State of Washington
Companion Guide

To the
Accredited Standards Committee (ASC) X12
Technical Report Type 3 (TR3)
820 Payroll Deducted & Other Premium Payment
Based on Version 005010X218A1

Acentra Health

676A Woodland Square Loop SE

Suite 201

Lacey, Washington 98503

February 2025

Disclaimer

Express permission to use ASC X12 copyrighted materials has been granted.

This companion guide contains data clarifications derived from specific business rules that apply exclusively to Washington State Medicaid processing for Washington State HCA. The guide also includes useful information about receiving data from the Washington State ProviderOne system.

Revision History

Documented revisions are maintained in this document through use of the Revision History Table shown below. All revisions made to this companion guide after the creation date are noted along with the date, page affected, and reason for the change.

Revision Level	Date	Page	Description	Change Summary
WAMMIS-CG820-5010-01-01	11/30/2010		Initial Document	
WAMMIS-CG-820-5010-01-02	03/01/2012		Version number updated due to the inclusion of full Companion Guide Boilerplate information	
WAMMIS-CG-820-5010-01-03	04/2016		Updated per ASC X12 recommendations	
WAMMIS-CG-820-5010-01-04	12/14/2018		Updated format and version number for reposting	
WAMMIS-CG-820-5010-01-05	06/24/2020		Update screen prints and web links. Also add SBE identifiers	
WAMMIS-CG-820-5010-01-06	06/20/2022		Add SBE identifiers	
WAMMIS-CG-820-5010-01-07	02/24/2025		Add SBE identifiers and update logo	

Contents

Disclaimer ii

Revision History iii

1 Introduction 5

1.1 Document Purpose 5
1.1.1 Intended Users 5
1.1.2 Relationship to HIPAA Implementation Guides 5
1.2 Transmission Schedule 6

2 Technical Infrastructure and Procedures 7

2.1 Technical Environment 7
2.1.1 Communication Requirements 7
2.1.2 Testing Process 7
2.1.3 Who to contact for assistance 8
2.2 Retrieve batches via Web Interface 9
2.3 Set-up, Directory, and File Naming Convention 10
2.3.1 SFTP Set-up 10
2.3.2 SFTP Directory Naming Convention 10
2.3.3 File Naming Convention 12
2.4 Transaction Standards 12
2.4.1 General Information 12
2.4.2 Data Format 13
2.4.3 Data Interchange Conventions 13
2.4.4 Acknowledgement Procedures 13
2.4.5 Rejected Transmissions and Transactions 13

3 Transaction Specifications 14

Appendix A – Transaction reason code for Organization 19

Appendix B – Reason code for Individual 20

1 Introduction

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) includes requirements that national standards be established for electronic health care transactions, and national identifiers for providers, health plans, and employers. This requires Washington State Health Care Authority (HCA) to adopt standards to support the electronic exchange of administrative and financial health care transactions between covered entities (health care providers, health plans, and healthcare clearinghouses).

The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange standards in health care. The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were developed by processes that included significant public and private sector input.

1.1 Document Purpose

Companion Guides are used to clarify the exchange of information on HIPAA transactions between the HCA ProviderOne system and its trading partners. HCA defines trading partners as covered entities that either submit or retrieve HIPAA batch transactions to and from ProviderOne.

This Companion Guide provides information about the 820 Payroll Deducted & Other Premium Payment transaction that is specific to HCA and HCA trading partners. This Companion Guide is intended for trading partner use in conjunction with the ASC X12 TR3 820 Payroll Deducted & Other Premium Payment version 005010X218A1. The ASC X12 TR3s that detail the full requirements for all HIPAA mandated transactions are available at http://store.x12.org/store/.

1.1.1 Intended Users

Companion Guides are intended for members of the technical staff of trading partners who are responsible for electronic transaction/file exchanges.

1.1.2 Relationship to HIPAA Implementation Guides

Companion Guides are intended to supplement the ASC X12 TR3 HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This Companion Guide describes the technical interface environment with HCA, including connectivity requirements and protocols, and electronic interchange procedures. This guide also provides specific information on data elements and the values required for transactions sent to or received from HCA.

Companion Guides are intended to supplement rather than replace the ASC X12 TR3 for each transaction set. The information in these documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

1.2 Transmission Schedule

820 files will be posted on Fridays unless communicated otherwise.

2 Technical Infrastructure and Procedures

2.1 Technical Environment

2.1.1 Communication Requirements

This section will describe how trading partners will receive 820 Transactions from HCA using 2 methods:

- Secure File Transfer Protocol (SFTP)
- ProviderOne Web Portal

2.1.2 Testing Process

Completion of the testing process must occur prior to production electronic retrieval from ProviderOne. Testing is conducted to ensure the following:

1. Syntactical integrity: Testing of the EDI file for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 or NCPDP syntax, and compliance with X12 and NCPDP rules.
2. Syntactical requirements: Testing for HIPAA Implementation Guide specific syntax requirements (such as limits on repeat counts), qualifiers, codes, elements and segments. This process should also include testing for HIPAA required or situational data elements, medical code sets, and values and codes noted in the Implementation Guide via an X12 code list or table.

Additional testing may be required in the future to verify any changes made to the ProviderOne system. Changes to the formats may also require additional testing. Assistance is available throughout the testing process.

Trading Partner Testing Procedures

1. ProviderOne companion guides and trading partner agreement forms are available for download via the web at https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/hipaa-electronic-data-interchange-edi
2. The Trading Partner completes the Trading Partner Agreement and submits the signed agreement to HCA.

   Submit to: HCA HIPAA EDI Department
   626 8th Avenue SE
   PO Box 45564
   Olympia, WA 98504-5564

   For questions email hipaa-help@hca.wa.gov

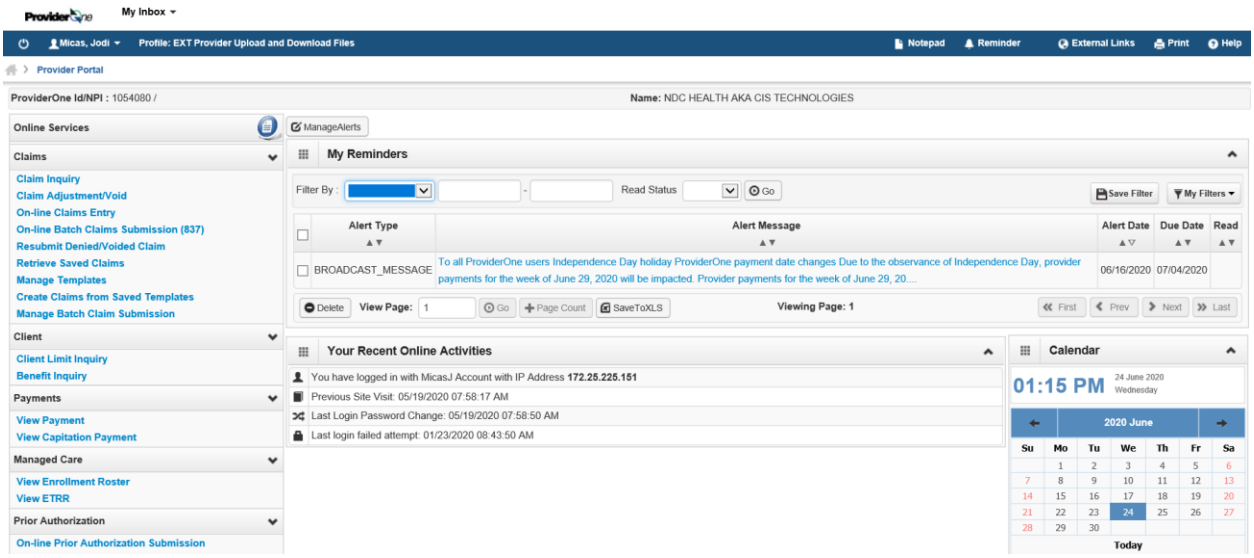
3. The trading partner is assigned a ProviderOne/Domain ID, logon user ID and password.
4. ProviderOne system processes and validates all outbound HIPAA test files. All files will be available for download via the ProviderOne web portal or Secure File Transfer Protocol (SFTP).
    - ProviderOne Test Web Portal URL: https://www.waproviderone.org/edi
    - SFTP URL: sftp://ftp.waproviderone.org/
5. The trading partner downloads the file from the ProviderOne web portal or Secure File Transfer Protocol (SFTP).
6. If the test file download is successful and the trading partner's system accepts the file for processing, the trading partner is approved for transaction download in the ProviderOne production environment.
7. If the test file download is unsuccessful, the trading partner should immediately email hipaa-help@hca.wa.gov to report the failure. They will continue testing in the testing environment until a successful download is completed.

2.1.3 Who to contact for assistance

- Email: hipaa-help@hca.wa.gov
    - All emails result in the assignment of a Ticket Number for problem tracking
- Information necessary for initial email:
    - Name
    - Phone Number
    - Email Address
    - 7-digit ProviderOne/Domain ID
    - Transaction you are inquiring about
    - File Name
    - Detailed description of the concern
- Information required for follow up:
    - Assigned Ticket Number

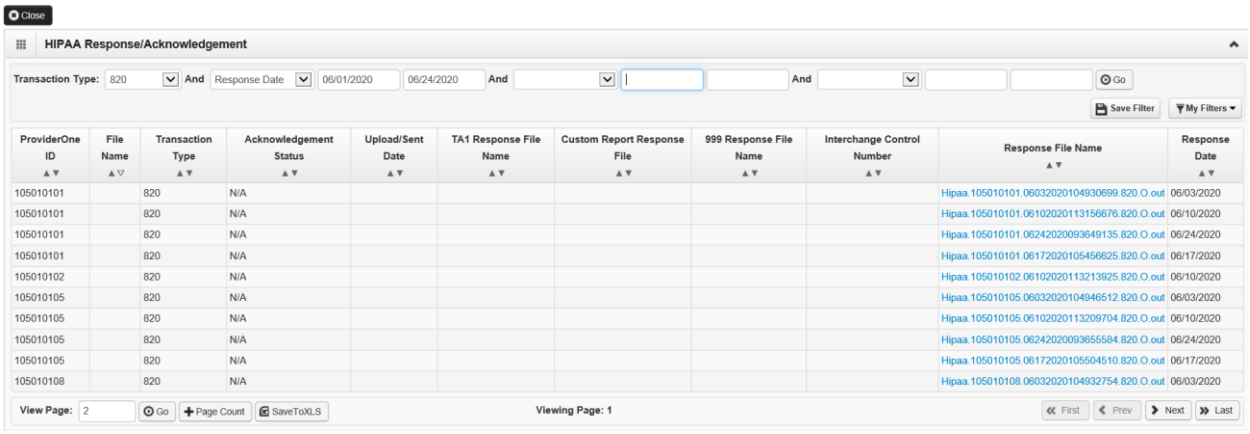
2.2 Retrieve batches via Web Interface

Log into the ProviderOne Portal, select the appropriate security profile and the following options will be presented to the user:



Scroll down to the HIPAA heading to manage the submission and retrieval of HIPAA transactions.

Select Retrieve HIPAA Batch Responses option from the main screen to retrieve HIPAA Outbound files (TA1, 999, 271, 277, 820, 834, 835, and 277U) as shown below:



*Note: The data can be sorted by clicking on the up or down arrows.

2.3 Set-up, Directory, and File Naming Convention

2.3.1 SFTP Set-up

Trading partners can contact hipaa-help@hca.wa.gov for information on establishing connections through the SFTP server. Information on SFTP usage is below.

2.3.2 SFTP Directory Naming Convention

There would be two categories of folders under Trading Partner's SFTP folders:

1. **TEST – Trading Partners should submit and receive their test files under this root folder**
2. **PROD – Trading Partners should submit and receive their production files under this root folder**
3. **README – This folder will include messages regarding password update requirements, outage information and general SFTP messages.**

The following sub-folders will be available under the SFTP TEST/PROD main folders:

'HIPAA_Inbound' - This folder should be used to drop the Inbound files that needs to be submitted to HCA

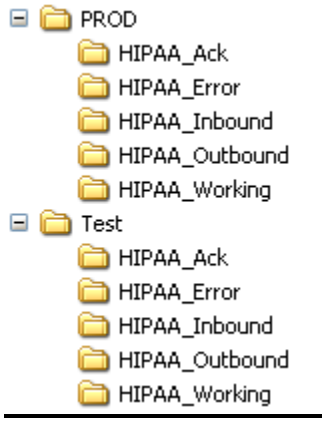
'HIPAA_Ack' – This folder contains acknowledgements transactions such as the TA1, 999 and custom error report will be available for all the files submitted by the Trading Partner

'HIPAA_Outbound' – X12 outbound transactions generated by HCA will be available in this folder

'HIPAA_Error' – Any inbound file that is not HIPAA compliant or is not recognized by ProviderOne will be moved to this folder

'HIPAA Working' – There is no functional use for this folder at this time

<u>Folder structure will appear as:</u>



2.3.3 File Naming Convention

HIPAA files are named in the following format.

For Outbound transactions:

HIPAA.<TPId>.<datetimestamp>.<TxID>.O.<out>

Example of file name: HIPAA.123456700.12262007211315.820.O.out

- <TPId> is the Trading Partner Id
- <datetimestamp> is the Date timestamp
- <TxID> is the Transaction Id.

2.4 Transaction Standards

2.4.1 General Information

HIPAA standards are specified in the Implementation Guide for each mandated transaction and modified by authorized Addenda. Currently, the 820 transaction has one Addendum. This Addendum has been adopted as final and is incorporated into HCA requirements.

An overview of requirements specific to each transaction can be found in the 820 Implementation Guide. Implementation Guides contain information related to:

- Format and content of interchanges and functional groups
- Format and content of the header, detailer and trailer segments specific to the transaction
- Code sets and values authorized for use in the transaction
- Allowed exceptions to specific transaction requirements

Transmission sizes are limited based on two factors:

- Number of Segments/Records allowed by HIPAA standards
- HCA file transfer limitations

ProviderOne will send all the payment information (Organization & Individual) within one ST-SE Segment within one Functional Group (GS-GE). HCA has no size limitations for postings to its SFTP Server.

2.4.2 Data Format

Delimiters

The ProviderOne will use the following delimiters on outbound transactions:

- Data element separator, Asterisk, (*)
- Sub-element Separator, Vertical Bar, (:)
- Segment Terminator, Tilde, (~)
- Repetition Separator, Caret, (^)

2.4.3 Data Interchange Conventions

When transmitting 820 Transactions, HCA follows standards developed by the Accredited Standards Committee (ASC). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or “outer envelopes”. All 820 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B1 of the 820 Implementation Guide. Specific information on how individual data elements are populated by HCA on ISA/IEA and GS/GE envelopes are shown in the table beginning later in this section.

HCA transmits 820 Transaction files with single ISA/IEA and GS/GE envelopes. In order to maintain balancing requirements within 820, ProviderOne will send all the Organization & Individual payment within the same ST-SE Segment.

2.4.4 Acknowledgement Procedures

N/A

2.4.5 Rejected Transmissions and Transactions

HCA will validate all 820 transactions up to HIPAA validation levels 1 and 2. If a receiver rejects any part of a transmission, they must reject the entire transmission. Data on rejected 820 transmissions should not be used to update health plan databases.

3 Transaction Specifications

Page	Loop	Segment	Data Element	Element Name	Comments
Interchange Control Header					
App. B	Envelope	ISA	06	Interchange Sender ID	77045 followed by spaces
App. B	Envelope	ISA	08	Interchange Receiver ID	9 Digit ProviderOne ID of the receiver followed by spaces
App. B	Envelope	ISA	11	Repetition Separator	Use ^ for repetition separator
App. B	Envelope	ISA	16	Component Element Separator	:
Functional Group Header					
App. B	Envelope	GS	02	Application Sender's Code	77045
App. B	Envelope	GS	03	Application Receiver's Code	9 Digit ProviderOne ID
Financial Information					
40	Header	BPR	10	Originating Company Identifier	1916001088

Re-Association Trace Number					
44	Header	TRN	03	Originating Company Identifier	1916001088
Premium Receivers Identification Key					
49	Header	REF	02	Reference Identification	The plan's 9-digit alphanumeric ProviderOne ID
Premium Payer's Name					
65	1000B	N1	04	Identification Code	916001088
Premium Payer's Administrative Contact					
71	1000B	PER	02	Name	DSHS Provider Relations
71	1000B	PER	04	Communication Number	8005623022
Organization Summary Remittance					
84	2000A	ENT	04	Identification Code	MCOs or RSNs Federal Taxpayer's Identification Number
Organization Summary Remittance Detail					
Note: Gross Adjustments, Receivables, Cash Receipts and Warrant Cancellation Offset Reporting Loop 2300A will be repeated to deliver Organization level Receivable Balances i.e. Forward/Carry Forward/CARS Initiated balances, Gross Adjustments, Cash Receipts and Warrant Cancellation Offset information within the 820 when applicable in addition to consolidated payments.					
88	2300A	RMR	02	Reference Identification	This field will be populated with the Receiver's Provider One ID (9 digits) In case of gross adjustment, receivables forward/carried forward/CARS

					initiated balance, Cash Receipts and Warrant Cancellation Offset it will be concatenated with 2 digits Transaction Type and 2 characters Reason Code to provide additional information. For example a CARS forward balance receivables, RMR02 will look like: 123456789-21-CR Refer to Appendix A for transaction type, and Reason codes.
88	2300A	RMR	04	Monetary Amount	Organizational payment amount. This field will have the CF/FB/CA amounts in the case of receivables.
Member Count					
101	2315A	SLN	04	Quantity	Count of members for which payment is made. Quantity will be '0' in the case of receivables, gross adjustments, cash receipt and warrant cancellation offset. This field will only be used in case of monthly payments to the RSN
Individual Remittance					

106	2000B	ENT	04	Identification Code	ProviderOne Client Identification Number in the following format. 9-digit numeric and 2-digit alpha. e.g. 123456789WA.
Individual Premium Remittance Detail					
Note: Loop 2300B will be sent for all individual prospective payments and retro adjustments except in the case of RSN prospective payments.					
112	2300B	RMR	01	Reference Identification Qualifier	This field will be populated with; “AZ” for monthly capitated premium payments and enhanced payments “IK” for Service Based Enhancement (SBE) payments.
113	2300B	RMR	02	Reference Identification	This field will be populated with the 15 digit 834 transaction reference number when RMR01 = 'AZ' OR the patient account number delivered in the Claim Information Loop (2300 CLM-01), submitted on the encounter corresponding to SBE when RMR01 = 'IK'. This will be followed by 2 digit transaction reason code for additional information on the type of payment e.g.

					123456789012345-P1. Refer to Appendix B for Reason Codes

Appendix A – Transaction reason code for Organization

Transaction code	Transaction description	Reason Code	Reason description
20	Organization Level Adjustments	IP	IP Provider Payments
		TR	Transportation
		VP	Vacation pay
		PR	Provider Training Reimbursement
		FE	FICA Tax Employer
		FT	FICA Tax
		FA	FUTA
		SA	SUTA
		FW	FIT WH
		UD	Union Dues
		AC	AEIC
		LE	LI Employer
		ML	Medical
		ME	Medical Employer
		SO	Non-Medicaid Services (State Only)
		JS	Discharged MIO Services (Jail Services)
		CI	Non-Medicaid Inpatient Psych Rates (Community Psychiatric Inpatient Rate Increase)
		MI	Community MH Wage Increase (MH Worker Wage Increase, Vendor Rate Increase)
		MS	MH Professional Double Staffing
		ES	Performance Based Incentive (Expanded Community Services)
		WP	WMIP
		IR	Integrated Crisis Response
		PT	System Transformation Initiative (PACT)
		PS	System Transformation Initiative (PALS)
		RR	RSN Hospital Reimbursement
		ZZ	Warrant Cancellation
		OT	Other
		MG	Monthly IMD Premium Payment
		PL	Preferred Drug List Monthly Payment
		HH	Health Homes Quarterly Bonus Payment
		LB	Quarterly Low Birth Weight Payment
		RP	Inpatient Psych Recoupment

Transaction code	Transaction description	Reason Code	Reason description
21	Receivable Forward Balance- FB	CR	Cars Created Receivable
		PR	Vendor Initiated Receivable
		DR	DSHS Initiated Receivable
22	Receivable Carried Forward- CF	CR	Cars Created Receivable
		PR	Vendor Initiated Receivable
		DR	DSHS Initiated Receivable
23	Receivable sent to CARS - CA	CA	Receivable sent to Cars
24	Cash Receipt - CS	CS	Cash Receipt
25	Warrant Cancellation Adjustment	ZZ	Warrant Cancellation offset

Appendix B – Reason code for Individual

Transaction Reason Code	Description
NR	Provider Negation Regular
NV	Provider Negation Void
P1	Regular Prospective Payments
P2	Disenrollment Recoupment
P3	Retroactive Enrollment
P5	Retroactive rate increase
P6	Retroactive rate decrease
RA	Client Responsibility Adjustment
ZZ	Warrant Cancellation

Please use the chart on the next page to identify the SBE payment or reversal description that coordinates with the “P” Reason code noted above in Appendix B.

Example of Delivery Case Rate (DCR) payment and reversal

RMR*IK*KI03254717-P1901**6,760.88

OR

RMR*IK*KI03254717-P2901**6,760.88

SBE Description	820 Identifiers
Delivery Case Rate (DCR)	901
National Drug Code (NDC) on Preferred Drug List (PDL)	906
Health Home - G9148	911
Health Home - G9149	912
Health Home - G9150	913
Health Home – Tribal	914
Enhancement Payment	921
Foundational Community Services (FCS) - Housing and Employment	922
Foundational Community Services (FCS) - Housing	923
Foundational Community Services (FCS) - Preemployment	924
Foundational Community Services (FCS) - Employment	925
Wraparound with Intensive Services (WISe)	955
Tribal – Medical	956
Tribal – Dental	957
Tribal - Mental Health	958
Tribal - Substance Use Disorder	959
Rural Health Clinic (RHC) - Medical	962
Federally Qualified Health Center (FQHC) - Medical	966
Federally Qualified Health Center (FQHC) - Mental Health	967
Federally Qualified Health Center (FQHC) - Dental	968
Federally Qualified Health Center (FQHC) - SUD	969
Tribal FQHC - Medical	970
Tribal FQHC - Dental	971
Tribal FQHC - Mental Health	972
Tribal FQHC - SUD	973
Tribal FQHC for non-AI/AN - Medical	974
Tribal FQHC for non-AI/AN - Dental	975
Tribal FQHC for non-AI/AN - Mental Health	976

Tribal FQHC for non-AI/AN - SUD	977

SBE Description Continued	820 Identifiers
New Journeys: Engage Outreach	978
New Journeys: Recovery Resiliency	979
New Journeys: Encounter	980
CBHSS Tier 1	981
CBHSS Tier 2	982
CBHSS Tier 3	983
CBHSS Tier 4	984
CBHSS Tier 5	985
CBHSS Tier 6	986