



## **837 Professional Fee-For-Service Claims**

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## Document Information

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## Amendment History

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| 1.0            | 05/11/2014  | ODM & HP EDI Team  | Initial Creation  |
| 1.1            | 12/02/2015  | ODM & HPE EDI Team | Updated references related to Agency name changes.  |
| 1.2            | 02/25/2017  | ODM & HPE EDI Team | Added 2300:REF for Demonstration Project Identifier to provide guidance on vendor approved resubmissions.   |
| 1.3            | 03/22/2017  | ODM & HPE EDI Team | Updated the contact information in Section 5.   |
| 1.4            | 05/31/2017  | ODM & DXC EDI Team | Added guidance for Supervising Provider in 2310D and 2420D. Updated notes for Referring and Ordering Providers in 2310A, 2420E and 2420F. Also, updated the email addresses in Section 5. |
| 1.5            | 09/13/2017  | ODM & DXC EDI Team | Added notes on how the NDC code is entered in 2410:LIN03.   |
| 1.6            | 10/03/2017  | ODM & DXC EDI Team | Added 2400:NTE to indicate details for recording visit times for Home and Community-Based Services.   |

## 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/005010X222A1 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.

The ASC X12 HIPAA 837 Professional Implementation Guide presents the basic requirements for planning and implementing an EDI-based system for the exchange of ASC X12 HIPAA compliant transactions with the Ohio Medicaid Information Technology System (MITS). In order to create a HIPAA compliant transaction, you must first meet the requirements of the ASC X12 HIPAA 837 Professional Implementation Guide and then incorporate the ODM specific requirements.

The segments and elements used in this document are necessary for the ODM adjudication system for Professional Claims.

## 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: <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/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 4:30 pm

**Phone:** (844) 324-7089

**Email:** [ohiomcd-edi-support@dxc.com](mailto:ohiomcd-edi-support@dxc.com)

### 5.2 EDI Technical Assistance

**Days Available:** Monday through Friday

**Time Zone:** Eastern Time (ET)

**Time Available:** 8:00 am to 4:30 pm

**Phone:** (844) 324-7089

**Email:** [ohiomcd-edi-support@dxc.com](mailto:ohiomcd-edi-support@dxc.com)

### 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               |           |        | 7 digit Trading Partner ID assigned by ODM.<br><br>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             | 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.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   |           |        | 7 digit Trading Partner ID assigned by ODM |
| C.7    |         | GS03      | Application Receiver's Code | MMISODJFS |        |  |
| 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                 |
|--------|---------|-----------|--------------------------------|-------|--------|--------------------------------|
| 70     |         | ST        | Transaction Set Header         |       |        |                                |
| 70     |         | ST02      | Transaction Set Control Number |       |        | Identical to the value in SE02 |

| Page # | Loop ID | Reference | Name                           | Codes | Length | Notes/Comments  |
|--------|---------|-----------|--------------------------------|-------|--------|---|
| 496    |         | SE        | Transaction Set Trailer        |       |        |   |
| 496    |         | SE01      | Number of Included Segments    |       |        | Total number of segments included in a transaction set including ST and SE segments |
| 496    |         | 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 send 837 Professional 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**

### **8.1 The 999 Implementation Acknowledgement**

Each time a properly formatted 5010 X12 file is submitted to Ohio Medicaid, a 999 acknowledgement is returned to the submitter.

### **8.2 Report Inventory**

If a 5010 X12 file fails compliance, a TRC report file is returned to the submitter. This file contains details that will assist the submitter to identify the issue and correct the problem.

## 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.
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with ODM.

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

| Page # | Loop ID | Reference | Name                                  | Codes     | Length | Notes/Comments   |
|--------|---------|-----------|---------------------------------------|-----------|--------|--|
| 71     |         | BHT       | Beginning of Hierarchical Transaction |           |        |  |
| 71     |         | BHT02     | Transaction Set Purpose Code          | 00        |        | Original   |
| 72     |         | BHT06     | Claim or Encounter Identifier         | CH        |        | Chargeable   |
| 74     | 1000A   | NM1       | Submitter Name                        |           |        |  |
| 75     | 1000A   | NM109     | Submitter Identifier                  |           |        | 7 digit Ohio Medicaid Trading Partner ID assigned by ODM                                     |
| 79     | 1000B   | NM1       | Receiver Name                         |           |        |  |
| 80     | 1000B   | NM109     | Receiver Primary Identifier           | MMISODJFS |        |  |
| 87     | 2010AA  | NM1       | Billing Provider Name                 |           |        |  |
| 90     | 2010AA  | NM109     | Billing Provider Identifier           |           |        | Provider NPI   |
| 114    | 2000B   | HL        | Subscriber Hierarchical Level         |           |        | For Ohio Medicaid, the “insured”, “subscriber” and the “patient” are always the same person. |
| 115    | 2000B   | HL04      | Hierarchical Child Code               | 0         |        | No subordinate HL segment in this hierarchical structure.                                    |
| 116    | 2000B   | SBR       | Subscriber Information                |           |        |  |
| 118    | 2000B   | SBR09     | Claim Filing Indicator Code           | MC        |        | Medicaid   |

| Page # | Loop ID | Reference | Name                                      | Codes  | Length | Notes/Comments   |
|--------|---------|-----------|---|--|--------|--|
| 121    | 2010BA  | NM1       | Subscriber Name                           |  |        |  |
| 122    | 2010BA  | NM108     | Identification Code Qualifier             | MI   |        | Member Identification Number   |
| 123    | 2010BA  | NM109     | Subscriber Primary Identifier             |  |        | 12-digit Medicaid recipient billing number   |
| 133    | 2010BB  | NM1       | Payer Name                                |  |        |  |
| 134    | 2010BB  | NM108     | Identification Code Qualifier             | PI   |        | Payor Identification   |
| 134    | 2010BB  | NM109     | Payer Identifier                          | MMISODJFS  |        |  |
| 140    | 2010BB  | REF       | Billing Provider Secondary Identification |  |        |  |
| 140    | 2010BB  | REF01     | Reference Identification Qualifier        | G2   |        | Provider Commercial Number   |
| 141    | 2010BB  | REF02     | Billing Provider Secondary Identifier     |  |        | Atypical Provider ID assigned by ODM (Medicaid Billing ID)   |
| 182    | 2300    | PWK       | Claim Supplemental Information            |  |        | Follow these instructions when an EDI claim requires an attachment. Completion of this information indicates an attachment is being sent. The claim will be suspended waiting for the attachment.  |
| 183    | 2300    | PWK01     | Attachment Report Type Code               | B4   |        | Referral Form  |
| 184    | 2300    | PWK02     | Attachment Transmission Code              | BM, EL, FT   |        | FT - use when sending the attachment via the MITS Portal   |
| 185    | 2300    | PWK06     | Attachment Control Number                 | ODM03197,<br>ODM03198,<br>ODM03199,<br>ODM06653,<br>ODM99999 |        | <p>ODM03197 – the attachment documents include the Abortion Certification Form</p> <p>ODM03198 – the attachment document(s) include the Consent for Sterilization Form</p> <p>ODM03199 – the attachment document(s) include the Acknowledgment of Hysterectomy Information Form</p> <p>ODM06653 – attachment document(s) include the Medical Claim Review Request Form</p> <p>ODM99999 – Other attachment document(s) do not include any of the forms listed above</p> |

| Page # | Loop ID | Reference | Name                               | Codes    | Length | Notes/Comments   |
|--------|---------|-----------|------------------------------------|----------|--------|--|
| 188    | 2300    | AMT       | Patient Amount Paid                |          |        |  |
| 188    | 2300    | AMT01     | Amount Qualifier Code              | F5       |        | Patient Amount Paid  |
| 188    | 2300    | AMT02     | Patient Amount Paid                |          |        | <p>In most cases the Patient Amount Paid should not be submitted.</p> <p>Never report Medicaid copayment amounts collected (or incurred) or the copayments will be deducted twice.</p> <p>Report spend down amounts incurred or paid if the billed charges for the services on the claim were used to become eligible for Medicaid.</p> <p>Report Patient Liability amounts whenever applicable (e.g., Hospice room and board, waiver claims).</p> |
| 205    | 2300    | REF       | Demonstration Project Identifier   |          |        | Used for vendor approved resubmissions.  |
| 205    | 2300    | REF01     | Reference Identification Qualifier | P4       |        | Project Code   |
| 205    | 2300    | REF02     | Demonstration Project Identifier   |          |        | Original ICN   |
| 209    | 2300    | NTE       | Claim Note                         |          |        |  |
| 209    | 2300    | NTE01     | Note Reference Code                | ADD, CER |        | <p>ADD - will be used by providers to denote a copayment exemption applies (see NTE02 Comments)</p> <p>ADD - will be used by providers to denote timely filing exemption (See NTE02 Comments)</p> <p>CER - required if Billing Provider is a Medicaid School Program (MSP) Provider (See NTE02 Comments)</p>   |
| 210    | 2300    | NTE02     | Claim Note Text                    |          |        | <p>When a Medicaid co-payment exclusion applies, the 10 character code (see Application Value List below) must be the first item listed in the NTE02. There must always be a single space between the word COPAY and the four character exclusion code.</p> <p>Application Value List (Select one):<br/>                     COPAY EMER (Emergency)<br/>                     COPAY HSPC (Hospice)</p>  |

| Page # | Loop ID | Reference | Name                    | Codes | Length | Notes/Comments  |
|--------|---------|-----------|-------------------------|-------|--------|---|
|        |         |           |                         |       |        | <p>COPAY PREG (Pregnancy)</p> <p>Example: NTE*ADD*COPAY EMER</p> <p>When a claim could not be filed within the normal claim filing limit due to the pendency of an administrative hearing decision by ODM or an eligibility determination by a County Department of Job and Family Services (CDJFS) the (1) or (2) below applies.</p> <p>(1) For appeals/hearings, report the appeals/hearing number and date (The XXXXXXXX is the hearing number) in this format:</p> <p><b>APPEALS XXXXXXXX CCYYMMDD</b></p> <p>(2) For a delayed eligibility determination, enter the eligibility determination decision date in this format.</p> <p><b>DECISION CCYYMMDD</b></p> <p>Example (1): NTE*ADD*APPEALS<br/>123456A 110906</p> <p>Example (2): NTE*ADD*DECISION<br/>110831</p> <p>(3) When a Medicaid Schools Program claim is submitted, the 10 character code (see Application Value List below) must be the first item listed in the NTE02. There must always be a single space between the word ATTEST and the three character exclusion code.</p> <p>Application Value List:<br/>ATTEST NAY<br/>ATTEST YES</p> <p>Example: NTE*CER*ATTEST YES</p> |
| 257    | 2310A   | NM1       | Referring Provider Name |       |        | <p>Provider must be enrolled with Ohio Medicaid.</p> <p>When a Medicaid School Program (MSP) provider is billing for a therapy service, either an Ordering or Referring provider is required.</p>   |

| Page # | Loop ID | Reference | Name  | Codes              | Length | Notes/Comments   |
|--------|---------|-----------|---|--------------------|--------|--|
| 259    | 2310A   | NM109     | Referring Provider Identifier                 |                    |        | Provider NPI   |
| 260    | 2310A   | REF       | Referring Provider Secondary Identification   |                    |        | ODM generally expects Referring Providers to be 'Typical' Providers  |
| 260    | 2310A   | REF01     | Reference Identification Qualifier            | G2                 |        | Provider Commercial Number   |
| 261    | 2310A   | REF02     | Referring Provider Secondary Identifier       |                    |        | Atypical Provider ID assigned by ODM (Medicaid Billing ID)   |
| 262    | 2310B   | NM1       | Rendering Provider Name                       |                    |        |  |
| 264    | 2310B   | NM109     | Rendering Provider Identifier                 |                    |        | Provider NPI   |
| 267    | 2310B   | REF       | Rendering Provider Secondary Identification   |                    |        |  |
| 267    | 2310B   | REF01     | Reference Identification Qualifier            | G2                 |        | Provider Commercial Number   |
| 268    | 2310B   | REF02     | Rendering Provider Secondary Identifier       |                    |        | Atypical Provider ID assigned by ODM (Medicaid Billing ID)   |
| 280    | 2310D   | NM1       | Supervising Provider Name                     |                    |        | Provider must be enrolled with Ohio Medicaid   |
| 282    | 2310D   | NM109     | Supervising Provider Identifier               |                    |        | Provider NPI   |
| 283    | 2310D   | REF       | Supervising Provider Secondary Identification |                    |        | ODM generally expects Supervising Providers to be 'Typical' Providers  |
| 283    | 2310D   | REF01     | Reference Identification Qualifier            | G2                 |        | Provider Commercial Number   |
| 284    | 2310D   | REF02     | Supervising Provider Secondary Identifier     |                    |        | Atypical Provider ID assigned by ODM (Medicaid Billing ID)   |
| 295    | 2320    | SBR       | Other Subscriber Information                  |                    |        |  |
| 296    | 2320    | SBR09     | Claim Filing Indicator Code                   | MA, MB, 16, CI, BL |        | <p>MA - For Original Medicare Part A claims</p> <p>MB - For Original Medicare Part B claims</p> <p>16 - When other payer is a Medicare HMO / Part C plan</p> <p>CI - When other payer is commercial insurance (other than Blue Cross)</p> <p>BL - When other payer is Blue Cross/ Blue Shield Plan</p> <p>Any other appropriate value except MC (MC should only be used in 2000B loop)</p> |

| Page # | Loop ID | Reference | Name                        | Codes              | Length | Notes/Comments   |
|--------|---------|-----------|-----------------------------|--------------------|--------|--|
| 299    | 2320    | CAS       | Claim Level Adjustments     |                    |        | <p>Medicaid is the payer of last resort. The claim must first be adjudicated by all payers submitted in the 2330B loop before submitting the claim to ODM, unless an exception set forth in Rule 5160-1-05 or 5160-1-08 of the Ohio Administrative Code (OAC) applies. The total amount paid by the payer in 2330B for all services on the claim must be submitted (AMT 2320). If the payer in 2330B adjudicated the claim at the claim/header level, the associated Adjustment Code Group (s), Adjustment Reason Code(s) and Amount(s) must be submitted in this loop/segment. If the payer in 2330B adjudicated the claim at the detail level (i.e., made line payments and/or made line adjustments that caused the line payment to differ from the line billed charges), the 2430 loop must be completed. If the payer in 2330B adjudicated the claim at the detail, but made some adjustments at the header/claim level that caused the claim payment to differ from the sum of the line payments, the 2320 CAS must be submitted in addition to the appropriate adjustments made in 2430 CAS.</p> <p>COB balancing rules apply and may be enforced (See IG Balancing).</p> |
| 301    | 2320    | CAS01     | Claim Adjustment Group Code | CO, CR, OA, PI, PR |        | <p>CO - Contractual Obligations<br/>                     CR - Correction and Reversals<br/>                     OA - Other adjustments<br/>                     PI - Payer Initiated Reductions<br/>                     PR - Patient Responsibility</p>   |
| 413    | 2400    | NTE       | Line Note                   |                    |        | Used by providers rendering Home and Community-Based Services that require Electronic Visit Verification.  |
| 413    | 2400    | NTE01     | Note Reference Code         | ADD                |        | Additional Information   |
| 413    | 2400    | NTE02     | Line Note Text              |                    |        | <p>Enter the Home and Community-Based Services visit time details in one of the following 2 formats:</p> <ul style="list-style-type: none"> <li>• HHMMxxHHMMxx or</li> <li>• HHMMxxHHMMxxY (when the service duration is less than 90 days)</li> </ul>   |



| Page # | Loop ID | Reference | Name  | Codes | Length | Notes/Comments   |
|--------|---------|-----------|---|-------|--------|--|
|        |         |           |   |       |        | These formats indicate the start time followed by the end time. Here,<br>HH = hour (01 – 12 )<br>MM = minutes (00 – 59)<br>xx = AM or PM   |
| 423    | 2410    | LIN       | Drug Identification                           |       |        |  |
| 425    | 2410    | LIN03     | National Drug Code                            |       |        | National Drug Code. Enter the code without dashes or hyphens.  |
| 430    | 2420A   | NM1       | Rendering Provider Name                       |       |        |  |
| 432    | 2420A   | NM109     | Rendering Provider Identifier                 |       |        | Provider NPI   |
| 434    | 2420A   | REF       | Rendering Provider Secondary Identification   |       |        |  |
| 434    | 2420A   | REF01     | Reference Identification Qualifier            | G2    |        | Provider Commercial Number   |
| 435    | 2420A   | REF02     | Rendering Provider Secondary Identifier       |       |        | Atypical Provider ID assigned by ODM (Medicaid Billing ID)   |
| 449    | 2420D   | NM1       | Supervising Provider Name                     |       |        | Provider must be enrolled with Ohio Medicaid   |
| 451    | 2420D   | NM109     | Supervising Provider Identifier               |       |        | Provider NPI   |
| 452    | 2420D   | REF       | Supervising Provider Secondary Identification |       |        | ODM generally expects Supervising Providers to be 'Typical' Providers  |
| 452    | 2420D   | REF01     | Reference Identification Qualifier            | G2    |        | Provider Commercial Number   |
| 453    | 2420D   | REF02     | Supervising Provider Secondary Identifier     |       |        | Atypical Provider ID assigned by ODM (Medicaid Billing ID)   |
| 454    | 2420E   | NM1       | Ordering Provider Name                        |       |        | Provider must be enrolled with Ohio Medicaid.<br><br>Required when an MSP provider is billing for a nursing service.<br><br>When an MSP provider is billing for a therapy service, either an Ordering or Referring provider is required. |
| 456    | 2420E   | NM109     | Ordering Provider Identifier                  |       |        | Provider NPI   |
| 460    | 2420E   | REF       | Ordering Provider Secondary Identification    |       |        |  |
| 460    | 2420E   | REF01     | Reference Identification Qualifier            | G2    |        | Provider Commercial Number   |
| 461    | 2420E   | REF02     | Ordering Provider Secondary Identifier        |       |        | Atypical Provider ID assigned by ODM (Medicaid Billing ID)   |

| Page # | Loop ID | Reference | Name  | Codes              | Length | Notes/Comments  |
|--------|---------|-----------|---|--------------------|--------|---|
| 465    | 2420F   | NM1       | Referring Provider Name                     |                    |        | Provider must be enrolled with Ohio Medicaid.<br><br>When an MSP provider is billing for a therapy service, either an Ordering or Referring provider is required.   |
| 467    | 2420F   | NM109     | Referring Provider Identifier               |                    |        | Provider NPI  |
| 468    | 2420F   | REF       | Referring Provider Secondary Identification |                    |        | ODM generally expects Referring Providers to be 'Typical' Providers   |
| 468    | 2420F   | REF01     | Reference Identification Qualifier          | G2                 |        | Provider Commercial Number  |
| 469    | 2420F   | REF02     | Referring Provider Secondary Identifier     |                    |        | Atypical Provider ID assigned by ODM (Medicaid Billing ID)  |
| 484    | 2430    | CAS       | Line Adjustment                             |                    |        | Medicaid is the payer of last resort. The claim must first be adjudicated by all payers submitted in the 2330B loop before submitting the claim to ODM, unless an exception set forth in Rule 5160-1-05 or 5160-1-08 of the Ohio Administrative Code applies. The total amount paid by the payer in 2330B for all services on the claim must be submitted (AMT 2320). If the payer in 2330B adjudicated the claim at the detail level (i.e., made line payments and/or made line adjustments that caused the line payment to differ from the line billed charges), the 2430 loop must be completed. If the payer in 2330B adjudicated the claim at the detail but made some adjustments at the header/claim level that caused the claim payment to differ from the sum of the line payments, the 2320 CAS must be submitted in addition to the appropriate adjustments made in 2430 CAS.<br><br>COB balancing rules may be enforced (See IG Balancing). |
| 485    | 2430    | CAS01     | Claim Adjustment Group Code                 | CO, CR, OA, PI, PR |        | CO - Contractual Obligations<br>CR - Correction and Reversals<br>OA - Other adjustments<br>PI - Payer Initiated Reductions<br>PR - Patient Responsibility   |

## APPENDICES

### A. Implementation Checklist

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

### B. Frequently Asked Questions

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