Ohio | Department of Medicaid

837 Institutional Fee-For-Service Claims

Version 1.7

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Document Information

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Amendment History

Version	Date	Modified By	Modifications
1.0	05/12/2014	ODM & HP EDI Team	Initial Creation
1.1	05/12/2015	ODM & HP EDI Team	Updates for ICF/IID
1.2	12/02/2015	ODM & HPE EDI Team	Updated references related to Agency name changes.
1.3	02/25/2017	ODM & HPE EDI Team	Added 2300:REF for Demonstration Project Identifier to provide guidance on vendor approved resubmissions.
1.4	03/22/2017	ODM & HPE EDI Team	Updated the contact information in Section 5.
1.5	05/31/2017	ODM & DXC EDI Team	Moved guidance around 2400:SV201 to Section 7. Also updated the email addresses in Section 5.
1.6	09/13/2017	ODM & DXC EDI Team	Added notes on how the NDC code is entered in 2410:LIN03.
1.7	08/13/2018	ODM & DXC EDI Team	Updated the notes for 2300:AMT02.

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.

Table of Contents

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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.

The segments and elements used in this document are necessary for the ODM adjudication system for Institutional 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

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			
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. 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
67		ST	Transaction Set Header			
67		ST02	Transaction Set Control Number			Identical to the value in SE02

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 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.

There is guidance around the use of the **SV201 (Service Line Revenue Code)** element in the 2400 loop.

- For Independent Free-standing ESRD Dialysis Clinics, the following revenue codes do not allow procedure (CPT/HCPCS) codes:

  0821-Hemodialysis
  0831-IPD
  0841-CAPD
  0851-CCPD
  0825-Hemodialysis Support Services
  0835-IPD Support Service
  0845-CAPD Support Services
  0855-CCPD Support Services
  0829-Hemodialysis Training
  0839-IPD Training
  0849-CAPD Training
  0859-CCPD Training

- For Independent Free-standing Dialysis Clinics, the following revenue center codes do require procedure (CPT/HCPCS) codes:

  0304 - Clinical Laboratory
  0310 - Pathological Laboratory
  0730 - Diagnostic Services
  0634 - Erythropoietin (EPO) less than 10,000 units
  0635 - Erythropoietin (EPO) 10,000 units or greater
  0636 - Separately billable drugs / injections / immunizations

- For Nursing Facility room and board claims, the valid revenue codes are:

  0101 - All inclusive room and board
  0160 - Short-term stay for waiver consumer
  0183 - therapeutic leave
  0185 - hospitalization leave
  0220 - Flat Fee: Full Day (relates to RCC 0101)
  0169 - Flat Fee: Short-term NF stay for Waiver consumer (relates to RCC 0160)
  0189 - Flat Fee Leave Days (relates to RCC 0183 & 0185)

- For Nursing Facility room and board claims, include charges associated with the revenue codes and identify those charges as covered or non-covered charges. Long Term Care facility room and board claims do not require procedure (CPT/HCPCS) codes. See Note for Loop 2400: DTP-Service Line Date.

- For ICF-IID room and board claims, the valid revenue codes are:

0101 - All inclusive room and board
0182 - Patient Convenience (Visits with Friends and Family Leave)
0183 - Therapeutic Leave
0185 - Hospitalization
0410 - Respiratory Services (Pediatric Ventilator)

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.
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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		BHT06	Claim Identifier	CH		Chargeable
71	1000A	NM1	Submitter Name			
72	1000A	NM109	Submitter Identifier			7 digit Ohio Medicaid Trading Partner ID assigned by ODM
76	1000B	NM1	Receiver Name			
77	1000B	NM109	Receiver Primary Identifier	MMISODJFS		
84	2010AA	NM1	Billing Provider Name			
86	2010AA	NM109	Billing Provider Identifier			Provider NPI
107	2000B	HL	Subscriber Hierarchical Level			For Ohio Medicaid, the "insured", "subscriber" and the "patient" are always the same person.
108	2000B	HL04	Hierarchical Child Code	0		No subordinate HL segment in this hierarchical structure.
109	2000B	SBR	Subscriber Information			
110	2000B	SBR09	Claim Filing Indicator Code	MC		

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
112	2010BA	NM1	Subscriber Name			
113	2010BA	NM108	Identification Code Qualifier	MI		
114	2010BA	NM109	Subscriber Primary Identifier			12-digit Medicaid recipient billing number
122	2010BB	NM1	Payer Name			
123	2010BB	NM108	Identification Code Qualifier	PI		
123	2010BB	NM109	Payer Identifier	MMISODJFS		
143	2300	CLM	Claim Information			
145	2300	CLM05-3	Claim Frequency Code	1, 2, 3, 4, 7, 8		1 = Original claim submission 2 = Interim – First Claim 3 = Interim – Continuing Claim 4 = Interim – Last Claim 7 = Replacement (adjustment) 8 = Void/cancel of prior claim.
156	2300	PWK02	Report Transmission Code	BM, EL, FT		FT - File Transfer. Use when sending the attachment via the MITS Portal
157	2300	PWK06	Attachment Control Number	ODM03197, ODM03198, ODM03199, ODM06653, ODM99999		ODM03197 − the attachment documents include the Abortion Certification Form ODM03198 − the attachment document(s) include the Consent for Sterilization Form ODM03199 – the attachment document(s) include the Acknowledgment of Hysterectomy Information Form ODM06653 − attachment document(s) include the Medical Claim Review Request Form ODM99999 − Other attachment document(s) do not include any of the forms listed above
160	2300	AMT	Patient Estimated Amount Due			
160	2300	AMT01	Amount Qualifier Code	F3		Patient Responsibility - Estimated
160	2300	AMT02	Patient Responsibility Amount			For LTC claims (NF & ICF-IID) and Inpatient Hospital claims, report the Recipient's Patient Liability amount.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Never report Medicaid co-payment amounts collected (or incurred) or the co-payments will be deducted twice.
174	2300	REF	Demonstration Project Identifier			Used for vendor approved resubmissions.
174	2300	REF01	Reference Identification Qualifier	P4		Project Code
174	2300	REF02	Demonstration Project Identifier			Original ICN
178	2300	NTE	Billing Note			
178	2300	NTE01	Note Reference Code	ADD		ADD – when the non-emergency emergency co-payment applies (See NTE02 comments) ADD – will be used by providers to denote timely filing exemption (See NTE02 Comments)
178	2300	NTE02	Billing Note Text			For hospitals, when the non-emergency emergency co-payment applies, the 10 character code (COPAY NEMR) must be the first item listed in the NTE02. There must always be a single space between the word COPAY and NEMR. Example: NTE*ADD*COPAY NEMR 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. (1) For appeals/hearings, report the appeals/hearing number and date (The XXXXXXX is the hearing number) in this format: **APPEALS XXXXXXX CCYYMMDD** (2) For a delayed eligibility determination, enter the eligibility determination decision date in this format: **DECISION CCYYMMDD** Example (1): NTE*ADD*APPEALS 123456A 20110906

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Example (2): NTE*ADD*DECISION 20110831
258	2300	HI	Occurrence Span Information			This is required when there is an Occurrence Span Code that applies to the claim.
258	2300	HI01-1	Code List Qualifier Code	BI		Occurrence Span
258	2300	HI01-2	Occurrence Span Code	73		Benefit Eligibility Period
259	2300	HI01-3	Date Time Period Format Qualifier	RD8		Format: CCYYMMDD-CCYYMMDD
259	2300	HI01-4	Occurrence Span Code Date			For ICF-IID claims, this indicates the date range of pediatric ventilator services for the recipient.
284	2300	HI	Value Information			Hospitals must use value code 54 (newborn birth weight in grams) to specify the birth weight for newborn hospitalizations as well as any neonates that group to DRG 385. Report birth weight in C02205, Monetary Amount. For nursing facility & ICF-IID room and board claims, use value code 31 patient liability amount, to report the amount of lump sum payment per month. See AMT 2300 when patient liability is not lump sum.
284	2300	HI01-1	Code List Qualifier Code	BE		Value
284	2300	HI01-2	Value Code	24, 31, 54		24 - Rate Code 31 - Patient Liability Amount 54 - Newborn birth weight, in grams
285	2300	HI01-5	Value Code Amount	5, 6		When HI01-2 = 24, this is the acuity level code.
285	2300	HI01-5	Value Code Amount			When HI01-2 = 31, this is the lump sum payment amount per month on nursing facility room and board claims. When HI01-2 = 54, this is the birth weight in grams.
319	2310A	NM1	Attending Provider Name			Provider must be enrolled with Ohio Medicaid.
321	2310A	NM109	Attending Provider Primary Identifier			Provider NPI
324	2310A	REF	Attending Provider Secondary Identification			
324	2310A	REF01	Reference Identification Qualifier	G2		Provider Commercial Number

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
325	2310A	REF02	Attending Provider Secondary Identifier			Atypical Provider ID assigned by ODM (Medicaid Billing ID)
349	2310F	NM1	Referring Provider Name			Provider must be enrolled with Ohio Medicaid.
351	2310F	NM109	Referring Provider Identifier			Provider NPI
352	2310F	REF	Referring Provider Secondary Identification			
352	2310F	REF01	Reference Identification Qualifier	G2		Provider Commercial Number
353	2310F	REF02	Referring Provider Secondary Identifier			Atypical Provider ID assigned by ODM (Medicaid Billing ID)
354	2320	SBR	Other Subscriber Information			
356	2320	SBR09	Claim Filing Indicator Code	MA, MB, 16, CI, BL		MA - For Original Medicare Part A claims MB - For Original Medicare Part B claims 16 - When other payer is a Medicare HMO / Part C plan CI - When other payer is commercial insurance (other than Blue Cross) BL - When other payer is Blue Cross/ Blue Shield Plan Any other appropriate value except MC (MC should only be used in 2000B loop)
358	2320	CAS	Claim Level Adjustments			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 Coordination of benefits 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

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						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. Most inpatient institutional claims are adjudicated at the header/claim level. COB balancing rules apply and may be enforced (See IG Balancing).
360	2320	CAS01	Claim Adjustment Group Code	CO, OA, PI, PR		CO - Contractual Obligations OA - Other adjustments PI - Payer Initiated Reductions PR - Patient Responsibility
424	2400	SV2	Institutional Service Line			For NF claims see special detail billing instruction Note for Loop 2400: DTP-Service Line Date
424	2400	SV201	Service Line Revenue Code			Specific guidance is provided in Section 7 (Payer specific Business Rules and Limitations)
427	2400	SV203	Line Item Charge Amount			When submitting an Institutional Service Line for a covered day within a Nursing Facility or ICF-IID, please enter covered charge amount. For non-covered days within a Nursing Facility or ICF-IID room and board claim, the SV203 must be set to zeros. Use the SV207 to enter the non-covered charge amount.
428	2400	SV204	Unit or Basis for Measurement Code	DA, UN		DA - Days – For ESRD Clinics, only one date of service may be submitted for a RCC. UN - Units – Multiple units may be billed by Independent Free-standing ESDR Dialysis Clinics only for certain CPT/ HCPCS codes itemized with certain RCCs.
428	2400	SV205	Service Unit Count			For Nursing Facility & ICF-IID room and board claims, enter the number of units (days) associated with each occurrence of a Revenue Code. When submitting an Institutional Service

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Line for a non-covered day within a Nursing Facility or ICF-IID room and board claim, the SV207 must contain the amount of non-covered charges, and the SV203 must be set to zeros.
428	2400	SV207	Line Item Denied Charge or Non-Covered Charge Amount			When submitting an Institutional Service Line for a non-covered day within a Nursing Facility or ICF-IID room and board claim, the SV207 must contain the amount of non-covered charges, and the SV203 must be set to zeros.
433	2400	DTP	Date - Service Date			NFs and ICFs are to no longer bill service dates at the detail section of the claim. As a result, MITS will use the service dates reported at the Header of the claim and the number of units on each detail to calculate the begin and end date for each detail of the claim. **Providers MUST bill the detail lines of their claims in date order sequence in order to ensure the correct assignment of dates at the detail line.**
434	2400	DTP02	Date Time Period Format Qualifier	D8		D8 – Format CCYYMMDD
449	2410	LIN	Drug Identification			
451	2410	LIN03	National Drug Code			National Drug Code. Enter the code without dashes or hyphens.
471	2420D	NM1	Referring Provider Name			Provider must be enrolled with Ohio Medicaid.
473	2420D	NM109	Referring Provider Identifier			Provider NPI
474	2420D	REF	Referring Provider Secondary Identification			
474	2420D	REF01	Reference Identification Qualifier	G2		Provider Commercial Number
475	2420D	REF02	Referring Provider Secondary Identifier			Atypical Provider ID assigned by ODM (Medicaid Billing ID)
480	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 Coordination of benefits 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

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						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. Most Inpatient claims are adjudicated at the header/claim level. COB balancing rules may be enforced (See IG Balancing).
481	2430	CAS01	Claim Adjustment Group Code	CO, OA, PI, PR		CO - Contractual Obligations OA - Other adjustments PI - Payer Initiated Reductions PR - Patient Responsibility

APPENDICES

A. Implementation Checklist

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

B. Business Scenarios

Using a NF claim that was billed with Header first date of service (FDOS) 9/1/11 and last date of service (TDOS) of 9/30/11 and 7 Detail Lines, the FDOS and TDOS for those detail lines will be determined as follows:

1) 101 (covered)	Units Billed = 1	FDOS = 9/1/11	TDOS = 9/1/11
2) 101 (non-covered)	Units Billed = 6	FDOS = 9/2/11	TDOS = 9/7/11
3) 185 (covered)	Units Billed = 5	FDOS = 9/8/11	TDOS = 9/12/11
4) 101 (covered)	Units Billed = 1	FDOS = 9/13/11	TDOS = 9/13/11
5) 101 (non-covered)	Units Billed = 7	FDOS = 9/14/11	TDOS = 9/20/11
6) 185 (covered)	Units Billed = 2	FDOS = 9/21/11	TDOS = 9/22/11
7) 185 (covered)	Units Billed = 8	FDOS = 9/23/11	TDOS = 9/30/11

C. Frequently Asked Questions

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