



277 Unsolicited Claim/Encounter Status Notification

Version 1.6

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Version	Date	Modified By	Modifications
1.0	03/04/2014	ODM & HP EDI Team	Initial Creation.
1.1	04/29/2014	ODM & HP EDI Team	Updated URL for the Ohio Administrative Code.
1.2	06/24/2014	ODM & HP EDI Team	Updated the EOB Codes in Appendix A.
1.3	04/28/2015	ODM & HP EDI Team	Updated the EOB Codes in Appendix A.
1.4	08/07/2015	ODM & HP EDI Team	Updated the EOB Codes in Appendix A.
1.5	12/02/2015	ODM & HPE EDI Team	Updated references related to Agency name changes.
1.6	06/02/2016	ODM & HPE Team	Updated the EOB Codes in Appendix A.

Disclosure Statement

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The ODM Companion Guides do not:

- Replace the HIPAA ANSI ASC X12N Implementation Guide.
- Contain any actions that would result in a Non-Compliant Transaction.

The ODM Companion Guides are subject to change without prior notice.

Providers and Trading Partners are responsible for periodically checking for Companion Guide updates on the ODM Trading Partner website - <http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>.

Each Medicaid Provider and/or Trading Partner has the ultimate responsibility to adhere to the HIPAA Federal Requirements as well as any Ohio State laws that are applicable including the Ohio Administrative Code (<http://codes.ohio.gov/oac/5160-1-20>).

Preface

This Companion Guide to the 5010 ASC X12N Technical Report Type 3 Implementation Guides and associated errata and addenda adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with ODM. Transmissions based on this companion guide, used in tandem with 005010 ASC X12 TR3 Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N TR3 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 TR3 Implementation Guides.

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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 the Ohio Department of Medicaid 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 the Ohio Department of Medicaid.

In addition to the row for each segment, one or more additional rows are used to describe ODM, 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.

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 comment about the segment itself goes 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 ODM.
			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 3 columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 Scope

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

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

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

This companion guide is intended to be used in conjunction with the ASC X12N/005010X212 Implementation Guide (IG). It provides supplementation instructions not included in the IG that must be followed for implementation and conducting the transaction with ODM. It does not change the requirements of the IG in any way.

1.2 Overview

The Health Insurance Portability and Accountability Act (HIPAA) require all Providers, Trading Partners and Payers in the United States to comply with the Electronic Data Interchange (EDI) Standards for Health Care.

This is not a HIPAA 'mandated' Transaction, and the only change noted was the name to the 277U Health Care Claim Pending Status Information to meet the original intent of the Transaction. This was documented in the 277 ERRATA.

The new name does not reflect the ODM use of the Transaction.

This outbound transaction is not checked for compliance by ODM. Thus the inbound transaction should not be checked for compliance.

ODM returns the 277U once a claim/encounter passes compliance and the EDI edit process. The EDI edit process can 'reject' any claim/encounter that does not pass the edit criteria. The 'rejected' claims/encounters will not be loaded into MITS, whereas those that do pass the edit process will be loaded into MITS. Once adjudication has occurred, the 277U will be generated for every claim/encounter, listing the adjudication status of 'Accepted' (including suspended) or 'Denied'.

Encounters denied by MITS in this transaction set may be corrected and the encounter resubmitted according to the MCP encounter data submission companion guides and submission schedule. Denied claims should also be corrected and resubmitted as original claims.

The 277U X12 Transaction was created as a non-mandated Transaction to accommodate Medicaid States that report 'Suspended/Pended' Claims to their TP/Providers.

Since it is not a HIPAA Mandated Transaction it can be customized and used to suit the needs of each Payer.

This EDI Companion Guide provides the Trading Partners with a Status of 'Accepted' (includes Suspended/Pended claims) or 'Rejected' for each claim when an 837 file is adjudicated.

ODM has elected to utilize the 5010 277 as a point of reference to update their 277U.

1.3 References

In addition to the resources available on the ODM Trading Partner Website (<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>), there are other websites that contain helpful information to assist in the implementation of the electronic data interchange process. Links to these websites are listed below and are separated by category for easy reference.

1.3.1 EDI Basics

For information about EDI software and services, visit: 1EDI Source, Inc (<http://www.1edisource.com>).

1.3.2 Government and Other Associations

- Center for Medicare and Medicaid Services (CMS): <http://www.cms.hhs.gov>
- Answers to Frequently Asked Questions: <https://questions.cms.gov>
- HHS Office for Civil Rights (Privacy) <http://www.hhs.gov/ocr/hipaa>
- WEDI - Workgroup for Electronic Data Interchange: <http://www.wedi.org>
- CMS website for NPI: <http://www.cms.hhs.gov/NationalProvIdentStand>

1.3.3 ASC X12 Standards

- Washington Publishing Company: <http://www.wpc-edi.com>
- Data Interchange Standards Association: <http://disa.org>
- American National Standards Institute: <http://ansi.org>
- Accredited Standards Committee: <http://www.x12.org>

1.4 Additional Information

For additional information, the Trading Partner Information Guide can be found here:
<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>

2 GETTING STARTED

To get started, the Trading Partner Information Guide can be found here:

<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>

3 TESTING WITH THE PAYER

Details related to testing are in the Trading Partner Information Guide which can be found here:

<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>

4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

Connectivity information is in the Trading Partner Information Guide which can be found here:

<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>

5 CONTACT INFORMATION

5.1 EDI Customer Service

Days Available: Monday through Friday

Time Zone: Eastern Time (ET)

Time Available: 8:00 am to 5:00 pm

Phone: (614) 387-1212

Email: DAS-EDI-Support@das.ohio.gov

5.2 EDI Technical Assistance

Days Available: Monday through Friday

Time Zone: Eastern Time (ET)

Time Available: 8:00 am to 5:00 pm

Phone: (614) 387-1212

Email: DAS-EDI-Support@das.ohio.gov

5.3 Provider Service Number

Provider Assistance Unit 1-800-686-1516. Please listen to the entire message before making your selection.

Web URL: <http://medicaid.ohio.gov/PROVIDERS.aspx>

5.4 Applicable Websites/Email

Ohio Medicaid Website: <http://medicaid.ohio.gov>

The Trading Partner web page can be found by following: Providers > Billing > Trading Partners
(<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>)

To contact Ohio Medicaid for assistance, use the link - <http://medicaid.ohio.gov/CONTACT.aspx>

6 CONTROL SEGMENTS/ENVELOPES

6.1 ISA-IEA

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

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.3		ISA	Interchange Control Header			
C.4		ISA01	Authorization Information Qualifier	00		No Authorization Information Present (No Meaningful Information in ISA02)
C.4		ISA03	Security Information Qualifier	00		No Security Information Present (No Meaningful Information in ISA04)
C.4		ISA05	Interchange ID Qualifier	ZZ		Mutually Defined
C.4		ISA06	Interchange Sender ID	MMISODJFS		This is a fixed-length field and should be left justified and filled with spaces to meet the minimum length requirement of 15.
C.4		ISA07	Interchange ID Qualifier	ZZ		Mutually Defined
C.4		ISA08	Interchange Receiver ID			7 digit Trading Partner ID assigned by ODM. This is a fixed-length field and should be left justified and filled with spaces to meet the minimum length requirement of 15.
C.5		ISA13	InterChange Control Number			Must be identical to the associated interchange control trailer IEA02
C.6		ISA14	Acknowledgment Requested	0		No Interchange Acknowledgment Requested

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.10		IEA	Interchange Control Trailer			
C.10		IEA01	Number of Included Functional Groups			Number of included functional groups.
C.10		IEA02	Interchange Control Number			The control number assigned by the interchange sender. Must be identical to the value in ISA13.

6.2 GS-GE

This section describes ODM's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how ODM expects functional groups to be sent and how ODM will send functional groups. These discussions will describe how similar

transaction sets will be packaged and ODM use of functional group control numbers.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.7		GS	Functional Group Header			
C.7		GS02	Application Sender's Code	MMISODJFS		
C.7		GS03	Application Receiver's Code			7 digit Trading Partner ID assigned by ODM
C.8		GS06	Group Control Number			Must be identical to the value in GE02.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.9		GE	Functional Group Trailer			
C.9		GE01	Number of Transaction Sets Included			Number of included transaction sets.
C.9		GE02	Group Control Number			The functional group control number. Must be the same value as GS06.

6.3 ST-SE

This section describes how ODM uses transaction set control numbers.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
106		ST	Transaction Set Header			
106		ST02	Transaction Set Control Number			Identical to the value in SE02

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
213		SE	Transaction Set Trailer			
213		SE01	Number of Included Segments			Total number of segments included in a transaction set including ST and SE segments
213		SE02	Transaction Set Control Number			Transaction set control number. Identical to the value in ST02.

7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

In order to receive 277U X12 transactions, trading partners must be authorized by Ohio Medicaid and in active status. These details are documented in the Trading Partner Information Guide which can be found at this link - <http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>.

8 ACKNOWLEDGEMENTS AND/OR REPORTS

The 277U is an outbound transaction and there are no associated responses.

9 TRADING PARTNER AGREEMENTS

These details can be found in the Trading Partner Information Guide which can be found at this link - <http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>.

10 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 ODM 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.
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Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
107		BHT	Beginning of Hierarchical Transaction			
107		BHT01	Hierarchical Structure Code	0010		Information Source, Information Receiver, Provider of Service, Subscriber, Dependent
107		BHT02	Transaction Set Purpose Code	08		Status
107		BHT03	Originator Application Transaction Identifier			Concatenation of Trading Partner ID and System Date
108		BHT06	Transaction Type Code	DG		Response
109	2000A	HL	Information Source Level			
110	2000A	HL03	Hierarchical Level Code	20		Information Source
110	2000A	HL04	Hierarchical Child Code	1		Additional Subordinate HL Data Segment in This Hierarchical Structure.
111	2100A	NM1	Payer Name			
111	2100A	NM101	Entity Identifier Code	PR		Payer
111	2100A	NM102	Entity Type Qualifier	2		Non-Person Entity
111	2100A	NM103	Name Last or Organization Name	Ohio Department of Medicaid		Payer Name
112	2100A	NM108	Identification Code Qualifier	PI		Payor Identification

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
112	2100A	NM109	Identification Code	MMISODJFS		
137	2200D	TRN	Claim Status Tracking Number			
137	2200D	TRN01	Trace Type Code	2		Referenced Transaction Trace Numbers
137	2200D	TRN02	Reference Identification			For Encounters, this will be the MCP's Transaction Control Number (TCN). For FFS Claims, this will be the original Patient Control Number (CLM01) from the 837 Claim.
138	2200D	STC	Claim Level Status Information			
138	2200D	STC01-1	Industry Code	A2, A7		A2 = Encounters/FFS – Adjudication Status of 'Accepted' A7 = Encounter/FFS – Adjudication Status of 'Rejected'
138	2200D	STC12	Free-Form Message Text			This element is for Encounter Claims only. This will be the 4 digit Error (EOB) Codes regarding Encounter Transactions for both informational and critical Errors. Please see Appendix A for more information on the EOB Code(s). The Error Codes will appear as a continuous string of numbers. For example, the Error Codes of 201, 203, 269, and 3047 will be displayed as 0201020302693047
149	2200D	REF	Payer Claim Control Number	1K		Value used for Claims/Encounters accepted into MITS.
149	2200D	REF01	Reference Identification Qualifier			
149	2200D	REF02	Reference Identification			ODM assigned Internal Control Number (ICN). ICNs are assigned to every Claim/Encounter that has been accepted into MITS for adjudication.
155	2200D	DTP	Claim Service Date			
155	2200D	DTP02	Date Time Period Format Qualifier	D8, RD8		D8 = Date Expressed in Format CCYYMMDD RD8 = Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
156	2200D	DTP03	Date Time Period			Dates of service for the Institutional, Dental, and Professional Claim/Encounter.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
157	2220D	SVC	Service Line Information			
157	2220D	SVC01-1		AD, ER, HC, HP, IV, N4, NU, WK		<p>AD = American Dental Association Codes (ADA)</p> <p>ER = Jurisdiction Specific Procedure and Supply Codes</p> <p>HC = Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes</p> <p>HP = Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code</p> <p>IV = Home Infusion EDI Coalition (HIEC) Product/Service Code</p> <p>N4 = National Drug Code in 5-4-2 Format</p> <p>NU = National Uniform Billing Committee (NUBC) UB92 Codes</p> <p>WK = Advanced Billing Concepts (ABC) Codes</p>
161	2220D	STC	Service Line Status Information			
161	2220D	STC01-1	Industry Code	A2, A7		<p>A2 = Encounter/Claim Adjudication Status of 'Accepted'</p> <p>A7 = Encounter/Claim Adjudication Status of 'Rejected'</p>
170	2220D	STC12	Free-Form Message Text			<p>This element is for Encounter Claims only.</p> <p>This will be the 4 digit Error (EOB) Codes regarding Encounter Transactions for both informational and critical Errors.</p> <p>Please see Appendix A for more information on the EOB Code(s) for MCPs.</p> <p>The Error Codes will appear as a continuous string of numbers.</p> <p>For example, the Error Codes of 201, 203, 269, and 3047 will be displayed as</p>

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						0201020302693047.
172	2220D	DTP	Service Line Date			
172	2220D	DTP01	Date/Time Qualifier	472		Service – Begin and end dates of the service being rendered.
172	2220	DTP02	Date time Period Format Qualifier	D8, RD8		D8 = Date Expressed in Format CCYYMMDD RD8 = Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
172	2220	DTP03	Date Time Period			Service Line Date

APPENDICES

A. EOB Codes

EOB	DESCRIPTION	DISPOSITION
0019	CLAIM/DETAIL DENIED. PROCEDURE/NDC MISSING/INVALID.	THRESHOLD
0050	CLAIM DENIED. PLEASE CORRECT COVERED DAYS FIELD AND RESUBMIT	THRESHOLD
0051	PATIENT CONDITION/STATUS CODE MISSING, INVALID, OR INVALID FOR TYPE OF BI	THRESHOLD
0053	CLAIM/DENIED. NET BILLED NOT EQUAL TO TOTAL BILLED MINUS OTHER INSURANCE.	PAY/INFO
0062	CLAIM DENIED. THE HOUR OF ADMISSION IS MISSING OR INVALID.	THRESHOLD
0101	DATE OF SERVICE MISSING	THRESHOLD
0124	DATE OF SERVICE INVALID	THRESHOLD
0131	TOTAL/SUBMITTED CHARGE INVALID	THRESHOLD
0132	TOTAL/SUBMITTED CHARGE MISSING	THRESHOLD
0133	SUBMITTED CHARGES/TOTAL CLAIM CHARGE CONFLICT	THRESHOLD
0136	REVENUE CODE IS MISSING/INVALID/NOT ON FILE	THRESHOLD
0138	TYPE OF BILL IS MISSING	THRESHOLD
0139	TYPE OF BILL IS INVALID FOR THE DATE OF SERVICE	THRESHOLD
0152	NO NDC ON FILE	THRESHOLD
0165	INVALID HOSPICE UNITS FOR REVENUE CODE 657	PAY/INFO
0167	PATIENT STATUS IS INVALID FOR THE DATE OF SERVICE	THRESHOLD
0170	PLACE OF SERVICE IS MISSING OR INVALID	THRESHOLD
0198	DATES OF SERVICE FOR THIS CLAIM TYPE MUST ALL BE FROM THE SAME MONTH	PAY/INFO
0221	THE PROVIDER IS NOT ELIGIBLE ON DATE(S) OF SERVICE	PAY/INFO
0224	OCCURRENCE SPAN DATES ARE NOT BETWEEN THE FIRST AND LAST HEADER DATES OF	PAY/INFO
0230	THERAPY NOT COVERED FOR RECIPIENT 21 YEARS OF AGE OR OLDER	PAY/INFO
0233	EAPG GROUPER REQUIRES A VALID VIST	PAY/INFO
0254	FOR COMPOUND DRUGS, 2 OR MORE NDC CODE DTLS NEEDED	THRESHOLD
0267	INVALID SOURCE OF ADMISSION FOR THE DATE OF SERVICE	THRESHOLD
0278	CLAIM DENIED. CLAIM/DOCUMENTATION INDICATES THIRD PARTY PYMNT WAS RECEIVE	PAY/INFO
0279	ALIEN - CLAIM REQUIRES MEDICAL REVIEW. IF YOU DID NOT ATTACH MEDICAL TO T	PAY/INFO
0282	THE MEMBER HAS MEDICARE PART A PLEASE BILL MEDICARE	PAY/INFO
0283	OUR RECORDS INDICATE MEMBER HAS MEDICARE PART B: PLEASE BILL MEDICARE	PAY/INFO
0300	TREATING PROVIDER NUMBER NOT ON FILE	PAY/INFO
0321	PROCEDURE CODE INVALID FOR DATE OF SERVICE	THRESHOLD
0323	INVALID NDC CODE	THRESHOLD
0324	COMPOUND PRODUCT ID QUALIFIER (488-RE) MUST BE 03	THRESHOLD
0325	INVALID INGREDIENT QUANTITY	THRESHOLD
0358	TREATING PROVIDER/REFERRING PROVIDER NUMBER ARE EQUAL	PAY/INFO
0402	A CLAIM FOR INPATIENT SERVICES COVERS MORE THAN 15 DAYS, THE RECIPIENT IS	PAY/INFO
0406	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO	THRESHOLD
0482	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.	PAY/INFO

EOB	DESCRIPTION	DISPOSITION
0488	ABORTION CERTIFICATION MISSING	PAY/INFO
0504	DISPENSE DATE IS GREATER THAN MCP PAID DATE	THRESHOLD
0510	RECIPIENT LIMITED ON SELECTED INITIAL AND FOLLOW UP VISITS TO 1 PER DOS	PAY/INFO
0562	INVALID NURSING HOME LEVEL OF CARE	PAY/INFO
0563	INVALID LEVEL OF CARE PROV TYPE	PAY/INFO
0564	INVALID LOC FOR SNU PROVIDER	PAY/INFO
0566	ELECTRONIC ADJUSTMENT/VOID SET TO DENY	THRESHOLD
0604	INVALID FINANCIAL CLASS CODE	PAY/INFO
0630	UNITS OF SERVICE NOT COMPATIBLE WITH DATE SPAN BILLED. IF ONLY ONE DOS BI	PAY/INFO
0661	SNU LEAVE DAYS PRESENT	PAY/INFO
0664	PAY TO PROVIDERS MAIL IS UNDELIVERABLE. CONTACT PROVIDER ENROLLMENT FOR I	PAY/INFO
0779	INVALID PROCEDURE CODE MODIFIER	PAY/INFO
0800	ICD-9 CODE NOT VALID FOR ICD-10 CLAIM	THRESHOLD
0801	THE CODE DOES NOT EXIST IN MITS AS AN ICD-9 CODE, BUT IS RECOGNIZED AS AN	THRESHOLD
0802	ICD-9 AND ICD-10 CODES NOT VALID ON SAME CLAIM	THRESHOLD
0803	THE SUBMITTED ICD DIAGNOSIS CODE VERSION DOES NOT MATCH THE SUBMITTED EDI	THRESHOLD
0808	THE SUBMITTED INPATIENT PROCEDURE CODE VERSION DOES NOT MATCH THE SUBMITT	THRESHOLD
0819	SECOND PROCEDURE CODE MODIFIER INVALID	PAY/INFO
0820	THIRD PROCEDURE CODE MODIFIER INVALID	PAY/INFO
0823	DETAIL BILLED AMOUNT INVALID	THRESHOLD
0872	FIRST DIAGNOSIS CODE NOT ON FILE	THRESHOLD
0873	SECOND DIAGNOSIS CODE NOT ON FILE	THRESHOLD
0875	THIRD DIAGNOSIS CODE NOT ON FILE	THRESHOLD
0878	FOURTH DIAGNOSIS CODE INVALID OR NOT ON FILE	THRESHOLD
0885	FIFTH DIAGNOSIS CODE NOT ON FILE	THRESHOLD
0888	SIXTH DIAGNOSIS CODE NOT ON FILE	THRESHOLD
0891	NINTH DIAGNOSIS CODE NOT ON FILE	THRESHOLD
0892	SEVENTH DIAGNOSIS CODE NOT ON FILE	THRESHOLD
0898	EIGHTH DIAGNOSIS CODE NOT ON FILE.	THRESHOLD
0901	DRUG QUANTITY IS REQUIRED. COMPLETE THE MISSING INFORMATION AND RESUBMIT	PAY/INFO
0901	DRUG QUANTITY IS REQUIRED. COMPLETE THE MISSING INFORMATION AND RESUBMIT	THRESHOLD
0941	ONE TPL PAYER	PAY/INFO
0942	TWO TPL PAYERS	PAY/INFO
0943	THREE OR MORE TPL PAYERS	PAY/INFO
0975	UNITS MUST EQUAL NUMBER OF TEETH PER DETAIL FOR PROCDURE GINGIVECTOMY PRO	PAY/INFO
1027	FIRST SURGICAL PROCEDURE CODE NOT ON FILE	THRESHOLD
1028	SECOND SURGICAL PROCEDURE NOT ON FILE	THRESHOLD
1029	THIRD SURGICAL PROCEDURE NOT ON FILE	THRESHOLD
1030	4TH SURGICAL PROCEDURE NOT FOUND	THRESHOLD
1031	5TH SURGICAL PROCEDURE NOT FOUND	THRESHOLD
1032	6TH SURGICAL PROCEDURE NOT FOUND	THRESHOLD

EOB	DESCRIPTION	DISPOSITION
1050	SERVICE NOT REFERRED BY PRIMARY CARE CASE MANAGER	PAY/INFO
1053	TAXONOMY CODE INVALID FOR PERFORMING PROVIDER	PAY/INFO
1058	NO PAY TO PROVIDER RECORD FOR CROSSOVER CLAIM	PAY/INFO
1069	PROVIDER NOT AUTHORIZED TO TAPE BILL	PAY/INFO
1077	RECIPIENT IS UNDER REVIEW. POSSIBLE PA FOR TRANSPLANT SERVICE	PAY/INFO
1090	1ST SURGICAL PROCEDURE DATE IS MISSING OR ZEROS	THRESHOLD
1091	2ND SURGICAL PROCEDURE DATE IS MISSING OR ZEROS	THRESHOLD
1092	3RD SURGICAL PROCEDURE DATE IS MISSING OR ZEROS	THRESHOLD
1093	4TH SURGICAL PROCEDURE DATE INVALID	THRESHOLD
1094	5TH SURGICAL PROCEDURE DATE INVALID	THRESHOLD
1095	6TH SURGICAL PROCEDURE DATE INVALID	THRESHOLD
1098	MISSING 3RD TO 24TH OCCURRENCE SPAN CODE AND DATES	PAY/INFO
1100	REFERRING PROVIDER NPI FAILED CHECK-DIGIT	PAY/INFO
1103	MID-MONTH RATE CHANGE	PAY/INFO
1143	KICK PAY-TO-PROVIDER AND SERV PROV ERR	PAY/INFO
1150	PROV/PROC CODE MODIFIER/PLACE OF SERV CONFLICT. POST WITH ASC MOD 73 OR 7	PAY/INFO
1152	CREDIT/ADJUSTMENT REQUIRES TCN	THRESHOLD
1153	NO MATCH ON RECIPIENT ID	THRESHOLD
1155	CLAIM HAS ALREADY BEEN CREDITED/ADJUSTED	THRESHOLD
1156	ELECTRONIC ADJUSTMENT/VOID ADJUSTING A DENIED CLAIM	THRESHOLD
1157	CLAIM NOT ON HISTORY	THRESHOLD
1189	THE NON-HEALTH CARE BILLING MEDICAID PROVIDER ID (MCD) IS NOT ON FILE.	THRESHOLD
1200	PAY TO PROVIDER NUMBER IS NOT A GROUP	PAY/INFO
1957	BILLING PROVIDER ID FAILED CHECK-DIGIT	THRESHOLD
1958	PRESCRIBING PROVIDER ID FAILED CHECK-DIGIT	THRESHOLD
1999	THE NON-HEALTH CARE BILLING MEDICAID PROVIDER ID (MCD) IS NOT EFFECTIVE F	PAY/INFO
2010	NEWBORN OCCURRENCE CODE MISSING. WHEN ADMIT AND BIRTH DATES ARE EQUAL AND	PAY/INFO
2035	MCP PAID DATE IS PRIOR TO THE HEADER DATE OF SERVICE	THRESHOLD
2047	THE ENCOUNTER CLAIM PMP ID/CONTRACT ID DOES NOT MATCH THE PMP ID ASSOCIAT	THRESHOLD
2053	THE ENCOUNTER CLAIM PMP ID/CONTRACT ID DOES NOT MATCH THE PMP ID ASSOCIAT	THRESHOLD
2066	THE OTHER PAYER PATIENT RESPONSIBILITY PAYMENT AMOUNT MUST BE \$0 OR GREAT	THRESHOLD
2097	COVERED IN PER DIEM	PAY/INFO
2098	HCBW WAIVER HAS DENY/SUSPEND EDIT	PAY/INFO
2126	FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV	THRESHOLD
2168	INVALID SOURCE OF ADMISSION	PAY/INFO
2176	TO SUPPORT EAPG GROUPER PROCESSING, AN ADD-ON PROCEDURE CODE MUST BE REPO	PAY/INFO
2179	INPATIENT ONLY SERVICES ARE NOT ALLOWED TO BE SUBMITTED ON AN OUTPATIENT	PAY/INFO
2180	OUTPATIENT AND OUTPATIENT CROSSOVER CLAIMS CANNOT BE SUBMITTED WITH DATES	PAY/INFO
2183	MISSING OR INVALID FORMAT OF UNITS OF SERVICE	PAY/INFO
2198	MISSING ATTENDING SURGEON PRESCRIBER NUMBER	PAY/INFO
2199	INPATIENT PROCEDURE CODE 7-24 DATE IS MISSING	THRESHOLD

EOB	DESCRIPTION	DISPOSITION
2200	TYPE OF ADMISSION MISSING OR INVALID FOR THE DATE OF SERVICE	THRESHOLD
2214	DATE PRESCRIBED IS MISSING OR INVALID	THRESHOLD
2215	DATE DISPENSED IS MISSING	THRESHOLD
2216	DATE DISPENSED IS INVALID	THRESHOLD
2249	CLAIM HAS NO DETAILS	THRESHOLD
2312	ADMITTING DIAGNOSIS CODE NOT ON FILE	THRESHOLD
2314	SURGICAL PROCEDURE CODE 7-24 NOT FOUND	THRESHOLD
2317	PROCEDURE CODE/MODIFIER CONFLICT	PAY/INFO
2319	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED	PAY/INFO
2321	PROCEDURE CODE IS NO LONGER VALID	PAY/INFO
2349	ADMITTING DIAGNOSIS CODE INVALID	THRESHOLD
2454	INVALID ASSIGNMENT CODE	PAY/INFO
2485	DATE DISPENSED EARLIER THAN DATE PRESCRIBED	THRESHOLD
2488	ADMIT DATE DOES NOT EQUAL FIRST DATE OF SERVICE	THRESHOLD
2516	PROVIDER TYPE NOT ON TPL MATRIX	PAY/INFO
2524	OVERNITE LABOR ROOM REQUIRES OCC CODE 51 AND DATE	PAY/INFO
2572	EPSDT REFERRAL INDICATOR INVALID	THRESHOLD
2599	STOP LOSS THRESHOLD REACHED	PAY/INFO
2601	PART A CROSSOVER SPANS 20020501	PAY/INFO
2635	FIRST OTHER PHYSICIAN ID INVALID	PAY/INFO
2664	PCS OVER 31 DAYS BILLED	PAY/INFO
3023	FIRST SURGERY PROCEDURE IS ELECTIVE AND NO PRIOR AUTH NBR ENTERED. NON-PR	PAY/INFO
3024	ELECTIVE SURGERY: NO EMERGENCY REPORT	PAY/INFO
3034	EMERGENCY TREATMENT UNDER REVIEW-DENTAL	PAY/INFO
3035	PROCEDURE PERFORMED ON DOS AFTER PRIOR AUTHORIZATION EXPIRATION DATE	PAY/INFO
3036	ELECTIVE SURGERY EMERGENCY INDICATED	PAY/INFO
3037	ELECTIVE SURGERY - NO PRIOR AUTHORIZATION NUMBER ON CLAIM	PAY/INFO
3038	ELECTIVE SURGERY: NO SCREENING ON CLAIM	PAY/INFO
3039	OUT OF STATE CLAIM NOT PAYABLE, CLAIM REVIEWED. SERVICES NOT PRIOR AUTHOR	PAY/INFO
3041	PRIOR AUTH LINE NOT APPROVED	PAY/INFO
3045	DENTAL CLAIM FILED BEFORE PRIOR AUTHORIZATION BEGINNING VALID DATE	PAY/INFO
3047	SERVICE DATE 912 DAYS AFTER PA ISSUE	PAY/INFO
3048	DIAGNOSIS IS 290.0-314.9 AND PA DOES NOT BEGIN 7777 FOR ADMIT PRIOR TO 7/	PAY/INFO
3049	MEDICAL I/P PA NOT ON FILE OR DATE ON CLAIM IS NOT IN PA DATE SPAN	PAY/INFO
3050	PROCEDURE BILLED NOT IN PRIOR AUTHORIZATION RECORD	PAY/INFO
3054	UNIT RATE NOT ALLOWED	PAY/INFO
3055	WAIVER PA ERROR, CLAIM AMOUNT GREATER THAN PA ALLOWED	PAY/INFO
3058	SCREENING REQUIRED, NONE INDICATED	PAY/INFO
3059	FIRST SURG PROC IS ELECTIVE. PROC REQUIRES PRIOR AUTH UNLESS PERFORMED AS	PAY/INFO
3201	AS OF 7/1/2016, HOSPITAL PROVIDER SPECIALTIES; GENERAL HOSPITAL, CHILDREN	PAY/INFO
3229	MISSING OR INVALID SOURCE OF ADMISSION FOR THE DATE OF SERVICE	THRESHOLD

EOB	DESCRIPTION	DISPOSITION
4013	PROCEDURE CODE NOT ON FILE	PAY/INFO
4061	HEADER DELIVERY PROCEDURE REQUIRES GESTATIONAL AGE DIAGNOSIS	PAY/INFO
4062	DETAIL DELIVERY PROCEDURE REQUIRES GESTATIONAL AGE DIAGNOSIS	PAY/INFO
4252	DIAGNOSIS CODE 10-24 NOT ON FILE	THRESHOLD
4354	ADMITTING DIAGNOSIS SUBMITTED ON THE CLAIM IS NOT A VALID ADMIT DIAGNOSIS	PAY/INFO
4893	NDC CODE MISSING	THRESHOLD
4897	MULTIPLE CLAIM DETAILS WITH SAME NDC	PAY/INFO
5000	THIS IS A DUPLICATE OF ANOTHER CLAIM	PAY/INFO
5027	AN OUTPATIENT SERVICE IS NOT PAYABLE FOR THE SAME RECIPIENT, THE SAME BIL	PAY/INFO
5028	AN INPATIENT HOSPITAL CLAIM IS NOT PAYABLE FOR THE SAME RECIPIENT, THE SA	PAY/INFO
7919	THE DISPENSING FEE AMOUNT IS MISSING OR INVALID.	PAY/INFO
7921	A PHARMACY OR COMPOUND DRUG CLAIM WAS SUBMITTED WITH MISSING OTHER PAYMEN	THRESHOLD
7922	A PHARMACY OR COMPOUND DRUG CLAIM WAS SUBMITTED WITH INVALID OTHER PAYMEN	THRESHOLD
8659	5C-M/I OTHER PAYER COVERAGE TYPE	THRESHOLD
8786	E8-M/I OTHER PAYER DATE	THRESHOLD
8792	INVALID OTHER PAYER AMOUNT PAID QUALIFIER (342-HC).	THRESHOLD
8884	MCP PROVIDER NUMBER/NPI BILLED INCORRECTLY	PAY/INFO
8885	MCP PROVIDER NUMBER NOT ON FILE	PAY/INFO
8886	RECIPIENT IS NOT ENROLLED IN MCO	THRESHOLD
8887	INVALID MCP RECIPIENT ID	THRESHOLD
8888	NO MEDICAID ELIBIBILITY FOR MCO RECIPIENT	PAY/INFO
8889	PROCEDURE CODE REQUIRED AT DETAIL LEVEL FOR ENCOUNTERS	THRESHOLD
8890	MISSING OR INVALID MCP PAID DATE	THRESHOLD
8891	MCP PAID DATE IS LESS THAN DETAIL DOS	THRESHOLD
8892	MODIFIER CODE NOT ALLOWED FOR DATE OF SERVICE	THRESHOLD
8893	VALID LMP DATE REQUIRED FOR DELIVERY OR PRENATAL PROCEDURE	PAY/INFO
8894	INVALID LMP DATE	THRESHOLD
8895	LAST MENSTRUAL PERIOD DATE MUST BE LESS THAN FIRST DATE OF SERVICE	PAY/INFO
8896	THE RECIPIENT IS UNDER AGE 21 AS OF THE DATE OF SERVICE, THE PROCEDURE CO	PAY/INFO
8897	ADMIT HOUR MINUTES ARE INVALID	THRESHOLD
8898	MCP CLAIM NUMBER REQUIRED	THRESHOLD
8899	MCP CLAIM NUMBER MUST BE BETWEEN 1 AND 18 BYTES IN LENGTH AND ONLY CONTAI	THRESHOLD
8900	MISSING HEADER MCP PAYMENT AMOUNT	THRESHOLD
8902	CAPITATION INDICATOR REQUIRES AMOUNT > \$0 AT THE CLAIM AND DETAIL LEVELS	THRESHOLD
8903	CAPITATION INDICATOR AT ALL DETAILS REQUIRES AMOUNT > \$0 AT THE CLAIM LEV	THRESHOLD
8904	HEADER MCP PAYMENT MUST BE SUM OF DETAIL MCP PAYMENTS	THRESHOLD
8906	INVALID OR NEGATIVE DTL MCP AMOUNT SUBMITTED	THRESHOLD
8907	INVALID BIRTH WEIGHT	PAY/INFO
8908	INVALID MCP PAID DATE AT LINE LEVEL WHEN FINAL PER TYPE OF BILL	THRESHOLD
8909	INVALID DISCHARGE HOUR	THRESHOLD
8910	MISSING MCP PAID DATE AT LINE LEVEL WHEN FINAL PER TYPE OF BILL	THRESHOLD

EOB	DESCRIPTION	DISPOSITION
8911	MCP PAID DATE AT LINE LEVEL WHEN FINAL PER TYPE OF BILL LESS THAN FIRST A	THRESHOLD
8912	INVALID HEADER MCP PAYMENT AMOUNT	THRESHOLD
8913	MISSING DETAIL MCP PAYMENT AMOUNT	THRESHOLD
8914	INVALID DETAIL MCP PAYMENT AMOUNT	THRESHOLD
8917	INVALID TRADING PARTNER ID	THRESHOLD
8918	INVALID HEADER MCP PAYMENT AMOUNT	THRESHOLD
8919	CLAIM FREQUENCY VALUE MUST BE 1, 7 OR 8 (2300-CLM05-3)	THRESHOLD
8920	DATE TIME FORMAT QUALIFIER MUST BE SUBMITTED WITH D8	THRESHOLD
8921	CONTRACT TYPE CODE INVALID ON HEADER	THRESHOLD
8922	RECIPIENT ID NOT ON FILE	THRESHOLD
8924	INVALID CHECK DIGIT FOR NPI	PAY/INFO
8924	INVALID CHECK DIGIT FOR NPI	THRESHOLD
8925	FOR MEDICAID MANAGED CARE PLANS, THE PAYER RESPONSIBILITY MUST BE SUBMITT	THRESHOLD
8926	INDIVIDUAL RELATIONSHIP MUST BE SUBMITTED WITH 18 - SELF	THRESHOLD
8927	SEVEN-DIGIT REGION/PROGRAM-SPECIFIC MCP PROVIDER NUMBER MUST BE A VALID M	THRESHOLD
8928	FILING INDICATOR MUST BE SUBMITTED WITH HM - HEALTH MAINTENANCE ORGANIZAT	THRESHOLD
8929	PAYER PAID AMOUNT QUALIFIER MUST BE SUBMITTED WITH D / C4	THRESHOLD
8930	MONETARY AMOUNT MUST BE SUBMITTED	THRESHOLD
8931	2330B NM109 FIRST OCCURRENCE NOT SUBMITTED PROPERLY WITH 2320 AND 2430	THRESHOLD
8932	DATE TIME QUALIFIER MUST CONTAIN 573	THRESHOLD
8933	MCP PAID AMOUNT MUST NOT BE GREATER THAN CLAIM BILLED AMOUNT	THRESHOLD
8934	CONTRACT TYPE CODE INVALID ON DETAIL	THRESHOLD
8935	ID TYPE QUALIFIER MUST BE XX	THRESHOLD
8936	INVALID NPI CHECK DIGIT AT DETAIL	THRESHOLD
8938	INVALID REGION/PROGRAM SPECIFIC MCP PROVIDER NUMBER AT DETAIL LEVEL.	THRESHOLD
8939	FIRST OCCURRENCE OF AMOUNT IS REQUIRED AT DETAIL	THRESHOLD
8940	FIRST OCCURRENCE OF DATE/TIME QLFR MUST BE 573 AT DETAIL.	THRESHOLD
8941	FIRST OCCURRENCE OF DATE/TIME FMT QLFR MUST MUST BE D8 AT DETAIL	THRESHOLD
8942	THE HEADER BILLED AMOUNT IS LESS THAN THE SUM OF THE HEADER MCP PAID AMOU	PAY/INFO
8943	DRG CODE NOT SUPPLIED FOR INPATIENT	PAY/INFO
8944	MISSING INDICATOR ON PAID BY DRG CLAIM	THRESHOLD
8945	PAID BY DRG CLAIM REQUIRES 1ST DETAIL MCP AMOUNT >=\$0; IF > \$0, MUST MATC	THRESHOLD
8947	DETAIL DATES OF SERVICE OVERLAPS RESTRICTED MEDICAID DATA	THRESHOLD
8957	PRESCRIPTION NUMBER IS MISSING	THRESHOLD
8958	INVALID CHECK DIGIT FOR MCP ATTENDING PROVIDER NPI	THRESHOLD
8959	INVALID CHECK DIGIT FOR MCP HEADER REFERRING PHYSICIAN	THRESHOLD
8963	ON ENCOUNTERS, MCP PAYER ID / CONTRACT ID NOT ALLOWED ON SUBSEQUENT OTHER	THRESHOLD
8964	PRESCRIPTION NUMBER IS NOT IN ALPHANUMERIC FORMAT OR BETWEEN 1 AND 12 CHA	THRESHOLD
8965	MCP HEADER ATTENDING PROVIDER ID NOT ON FILE	PAY/INFO
8966	MCP FIRST OTHER PROVIDER ID NUMBER NOT ON FILE	PAY/INFO
8967	MCP HEADER SECOND OTHER PROVIDER ID NUMBER NOT ON FILE	PAY/INFO

EOB	DESCRIPTION	DISPOSITION
8968	MCP DETAIL ATTENDING PROVIDER ID NOT ON FILE	PAY/INFO
8980	CLMCN1 SEGMENT IS NOT FOUND	THRESHOLD
8981	OTHER PAYER INFORMATION MISSING OR INVALID	THRESHOLD
8982	FIRST OCCURRENCE OF OTHER PAYER COVERAGE TYPE MUST BE '01'	THRESHOLD
8984	ORIGINAL ICN IS MISSING OR INVALID ON THE PHARMACY REVERSAL [B2 TRANSACTI	THRESHOLD

B. Implementation Checklist

See Trading Partner Information Guide found here: <http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>.

C. Frequently Asked Questions

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