10. HEALTHCARE TRANSACTION SPECIFIC INFORMATION

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

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

In addition to the row for each segment, one or more additional rows are used to describe DHP's usage for composite and simple data elements and for any other information.

10.1 INSTITUTIONAL Field Requirements 005010X223A3 (837I)

This section is used to describe the required data values that will be used by DHP for those who submit an electronic INSTITUTIONAL (837I) claim.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
80	2000A	PRV	Billing Provider Specialty Information			
80	2000A	PRV03	Provider Taxonomy Code	Varied	10	The Taxonomy code for billing provider MUST be present and must be valid as registered with Texas Medicaid
84	2000AA	NM1	Billing Provider Name			
86	2010AA	NM109	Billing Provider Identification Code		10	National Provider ID (NPI) must be submitted, unless the provider has an Atypical Provider ID (API) assigned, in which case will be reported in loop 2010BB. NOTE: as of this writing all DHP providers have an NPI
91	2010AA	N3	Billing Provider			

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Address			
91	2010AA	N301	Billing Provider Address Line			The Billing Provider address will be validated against DHP address on file
92	2010AA	N4	Billing Provider City, State, Zip Code			
92	2010AA	N401	Billing Provider City Name			The Billing Provider city will be validated against DHP address on file
93	2010AA	N403	Billing Provider Postal Zone or ZIP Code			The Billing Provider zip code will be validated against DHP address on file
94	2010AA	REF	Billing Provider Tax Identification			
94	2010AA	REF01	Billing Provider Tax Identification Number qualifier	SY EI	2	SY = Social Security Number EI = Tax ID number
94	2010AA	REF02	Billing Provider Tax Identification Number qualifier		9	Will be validated against DHP Tax ID on file
109	2000B	SBR	Subscriber Information			NOTE: everyone in Medicaid is considered a subscriber, there is no need for a PAT segment unless it's to report the relationship between subscriber and patient for reporting commercial insurance
109	2000B	SBR01	Payer Responsibility Coe	P, S, T	1	Identifies primary, secondary, tertiary responsibility
109	2000B	SBR03	Reference Identification	CA1, CCP DE1, DM2, EC1, EP1,	3	Referred to as Benefit Code for the provider, must match what is on file in DHP's system. Note that for THSteps (EP1), the provider requires certification

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
				FP3, HA1, IM1, MA1, MH2, TB1, WC1		
110	2000B	SBR09	Claim Filing Indicator Code	11, CI MC		11 = CHIP CI = Commercial Ins MC = Medicaid
112	210BA	NM1	Subscriber Name			
114	2010BA	NM108	Identification Code Qualifier	MI		
114	2010BA	NM109	Subscriber Primary ID			Medicaid Subscriber ID
122	2010BB	NM103	Payer Name	DHP		Driscoll Health Plan
123	2010BB	NM108	Identification Code Qualifier	PI		
123	2010BB	NM109	Payer Identifier			TMHP = 617591011C21P Change = 78284
129	2010BB	REF	Billing Provider Secondary Identification			
129	2010BB	REF01	Identification Code Qualifier	G2		Qualifier for API, if the provider does not have an NPI, the API would be submitted in REF03 NOTE: all DHP providers currently have an NPI
145	2300	CLM	Claim Information			
145	2300	CLM05-03	Claim Frequency	1, 2, 3, 4, 5, 7, 8		1 = new claim 2 = interim hospital bill 3 = interim hospital bill 4 = final hospital bill 5 = late charges 7 = replacement 8 = void Replacement claims should reference the original claim in 2300/REF*F8
166	2300	REF	Payer Control			

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Number			
166	2300	REF02	Payer Claim Control Number			When appealing or replacing/adjusting a claim, REF02 should be submitted to tie back to the original claim number
173	2300	REF	Medical Record Number			
173	2300	REF02	Medical Record Number			Required on INPATIENT claims
319	2310A	NM1	Attending Provider Name			Required on INSTITUTIONAL claims
321	2310A	NM109	Attending Provider Primary Identifier			NPI must be submitted, all attending physicians must have an NPI but do not have to be a TX Medicaid providers
324	2310A	PRV	Attending Provider Specialty Information			Required on INSTITUTIONAL claims
324	2310A	PRV03	Reference Identification		10	Attending Provider's Taxonomy, use NPPES if necessary
328	2310B	NM1	Operating Physician Name			Required when the claim contains a surgical procedure
328	2310B	NM109	Operating Physician Primary Identifier		10	NPI must be submitted, all operating physicians must have an NPI but do not have to be a TX Medicaid provider.
336	2310D	NM1	Rendering Provider Name			
338	2310D	NM109	Rendering Provider Primary Identifier			NPI required for Rendering on clinic claims. NPI must be submitted, but provider does not have to be a TX Medicaid provider.
341	2310E	NM1	Service Facility Location Name			Not necessarily required on Facility claims unless the Billing Provider NPI is different. Only populate this if an NPI is available.
342	2310E	NM109	Service Facility		10	NPI must be submitted.

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Primary Identifier			Provider must be enrolled in TX Medicaid
347	2310F	NM1	Referring Provider Name			Required when the member is referred to the Facility. Only populate this is an NPI is available.
351	2310F	NM109	Referring Provider Identification Code		10	Provider must be enrolled in TX Medicaid
358	2320	CAS	Claim Adjustments			
360	2320	CAS02	Claim Adjustment Reason Codes			Required when balancing the claim
480	2430	CAS	Line Adjustments			
482	2430	CAS02	Claim Adjustment Reason Code			Required when balancing the claim

10.2 Professional Field Requirements 005010X222A2 (837P)

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
80	2000A	PRV	Billing Provider Specialty Information			
80	2000A	PRV03	Provider Taxonomy Code	Varied	10	The Taxonomy code for billing provider MUST be present and must be valid as registered with Texas Medicaid
84	2000AA	NM1	Billing Provider Name			
86	2010AA	NM109	Billing Provider Identification Code		10	National Provider ID (NPI) must be submitted, unless the provider has an Atypical Provider ID (API) assigned, in which case will be reported in loop 2010BB. NOTE: as of this writing all DHP providers have

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						an NPI
91	2010AA	N3	Billing Provider Address			
91	2010AA	N301	Billing Provider Address Line			The Billing Provider address will be validated against DHP address on file
92	2010AA	N4	Billing Provider City, State, Zip Code			
92	2010AA	N401	Billing Provider City Name			The Billing Provider city will be validated against DHP address on file
93	2010AA	N403	Billing Provider Postal Zone or ZIP Code			The Billing Provider zip code will be validated against DHP address on file
94	2010AA	REF	Billing Provider Tax Identification			
94	2010AA	REF01	Billing Provider Tax Identification Number qualifier	SY EI	2	SY = Social Security Number EI = Tax ID number
94	2010AA	REF02	Billing Provider Tax Identification Number qualifier		9	Will be validated against DHP Tax ID on file
109	2000B	SBR	Subscriber Information			NOTE: everyone in Medicaid is considered a subscriber, there is no need for a PAT segment unless it's to report the relationship between subscriber and patient for reporting commercial insurance
116	2000B	SBR01	Payer Responsibility Coe	P, S, T	1	Identifies primary, secondary, tertiary responsibility
117	2000B	SBR03	Reference Identification	CA1, CCP DE1, DM2,	3	Referred to as Benefit Code for the provider, must match what is on file in DHP's system. Note that for THSteps (EP1), the

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
				EC1, EP1, FP3, HA1, IM1, MA1, MH2, TB1, WC1		provider requires certification
118	2000B	SBR09	Claim Filing Indicator Code	11, CI MC		11 = CHIP CI = Commercial Ins MC = Medicaid
121	2010BA	NM1	Subscriber Name			
123	2010BA	NM108	Identification Code Qualifier	MI		
123	2010BA	NM109	Subscriber Primary ID			Medicaid Subscriber ID
133	2010BB	NM103	Payer Name	DHP		Driscoll Health Plan
134	2010BB	NM108	Identification Code Qualifier	PI		
134	2010BB	NM109	Payer Identifier			TMHP = 617591011C21P Change = 78284
140	2010BB	REF	Billing Provider Secondary Identification			
140	2010BB	REF01	Identification Code Qualifier	G2		Qualifier for API, if the provider does not have an NPI, the API would be submitted in REF03 NOTE: all DHP providers currently have an NPI
159	2300	CLM	Claim Information			
159	2300	CLM05-03	Claim Frequency	1, 2, 3, 4, 5, 7, 8		1 = new claim 7 = replacement 8 = void Replacement claims should reference the original claim in 2300/REF*F8
196	2300	REF	Payer Control Number			
196	2300	REF02	Payer Claim			When appealing or

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Control Number			replacing/adjusting a claim, REF02 should be submitted to tie back to the original claim number
257	2310A	NM1	Referring Provider			
259	2310A	NM109	Referring Provider Identifier		10	Consult the TMPPM for requirements for when Referring Provider is required. NPI is required for Referring Provider on all professional claims when the Referring Provider segment is provided. NPI must be submitted, but provider does not have to be a TX Medicaid provider.
265	2310B	NM1	Rendering Provider Name			
262	2310D	NM109	Rendering Provider Primary Identifier			NPI required for Rendering on clinic claims. NPI must be submitted, but provider must be enrolled in TX Medicaid.
265	2310B	PRV	Rendering provider Specialty Information			
265	2310B	PRV03	Provider Taxonomy Code			Required when Rendering Provider NPI is provided
269	2310C	NM1	Service Facility Location Name			Not necessarily required on Facility claims unless the Billing Provider NPI is different. Required when Place of Service is anything other than Home (12), Office (11) or School (03) Only populate this segment if an NPI is available.
271	2310C	NM109	Service Facility Primary Identifier		10	NPI must be submitted. Provider must be enrolled in TX Medicaid
299	2320	CAS	Claim Adjustments			

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
301	2320	CAS02	Claim Adjustment Reason Codes			Required when balancing the claim
	2430	CAS	Line Adjustments			
	2430	CAS02	Claim Adjustment Reason Code			Required when balancing the claim

10.3 Claim Acknowledgment Requirements 005010X214 (277CA)

Refer to the TR3s for information regarding information returned on a TA1 and 999. The requirements for the 277CA are as follows:

NOTE this portion of the Companion Guide assumes that Availity/Optum/TMHP is the senders/submitters. Values may change if other Clearinghouses are senders/receivers of the data/file.

DHP Outbound Claim Responses

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
HL						
	2000A	HL01	Hierarchical ID Number	HL	1/12	HL+Sequential increase
	2000A	HL02	Hierarchical Parent ID			Not used
	2000A	HL03	Hierarchical Level Code	20	1/2	Information Source
	2000A	HL04	Hierarchical Child Code	1	1/1	
NM1						
	2100A	NM101	Entity Identifier Code	PR	2/3	Payer
	2100A	NM102	Name Last or Organization Name		1/60	Availity/Optum TMHP
	2100A	NM108	Identification Code Qualifier	PI	1/2	Payer Identification
	2100A	NM109	Identification Code			Availity/Optum/ TMHP

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
TRN						
	2200A	TRN01	Trace Type Code	1	1/2	
	2200A	TRN02	Reference Identification		1/50	Information Source Application Trace, as received from the 837 file in BHT03
DTP						
	2200A	DTP01	Date/Time Qualifier	050	3/3	
	2200A	DTP02	Date Time Period Format Qualifier	D8	1/35	
	2200A	DTP03	Date Time Period	ccyymmdd		Information Source Receipt Date
DTP						
	2200A	DTP01	Date/Time Qualifier	009	3/3	
	2200A	DTP02	Date Time Period Format Qualifier	D8	1/35	
		DTP03	Date Time Period	ccyymmdd		Information Source Process Date
HL						
	2000B	HL01	Hierarchical ID			Sequential numbering within the ST/SE loop, will be incremented by 1
	2000B	HL03	Hierarchical Level Code	21	1/2	Information Receiver
	2000B	HL04	Hierarchical Child Code	1	1/1	
NM1						
	2100B	NM101	Entity Identifier Code	41	2/3	Receiver
	2100B	NM102	Entity Type Qualifier	1 or 2	1/1	Mapped from 837, 1000A/NM102
	2100B	NM103	Name Last or Organization Name			Information Receiver Last or Organization Name
	2100B	NM104	Name First			
	2100B	NM105	Name Middle			
	2100B	NM108	Identification	46	1/2	Electronic Transmitter

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Code Qualifier			Identification Number (ETIN)
	2100B	NM109	Identification Code		2/80	Information Receiver Identification Number
TRN						
	2200B	TRN01	Trace Type Code	2	1/2	
	2200B	TRN02	Reference Identification		1/50	Mapped from 837 BHT03
STC						
	2200B	STC01	Healthcare Claim Status	STC		
	2200B	STC01-1	Healthcare Claim Status Category Code	A1		Acknowledgment of receipt
	2200B	STC01-2	Healthcare Claim Status Code	19/20		Default for status level, acknowledgment of receipt
	2200B	STC01-3	Entity Identifier Code	PR	2/3	Payer
	2200B	STC02	Status Information Effective Date	ccyymmdd	8/8	Date of claims acknowledgment
	2200B	STC03	Action Code	WQ	1/2	Accept. Specific rejections/acceptance will be reported in loop 2200D
	2200B	STC04	Monetary Amount		1/18	Sum of all claims (CLM02 between ST/SE)
QTY						
	2200B	QTY01	Total ACCEPTED Quantity	90	2/2	Acknowledged Accepted Quantity (when all claims are rejected, the segment will not be created)
	2200B	QTY02	Quantity		1/15	Total Accepted Quantity
QTY						
	2200B	QTY01	Total REJECTED Quantity	AA	2/2	Acknowledged Accepted Quantity (when all claims are accepted, the segment will not be created)
	2200B	QTY02	Quantity		1/15	Total Rejected Quantity
AMT						
	2200B	AMT01	Total ACCEPTED	YU	1/3	Not created when all claims are rejected

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Amount			
	2200B	AMT01	Amount		1/15	Dollar amount accepted
AMT						
	2200B	AMT01	Total REJECTED Amount	YY	1/3	Not created when all claims are accepted
	2200B	AMT02	Amount		1/18	Total Rejected Amount
HL						
	2000C	HL01	Hierarchical ID Number		1/12	Sequential within the ST/SE loop
	2000C	HL02	Hierarchical Parent ID Number			
	2000C	HL03	Hierarchical Level Code	19	1/2	
	2000C	HL04	Hierarchical Child Code		1/1	0 or 1
NM1						
	2100C	NM101	Entity Identifier Code	85	2/3	
	2100C	NM102	Entity Type Qualifier	1 or 2		1 = Individual 2 = Organization
	2100C	NM103	Name Last or Organization Name		1/60	
	2100C	NM104	Name First		1/35	
	2100C	NM105	Name Middle		1/25	
	2100C	NM108	Identification Code Qualifier	XX	1/2	
	2100C	NM109	Identification Code			For National Provider Identifier (NPI). In absence of the NPI, the atypical (API) in 2010BB/REF*G2 will be returned when present
HL						
	2000D	HL01	Hierarchical ID Number		1/12	Patient Continued from previous numbering schema within the ST/SE, incremented by 1 NOTE: Medicaid members are the subscriber, this segment may be returned

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						from 837 data.
	2000D	HL02	Hierarchical Parent ID Number		1/12	
	2000D	HL03	Hierarchical Level Code	PT	1/2	
NM1						
	2100D	NM101	Entity Identifier Code	QC	2/3	
	2100D	NM102	Entity Type Qualifier	1	1/1	
	2100D	NM103	Name Last		1/60	Patient's Last Name – from 837, 2010BA/NM103
	2100D	NM104	Name First		1/35	Patient's First name – from 837, 2010BA/NM104
	2100D	NM105	Name Middle		1/25	Patient's Middle Name – from 837, 2010BA/NM105
	2100D	NM108	Identification Code Qualifier	MI	1/2	
	2100D	NM109	Identification Code		2/80	Patient ID – from 837, 2010BA NM109
TRN						
	2200D	TRN01	Trace Type Code	2	1/2	
	2200D	TRN02	Reference Identification		1/50	Patient Control Number (20 digits returned from 837)
	2200D	TRN				
STC						
	2200D	STC		STC		
	2200D	STC01-1	Healthcare Claim Status Category Code		1/30	Refer to X12 Code Source 507
	2200D	STC01-2	Healthcare Claim Status			Refer to X12 Code Source 508
	2200D	STC02	Status Information Effective Date	ccyymmdd	8/8	
	2200D	STC03	Action Code	U – rejected WQ – accepted		
	2200D	STC04	Monetary		1/18	Amount Billed

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Amount			
	2200D	STC12	Free Text		264	
REF						
	2200D	REF01	Reference Identification Qualifier	1K	2/3	
	2200D	REF02	Reference Identification		1/50	DHP Claim Number
REF						
	2200D	REF01	Reference Identification Qualifier	D9	2/3	
	2200D	REF02	Reference Identification		1/50	Clearinghouse Trace Number/Claim Number Claims coming in from TMHP will use the first 28 characters for the TMHP ETN. This number may trace claims coming into Change from another clearinghouse
REF						
	2200D	REF01	Reference Identification Qualifier	EA	2/3	Medical Record Qualifier
			Reference Identification		1/50	Medical Record Number (when present in the 837)
REF						
	2200D	REF01	Reference Identification Qualifier	BLT	2/3	
	2200D	REF01	Reference Identification		1/50	Institutional Bill Type Identifier
DTP						
	2200D	DTP01	Date/Time Qualifier	472	3/3	Claim Level Service Date
	2200D	DTP02	Date Time Period Format Qualifier	D8	2/3	
	2200D	DTP03	Date Time Period		1/35	837P – Earliest service date from 837 – 2400/DTP*472 837I Statement from date

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						from 837 – 2300/DTP*434)
SVC						
	2200D	SVC01	Composite Medical Procedure Identifier	SVC		
	2200D	SVC01-1	Product/Service ID Qualifier		1/48	Qualifier from 837 2400/SV1/SV201
	2200D	SVC01-2	Product/Service ID		1/48	Procedure, Bill/Revenue code from 837
	2200D	SVC01-3	Procedure Modifier		2/2	Modifier 1
	2200D	SVC01-4	Procedure Modifier		2/2	Modifier 2
	2200D	SVC01-5	Procedure Modifier		2/2	Modifier 3
	2200D	SVC01-6	Procedure Modifier		2/2	Modifier 4
	2200D	SVC02	Monetary Amount		1/18	Line Item Charge Amount
	2200D	SVC04	Product/Service ID		1/48	Revenue code when both HCPCS code are sent, HCPCS will be populated in SVC01-2
STC						
	2220D	STC		STC		Service Line Level Status Information
	2220D	STC01-1	Healthcare Claim Status Category Code			Refer to X12 Code Source 507
	2220D	STC01-2	Healthcare Claims Status code		1/20	Refer to X12 Code Source 508
	2220D	STC02	Status Information Effective Date	ccyymmdd	8/8	
	2220D	STC03	Action Code	U = Reject WQ = Accepted	1/2	Action code
	2220D	STC04	Monetary Amount		1/18	Amount Billed
	2220D	STC12	Free Text			

Page#	Loop ID	Reference	Name	Codes	Length	Notes/Comments
REF						
	2220D	REF01	Reference Identification Qualifier	FJ	2/3	
	2220D	REF02	Reference Identification		1/50	Line Item Control Number
DTP						
	2220D	DTP01	Date/Time Qualifier	472		Service Date/Line
	2220D	DTP02	Date Time Period Format Qualifier	D8		
	2220D	DTP03	Date Time Period	ccyymmdd	1/35	Service Line Date (ccyymmdd)

11. Change Log

Date	Version	Description
2/11/2019	1.0	Original document
12/12/2024	2.0	Updated clearinghouse information.
1/23/2025	2.1	Updated Logos
4/3/2025	2.2	Updated clearinghouses references.
6/26/2025	2.3	Updated “Acme” reference to Driscoll on page 1.