Ohio | Department of Medicaid

MyCare Ohio

837 Institutional Encounter Claims

Version 1.10

November 10, 2020

Document Information

Document Title:	**MyCare Ohio 837 Institutional Encounter Claims**
Document ID:	**MyCare Ohio 837I Enc CG.docx**
Version:	**1.10**
Owner:	**Ohio MITS Team**
Author:	**Ohio Department of Medicaid & DXC EDI Team**

Amendment History

Version	Date	Modified By	Modifications
1.0	05/11/2014	ODM & HP EDI Team	Initial Creation
1.1	04/28/2015	ODM & HP EDI Team	Updated notes around Check or Remittance Date sent in Loop 2330B or 2430.
1.2	12/02/2015	ODM & HPE EDI Team	Minor Updates.
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	Moved guidance around 2410:LIN and 2410:CTP to Section 7. Also updated the email addresses in Section 5.
1.5	09/13/2017	ODM & DXC EDI Team	Updated the notes for 2410:LIN and 2410:CTP. Added notes on how the NDC code is entered in 2410:LIN03.
1.6	09/18/2017	ODM & DXC EDI Team	Updated the note related to 2010BA:NM109 requiring the submission of Medicaid IDs.
1.7	07/23/2018	ODM & DXC EDI Team	Moved and updated the Payment Arrangement Information from Section 1 to Section 7. Also updated notes around 2300:CN102, 2320:AMT02 and 2430:SVD02.
1.8	01/15/2020	ODM & DXC EDI Team	Added notes to 2300:AMT and 2320:CAS related to Nursing Facility Patient Liability.
1.9	09/10/2020	ODM & DXC EDI Team	Added notes around 2300:CN104. Corrected section 8.2 to reference HTML report files.
1.10	11/10/2020	ODM & DXC EDI Team	Updated the notes for the 2300:REF02 that contains the claim identifier for transmission intermediaries.

Disclosure Statement

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/005010X223A2 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 Institutional 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 Institutional Implementation Guide and then incorporate the ODM specific requirements.

To properly process MyCare Ohio 837 transactions, Ohio MITS requires only ONE transaction type in each transmission file beginning with the Interchange Control Header (ISA) and ending with the Interchange Control Trailer (IEA) envelope segments. A separate file for each transaction type should be submitted – for example, one file containing only the 837P professional data, one file containing only 837I institutional data and one file containing only 837D dental data. ISA/IEA transaction sets should not exceed 5,000 encounters. ODM recommends that FTP submitters' scripts upload no more than one (1) file per five (5) minute intervals.

The page reference to the ASC X12 837 Institutional Implementation Guide (HIPAA IG) is provided along with each segment or element.

Every effort has been made to prevent errors in this document. However, if discrepancies exist between the EDI Companion Guide and the ASC X12 837 Institutional Implementation Guide, the Implementation Guide is the final authority.

Provider Information Flow

Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, insurer, primary administrator, contract holder, or claimant.

Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.

Loop 2420C is required if the Rendering Provider's information is different than that carried in the 2310A Attending Provider (claim-level) loop, or if the Rendering Provider information carried at the Billing Provider Loop (2010AA) and this particular service line has a different Rendering Provider than what is given in the 2010AA loop.

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

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

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			ISA/IEA transaction sets should not exceed 5,000 encounters. ODM recommends that FTP submitters' scripts upload no more than one (1) file per five (5) minute intervals.
C.4		ISA01	Authorization Information Qualifier	00		No Authorization Information Present (No Meaningful Information in ISA02)
C.4		ISA02	Authorization Information			Use 10 blank spaces
C.4		ISA03	Security Information Qualifier	00		No Security Information Present (No Meaningful Information in ISA04)
C.4		ISA04	Security Information			Use 10 blank spaces.
C.4		ISA05	Interchange ID Qualifier	ZZ		Mutually Defined
C.4		ISA06	Interchange Sender 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.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.4		ISA11	Repetition Separator	^		
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
C.6		ISA15	Usage Indicator	T, P		T = Test P = Production

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.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
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. This value must match the value in ISA06
C.7		GS03	Application Receiver's Code	MMISODJFS		This value must match the value in ISA08.
C.8		GS06	Group Control Number			Must be identical to the value in GE02.
C.8		GS08	Version/Release/Industry Identifier Code	005010X223A2		

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
67		ST	Transaction Set Header			
67		ST01	Transaction Set Identifier Code	837		Health Care Claim

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
67		ST02	Transaction Set Control Number			Identical to the value in SE02.
67		ST03	Implementation Convention Reference	005010X223A2		

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
488		SE	Transaction Set Trailer			
488		SE01	Number of Included Segments			Total number of segments included in a transaction set including ST and SE segments
488		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 MyCare Ohio 837 Institutional 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.

- The **LIN (Drug Identification)** segment in the 2410 loop is required when the HCPCS and/or CPT codes listed below are used:

  B4164 - B4240
  J0120 - J9999
  Q0090 - Q9989
  S0145 - S5001
  CPT codes in the 90281-90399 series

- The **CTP (Drug Quantity)** segment in the 2410 loop must be used in the following conditions:

  HCPCS Codes in the J series
  HCPCS Codes in the B, Q or S series that represent drugs
  CPT codes in the 90281-90399 series.

Payment Arrangement Information

ODM considers a capitation payment arrangement to include those arrangements for which a sub-contracted entity to the MCP assumes a risk. If any part of the encounter is part of capitation payment arrangement, the line-level item contract type should reflect whether the service is part of a capitation payment arrangement and the claim-level amount must be recorded as such with a contract type of capitation. For encounters which have a capitation payment arrangement, the MCP must provide approximate payment information as follows:

1. If an MCP sub-contracts with another entity to pay claims on the MCPs behalf (for example, a pharmacy benefit manager (PBM)), the amount paid to the servicing provider (for example, a pharmacy) must be submitted to ODM on the claim or encounter. The paid amount cannot be the amount the MCP paid the benefit manager.

2. For payments arrangements for which the MCP pays a per member per month rate to a provider or group of providers, the MCP must shadow price the encounter to be the amount that the MCP would have paid to the provider if the capitation arrangement did not exist.

   a. If the MCP also maintains a contractual arrangement on a fee-for-service basis with the provider, the MCP must submit the amount that the MCP's claims system would have priced the claim at the claim and line-level per the adjudication process specific to that provider.

   b. If the MCP does not maintain a contractual arrangement on a fee-for-service basis with the provider, the MCP must submit the amount that the MCP's claims system would have priced the claim at the claim and line-level per the adjudication process that is for the same provider type and specialty (if appropriate) which is within either the county, region, and/or state (prioritized in this order per the information that is available).

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, an HTML 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.
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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
68		BHT	Beginning of Hierarchical Transaction			
68		BHT02	Transaction Set Purpose Code	00		Original
69		BHT03	Originator Application Transaction Identifier			Must be a unique identifier across all files. Used to identify file level duplicates collectively with ISA13, GS06, and ST02.
69		BHT06	Claim Identifier	RP		Reporting
71	1000A	NM1	Submitter Name			
72	1000A	NM102	Entity Type Qualifier	2		Non-Person Entity
72	1000A	NM109	Submitter Identifier			7 digit Ohio Medicaid Trading Partner ID assigned by ODM. This value must match the value in ISA06.
73	1000A	PER	Submitter EDI Contact Information			
74	1000A	PER03	Communication Number Qualifier	TE		Submitter's telephone number
74	1000A	PER05	Communication Number Qualifier	EM		Submitter's email address
75	1000A	PER07	Communication Number Qualifier	FX		Submitter's fax number
76	1000B	NM1	Receiver Name			
76	1000B	NM102	Entity Type Qualifier	2		Non-Person Entity

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
77	1000B	NM103	Receiver Name	Ohio Department of Medicaid		
77	1000B	NM109	Receiver Primary Identifier	MMISODJFS		Identifies the receiver of the transaction
84	2010AA	NM1	Billing Provider Name			Any Billing Provider that has an NPI must submit it with this segment. The provider information submitted in this loop should be for a Medicaid billing provider that provides services. It should not be Trading Partner information. For group professional practices which are submitted as the billing provider, the individual attending provider should be submitted in the 2310A loop. The individual rendering should be included in the 2310C loop if different than attending. If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error. An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
86	2010AA	NM108	Identification Code Qualifier	XX		Centers for Medicare and Medicaid Services National Provider Identifier
86	2010AA	NM109	Billing Provider Identifier			Provider NPI
88	2010AA	N4	Billing Provider City, State, Zip Code			
88	2010AA	N403	Billing Provider Postal Zone or Zip Code			The full nine (9) digits of the Zip Code are required. If the last four (4) digits of the Zip code are not available, populate a default value of “9998”.
90	2010AA	REF	Billing Provider Tax Identification			
90	2010AA	REF01	Reference Identification Qualifier	EI		Employer’s Identification Number (EIN)
90	2010AA	REF02	Billing Provider Tax Identification Number	199999997		Institutional provider default EIN
107	2000B	HL	Subscriber Hierarchical Level			For Ohio Medicaid, the “insured”, “subscriber” and the “patient” are always the same person.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
108	2000B	HL04	Hierarchical Child Code	0		No subordinate HL segment in this hierarchical structure.
109	2000B	SBR	Subscriber Information			
109	2000B	SBR01	Payer Responsibility Sequence Number Code	S		Secondary Medicare-Medicaid Encounter Data System (MMEDSCMS) is considered as the secondary destination payer.
110	2000B	SBR09	Claim Filing Indicator Code	MA, **MC**		MA = Medicare Part A **MC = Medicaid**
112	2010BA	NM1	Subscriber Name			
113	2010BA	NM108	Identification Code Qualifier	MI		Member Identification Number
114	2010BA	NM109	Subscriber Primary Identifier			This is the Subscriber's Medicaid ID. Must match the value in Loop 2330A, NM109
122	2010BB	NM1	Payer Name			
123	2010BB	NM103	Payer Name	MMEDSCMS		Medicare-Medicaid Encounter Data System
123	2010BB	NM108	Identification Code Qualifier	PI		Payor Identification
123	2010BB	NM109	Payer Identifier	80888, **80891**		80888 = Medicare **80891 = Medicaid**
124	2010BB	N3	Payer Address			
124	2010BB	N301	Payer Address Line	7500 Security Blvd		
125	2010BB	N4	Payer City, State, Zip Code			
125	2010BB	N401	Payer City Name	Baltimore		
125	2010BB	N402	Payer State Code	MD		
126	2010BB	N403	Payer Postal Zone or Zip Code	212441850		
127	2010BB	REF	Payer Secondary Identification			
127	2010BB	REF01	Reference Identification Qualifier	2U		Payer Identification Number
128	2010BB	REF02	Payer Additional Identifier			Contract ID Number of the Managed Care Plan (MCP) or other entity
129	2010BB	REF	Billing Provider Secondary Identification			Complete only if Provider does not have an NPI.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
129	2010BB	REF01	Reference Identification Qualifier	G2		Commercial Provider ID or ODM Medicaid Reporting/ Provider ID
130	2010BB	REF02	Billing Provider Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
143	2300	CLM	Claim Information			
144	2300	CLM01	Claim Submitter's Identifier			This field should contain the Managed Care Plan (MCP) generated Transaction Control Number (TCN)
145	2300	CLM02	Total Claim Charge Amount			Total claim charges must be equal to the sum of all line item charges. For Third Party Liability (TPL) claims total charges must balance.
145	2300	CLM05-3	Claim Frequency Code	1, 2, 3, 4, 7, 8, 9		1 = Original claim submission 2 = Interim – First Claim 3 = Interim – Continuing Claim 4 = Interim – Last Claim 7 = Replacement 8 = Deletion 9 = Final Claim for a Home Health PPS Episode
151	2300	DTP	Admission Date/Hour			
151	2300	DTP02	Date Time Period Format Qualifier	D8, DT		D8 = CCYYMMDD DT = CCYYMMDDHHMM
151	2300	DTP03	Admission Date/Hour			Hours (HH) are expressed as "00" for midnight, "01" for 1A.M., and so on through "23" for 11 P.M. Minutes (MM) are expressed as "00" through "59". If the actual minutes are not known, use a default of "00". This is only required for original or final bills.
154	2300	PWK	Claim Supplemental Information			
155	2300	PWK01	Attachment Report Type Code	09, OZ, PY		09 = For chart review submissions only OZ = For encounters generated as a result of paper claims only PY = For encounters generated as a result of 4010 submission only
156	2300	PWK02	Attachment Transmission Code	AA		Populated for chart review, paper generated, and 4010 generated encounters
158	2300	CN1	Contract Information			MCP payment arrangement at the claim level.
158	2300	CN101	Contract Type code	01, 02, 03, 04, 05, 06, 09		01 = Diagnosis Related Group (DRG) 02 = Per Diem 03 = Variable Per Diem 04 = Flat

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						05 = Capitated 06 = Percent 09 = Other
158	2300	CN102	Contract Amount			This amount must match AMT02 identifying the MCP, or the MCP's subcontracted Benefit Manager, paid amount in the first occurrence of the 2320 loop. This amount must equal the sum of the SVD02 values in the 2430 loop: - except if the CN101 value is '01', - then either: the SVD02 values in the 2430 loop will be zero and the line level will not sum to the claim level - or if it is part of a capitated arrangement, the first line of SVD02 value in the 2430 loop will be equal to the claim level, with the other SVD02 values being 0.
159	2300	CN104	Contract Code	P, R, D		Please indicate if a claim is paid, partially paid or denied using the following 1 digit character: P = Paid R = Partially Paid D = Denied
160	2300	AMT	Patient Estimated Amount Due			Patient Co-Pay Amount DO NOT Use for Nursing Facility Patient Liability deduction
160	2300	AMT01	Amount Qualifier Code	F3		Patient Responsibility - Estimated
160	2300	AMT02	Patient Responsibility Amount			Report any co-payment charged and collected by the MCP.
166	2300	REF	Payer Claim Control Number			Use this REF segment when submitting a reversal/correction to the original encounter.
166	2300	REF01	Reference Identification Qualifier	F8		Original Reference Number
166	2300	REF02	Payer Claim Control Number			13 digit original ICN assigned by ODM to the original encounter without any spaces or hyphens.
170	2300	REF	Claim Identifier for Transmission Intermediaries			
170	2300	REF01	Reference Identification Qualifier	D9		Claim Number
171	2300	REF02	Value Added Network Trace Number			This is the ICN assigned by CMS. Submitting this information is optional and not required to be sent on MyCare encounters.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
173	2300	REF	Medical Record Number			
173	2300	REF01	Reference Identification Qualifier	EA		Medical Record Identification Number
173	2300	REF02	Medical Record Number	8		*Chart review delete diagnosis code only submission* – Identifies the diagnosis code populated in Loop 2300, HI must be deleted from the encounter ICN in Loop 2300, REF02.
			Medical Record Number	Deleted Diagnosis Code(s)		*Chart review add and delete specific diagnosis codes on a single encounter submissions only* – Identifies the diagnosis code(s) that must be deleted from the encounter ICN in Loop 2300, REF02
180	2300	NTE	Billing Note			
180	2300	NTE01	Note Reference Code	ADD		Additional Information
180	2300	NTE02	Billing Note Text			The reason for the use of default information. Loop 2300, NTE02 allows for a maximum of 80 characters and one iteration, which limits the submission of default data to one message per encounter.
181	2300	CRC	EPSDT Referral			Required by HIPAA for EPSDT claims. Used for Federal Reporting requirements.
181	2300	CRC01	Code Qualifier	ZZ		Mutually Defined EPSDT Screening referral information
182	2300	CRC02	Certification Condition Code Applies Indicator	Y, N		Y = Yes N = No
182	2300	CRC03	Condition Indicator	S2, ST		S2 = Under Treatment ST = New Services Requested Required if CRC02 = Y
218	2300	HI	Diagnosis Related Group (DRG) Information			
218	2300	HI01-1	Code List Qualifier Code	DR		Diagnosis Related Group (DRG) Required when the MCP pays the claim by DRG.
284	2300	HI	Value Information			Required on newborn encounter claims. Must use value code 54 (newborn birth weight in grams) to specify the birth weight for newborn hospitalizations. Report birth weight in C02205, Monetary Amount.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
284	2300	HI01-1	Code List Qualifier Code	BE		Value
284	2300	HI01-2	Value Code	A0		Required on all ambulance encounters
285	2300	HI01-5	Value Code Amount			Must include the ambulance pick-up location Zip Code+4, when available, in the following format: xxxxxxxx.x
319	2310A	NM1	Attending Provider Name			The provider information submitted in this loop should be for a Medicaid billing provider that provides services. It should not be Trading Partner information. For group professional practices which are submitted as the billing provider, the individual attending provider should be submitted in the 2310A loop. If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error. An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
321	2310A	NM109	Attending Provider Primary Identifier			Provider NPI
324	2310A	REF	Attending Provider Secondary Identification			Complete only if Provider does not have an NPI.
324	2310A	REF01	Reference Identification Qualifier	G2		Commercial Provider ID or ODM Medicaid Reporting/ Provider ID
325	2310A	REF02	Attending Provider Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
326	2310B	NM1	Operating Physician Name			The provider information submitted in this loop should be for a Medicaid billing provider that provides services. It should not be Trading Partner information. For group professional practices which are submitted as the billing provider, the individual operating provider should be submitted in the 2310B loop. If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
328	2310B	NM109	Operating Physician Primary Identifier			Provider NPI
329	2310B	REF	Operating Physician Secondary Identification			Complete only if Provider does not have an NPI.
329	2310B	REF01	Reference Identification Qualifier	G2		Commercial Provider ID or ODM Medicaid Reporting/ Provider ID
330	2310B	REF02	Operating Physician Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
331	2310C	NM1	Other Operating Physician Name			The provider information submitted in this loop should be for a Medicaid provider that provides services. It should not be Trading Partner information. For group professional practices which are submitted as the billing provider, the individual other operating provider should be submitted in the 2310C loop. If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error. An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
333	2310C	NM109	Other Operating Physician Identifier			Provider NPI
334	2310C	REF	Other Operating Physician Secondary Identification			Complete only if Provider does not have an NPI.
334	2310C	REF01	Reference Identification Qualifier	G2		Commercial Provider ID or ODM Medicaid Reporting/ Provider ID
335	2310C	REF02	Other Provider Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
349	2310F	NM1	Referring Provider Name			
351	2310F	NM109	Referring Provider Identifier			Provider NPI
352	2310F	REF	Referring Provider Secondary Identification			Complete only if Provider does not have an NPI.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
352	2310F	REF01	Reference Identification Qualifier	G2		Commercial Provider ID or ODM Medicaid Reporting/ Provider ID
353	2310F	REF02	Referring Provider Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
354	2320	SBR	Other Subscriber Information			This is required for the first occurrence and subsequent occurrences when there is other payer information.
355	2320	SBR01	Payer Responsibility Sequence Number Code	P, T		**The first occurrence must contain information for the MCP as the primary payer.** P = Primary (when MCPs or other entities populate the payer paid amount) T = Tertiary (when MCPs or other entities populate a true COB)
355	2320	SBR02	Individual Relationship Code	18		This is the only option for Institutional Encounter claims for the first occurrence. Subsequent occurrences should be billed as appropriate. **Refer to the Implementation Guide for the other codes/values to use.**
356	2320	SBR03	Insured Group or Policy Number			For the first occurrence this should be the Contract ID Number of the MCP. Subsequent occurrences may contain COB payer information.
356	2320	SBR09	Claim Filing Indicator Code	16		Health Maintenance Organization (HMO) Medicare Risk This is the only option for the first occurrence. Subsequent occurrences should be billed as appropriate. **Refer to the Implementation Guide for the other codes/values to use.**
358	2320	CAS	Line Adjustment			
360	2320	CAS01	Claim Adjustment Group Code			For **Nursing Facility Patient Liability**, use PR (Patient Responsibility)
360	2320	CAS02	Adjustment Reason Code			For **Nursing Facility Patient Liability,** use 142 (Monthly Medicaid Patient Liability)
364	2320	AMT	Coordination of Benefits (COB) Payer Paid Amount			
364	2320	AMT01	Amount Qualifier Code	D		Payor Amount Paid
364	2320	AMT02	Payer Paid Amount			For the first occurrence, this element will always contain the amount that the MCP, or the MCP's subcontracted Benefit Manager, paid on the claim.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Non-Capitated Encounters = zero (0) is an acceptable amount. Capitated Encounters = zero (0) is not an acceptable amount. The MCP must shadow price capitated encounters by placing the total payment amount at the claim level based on how the MCP's system adjudicated the claim from the provider. For DRG paid claims, this should contain the total paid on the claim by the MCP. Where applicable, in subsequent occurrences, this element will contain the amount paid by the other payer. For the first occurrence, the paid amount must match CN102 identifying the contract amount in the 2300 loop. This amount must equal the sum of the SVD02 values in the 2430 loop, except if the CN101 value is '01' then either: - the SVD02 values in the 2430 loop will be zero and the line level will not sum to the claim level, - or if it is part of a capitated arrangement, the first line of SVD02 value in the 2430 loop will be equal to the claim level, with the other SVD02 values being 0.
377	2330A	NM1	Other Subscriber Name			
379	2330A	NM108	Identification Code Qualifier	MI		Member Identification Number
379	2330A	NM109	Other Insured Identifier			Must match the value in Loop 2010BA, NM109
384	2330B	NM1	Other Payer Name			This is required for the first occurrence on all Encounter claims.
385	2330B	NM108	Identification Code Qualifier	XV		Centers for Medicare and Medicaid Services Plan ID
385	2330B	NM109	Other Payer Primary Identifier			MCP or other entity's Contract ID Number.
386	2330B	N3	Other Payer Address			
386	2330B	N301	Other Payer Address Line			MCP or other entity's Address

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
387	2330B	N4	Other Payer City, State, Zip Code			
387	2330B	N401	Other Payer City Name			MCP or other entity's City Name
387	2330B	N402	Other Payer State Code			MCP or other entity's State
388	2330B	N403	Other Payer Postal Zone or Zip Code			MCP or other entity's Zip Code
389	2330B	DTP	Claim Check or Remittance Date			Use only if the Line Check or Remittance Date is not sent in Loop 2430.
389	2330B	DTP01	Date Time Qualifier	573		Date claim was paid by the MCP.
389	2330B	DTP02	Date Time Period Format Qualifier	D8		Date Expressed in Format CCYYMMDD
389	2330B	DTP03	Adjudication or Payment Date			Use only if the Line Check or Remittance Date is not sent in Loop 2430.
433	2400	DTP	Date – Service Date			This is required for the first occurrence on all Encounter claims. Required also for subsequent occurrences where there is Other Payer information.
434	2400	DTP01	Date Time Qualifier	472		Service
434	2400	DTP02	Date Time Period Format Qualifier	D8		For Ohio Medicaid only D8 is valid. Medicaid does not allow date ranges. Procedures must be itemized separately for each date of service. D8 = Date Expressed in Format CCYYMMDD
434	2400	DTP03	Service Date			
449	2410	LIN	Drug Identification			**Required for MyCare Ohio Medicaid Encounters.** Specific details are provided in Section 7 (Payer specific Business Rules and Limitations)
451	2410	LIN02	Product or Service ID Qualifier	N4		National Drug Code in 5-4-2 Format
451	2410	LIN03	National Drug Code			National Drug Code. Enter the code without dashes or hyphens.
452	2410	CTP	Drug Pricing			**Required for MyCare Ohio Medicaid Encounters.** Specific details are provided in Section 7 (Payer specific Business Rules and Limitations)

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
452	2410	CTP04	National Drug Unit Count			
453	2410	CTP05-1	Unit or Basis for Measurement Code	GR, ML, UN		GR = Gram ML = Milliliter UN = Unit
456	2420A	NM1	Operating Physician Name			The provider information submitted in this loop should be for a Medicaid billing provider that provides services. It should not be Trading Partner information. If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error. An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
458	2420A	NM109	Operating Physician Primary Identifier			Provider NPI
459	2420A	REF	Operating Physician Secondary Identification			Complete only if Provider does not have an NPI.
459	2420A	REF01	Reference Identification Qualifier	G2		Commercial Provider ID or ODM Reporting/ Provider ID
460	2420A	REF02	Operating Physician Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
461	2420B	NM1	Other Operating Physician Name			The provider information submitted in this loop should be for a Medicaid billing provider that provides services. It should not be Trading Partner information. If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error. An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
463	2420B	NM109	Other Operating Physician Identifier			Provider NPI
464	2420B	REF	Other Operating Physician Secondary Identification			Complete only if Provider does not have an NPI.
464	2420B	REF01	Reference Identification Qualifier	G2		Commercial Provider ID or ODM Reporting/ Provider ID

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
465	2420B	REF02	Other Provider Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
471	2420D	NM1	Referring Provider Name			
473	2420D	NM109	Referring Provider Identifier			Provider NPI
474	2420B	REF	Referring Provider Secondary Identification			Complete only if Provider does not have an NPI.
474	2420B	REF01	Reference Identification Qualifier	G2		Commercial Provider ID or ODM Reporting/ Provider ID
475	2420B	REF02	Referring Provider Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
476	2430	SVD	Line Adjudication Information			This is required for the first occurrence of the 2320 loop and should contain the MCP paid amount of the line level.
476	2430	SVD01	Other Payer Primary Identifier			Must match the value in Loop 2330B, NM109.
477	2430	SVD02	Service Line Paid Amount			For the first occurrence this should be the MCP, or the MCP's subcontracted Benefit Manager, line level amount paid. Zero '0' is an acceptable value for this element. The MCP must shadow price capitated encounters by placing the allowed amount at the line level. For DRG paid claims, the line level amounts should be zero '0', unless it is part of a capitated arrangement in which case the MCP must submit the total paid amount at the claim-level and the same amount at the line-level as the room-and-board line item (submitted as the first line level amount). Subsequent occurrences may contain COB payment amounts.
480	2430	CAS	Line Adjustment			
482	2430	CAS02	Adjustment Reason Code			If a service line is denied in the MCP or other entity's adjudication system, the denial reason must be populated
486	2430	DTP	Line Check or Remittance Date			This is required for the first occurrence on all Encounter claims and may be provided for subsequent items. Use only if the Claim Check or Remittance Date is not sent in Loop 2330B.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
486	2430	DTP01	Date Time Qualifier	573		Date claim was paid by the Managed Care Plan.
486	2430	DTP02	Date Time Period Format Qualifier	D8		Date Expressed in Format CCYYMMDD
486	2430	DTP03	Adjudication or Payment Date			Populate the claim receipt date minus one (1) day as the default primary payer adjudication date only in the instance that the primary payer adjudication date is not available. Use only if the Claim Check or Remittance Date is not sent in Loop 2330B.

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.