MyCare Ohio

837 Professional Encounter Claims

Version 1.10

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Document Information

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Amendment History

Version	Date	Modified By	Modifications
1.0	06/24/2014	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	Added guidance for Supervising Provider in 2310D and 2420D. 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	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 a note to 2320:MOA related to EVV claims.
1.9	09/10/2020	ODM & DXC EDI Team	Added notes around 2300:CN104 and 2400: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

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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.

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 5000 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 Professional 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 Professional 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 2420A is required if the Rendering Provider's NM1 information is different than that carried in the 2310B (claim-level) loop, or if the Rendering Provider information is carried at the Billing loop level (2010AA) and this particular service line has a different Rendering Provider than what is given in the 2010AA loop. The identifying payer-specific

numbers are those that belong to the destination payer identified in loop 2010BB.

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	005010X222A1		

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			
		ST01	Transaction Set Identifier Code	837		Health Care Claim

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
70		ST02	Transaction Set Control Number			Identical to the value in SE02
70		ST03	Implementation Convention Reference	005010X222A1		

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 MyCare Ohio 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.

- 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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Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
71		BHT	Beginning of Hierarchical Transaction			
71		BHT02	Transaction Set Purpose Code	00		Original
72		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.
72		BHT06	Claim or Encounter Identifier	RP		Reporting
74	1000A	NM1	Submitter Name			
75	1000A	NM102	Entity Type Qualifier	2		Non-Person Entity
75	1000A	NM109	Submitter Identifier			7 digit Ohio Medicaid Trading Partner ID assigned by ODM. This value must match the value in ISA06.
76	1000A	PER	Submitter EDI Contact Information			
77	1000A	PER03	Communication Number Qualifier	TE		Submitter's telephone number
77	1000A	PER05	Communication Number Qualifier	EM		Submitter's email address
78	1000A	PER07	Communication Number Qualifier	FX		Submitter's fax number
79	1000B	NM1	Receiver Name			
79	1000B	NM102	Entity Type Qualifier	2		Non-Person Entity

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
80	1000B	NM103	Receiver Name	Ohio Department of Medicaid		
80	1000B	NM109	Receiver Primary Identifier	MMISODJFS		Identifies the receiver of the transaction
87	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 rendering 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. An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
89	2010AA	NM108	Identification Code Qualifier	XX		Centers for Medicare and Medicaid Services National Provider Identifier
90	2010AA	NM109	Billing Provider Identifier			Provider NPI
92	2010AA	N4	Billing Provider City, State, Zip Code			
93	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".
94	2010AA	REF	Billing Provider Tax Identification			
94	2010AA	REF01	Reference Identification Qualifier	EI		Employer's Identification Number (EIN)
94	2010AA	REF02	Billing Provider Tax Identification Number	199999998, 199999999		199999998 = Atypical professional provider default EIN 199999999 = DME provider default EIN
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.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
116	2000B	SBR	Subscriber Information			
116	2000B	SBR01	Payer Responsibility Sequence Number Code	S		Secondary Medicare-Medicaid Encounter Data System (MMEDSCMS) is considered as the secondary destination payer.
118	2000B	SBR09	Claim Filing Indicator Code	MB, **MC**		MB = Medicare Part B **MC = Medicaid**
121	2010BA	NM1	Subscriber Name			
122	2010BA	NM108	Identification Code Qualifier	MI		Member Identification Number
123	2010BA	NM109	Subscriber Primary Identifier			This is the Subscriber's Medicaid ID. Must match the value in Loop 2330A, NM109
133	2010BB	NM1	Payer Name			
134	2010BB	NM103	Payer Name	MMEDSCMS		Medicare-Medicaid Encounter Data System
134	2010BB	NM108	Identification Code Qualifier	PI		Payor Identification
134	2010BB	NM109	Payer Identifier	80889, 80890, **80892, 80895**		80889 = Medicare 80890 = Medicare DME **80892 = Medicaid** **80895 = Medicaid DME**
135	2010BB	N3	Payer Address			
135	2010BB	N301	Payer Address Line	7500 Security Blvd		
136	2010BB	N4	Payer City, State, Zip Code			
136	2010BB	N401	Payer City Name	Baltimore		
136	2010BB	N402	Payer State Code	MD		
137	2010BB	N403	Payer Postal Zone or Zip Code	212441850		
138	2010BB	REF	Payer Secondary Identification			
138	2010BB	REF01	Reference Identification Qualifier	2U		Payer Identification Number
139	2010BB	REF02	Payer Secondary Identifier			Contract ID Number of the Managed Care Plan (MCP) or other entity
140	2010BB	REF	Billing Provider Secondary Identification			Complete only if Provider does not have an NPI.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
140	2010BB	REF01	Reference Identification Qualifier	G2		Provider Commercial Number
141	2010BB	REF02	Billing Provider Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
157	2300	CLM	Claim Information			
158	2300	CLM01	Patient Control Number			This field should contain the Managed Care Plan (MCP) generated Transaction Control Number (TCN)
159	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.
159	2300	CLM05-3	Claim Frequency Code	1, 7, 8		1 = Original claim submission 7 = Replacement 8 = Deletion
169	2300	DTP	Date - Last Menstrual Period			
169	2300	DTP01	Date Time Qualifier	484		Last Menstrual Period
169	2300	DTP02	Date Time Period Format Qualifier	D8		Date Expressed in Format CCYYMMDD
169	2300	DTP03	Last Menstrual Period Date			ODM does not accept date ranges
182	2300	PWK	Claim Supplemental Information			
183	2300	PWK01	Attachment Report Type Code	09, AM, OZ, PY		09 = For chart review submissions only AM = On ambulance encounters when the true ambulance pick-up and drop-off complete addresses are not available and the Rendering or Billing Provider street address, city, state, and zip code is populated in 2310E and 2310F. OZ = For encounters generated as a result of paper claims only PY = For encounters generated as a result of 4010 submission only
184	2300	PWK02	Attachment Transmission Code	AA		Populated for chart review, paper generated encounters, 4010 generated encounters, or ambulance encounters when the true ambulance pick-up and drop-off locations are not available and the Rendering Provider or Billing Provider street address, city, state, and zip code is populated in Loops 2310E and 2310F
186	2300	CN1	Contract Information			MCP payment arrangement at the claim level.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
186	2300	CN101	Contract Type Code	02, 03, 04, 05, 06, 09		02 = Per Diem 03 = Variable Per Diem 04 = Flat 05 = Capitated 06 = Percent 09 = Other
186	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. It must equal the sum of the CN102 values in the 2400 loop.
187	2300	CN103	Contract Percentage			Allowance or charge percent
187	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
188	2300	AMT	Patient Amount Paid			
188	2300	AMT01	Amount Qualifier Code	F5		Patient Co-Pay Amount
188	2300	AMT02	Patient Amount Paid			Report any co-payment charged and collected by the MCP.
196	2300	REF	Payer Claim Control Number			Use this REF segment when submitting a reversal/correction to the original encounter.
196	2300	REF01	Reference Identification Qualifier	F8		Original Reference Number
196	2300	REF02	Payer Claim Control Number			13 digit original ICN assigned by ODM to the original encounter without any spaces or hyphens.
202	2300	REF	Claim Identifier for Transmission Intermediaries			
202	2300	REF01	Reference Identification Qualifier	D9		Claim Number
203	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.
204	2300	REF	Medical Record Number			
204	2300	REF01	Reference Identification Qualifier	EA		Medical Record Identification Number

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
204	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
209	2300	NTE	Billing Note			
209	2300	NTE01	Note Reference Code	ADD		Additional Information
210	2300	NTE02	Claim 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. |
| 223 | 2300 | CRC | EPSDT Referral | | | Required by HIPAA for EPSDT claims. Used for Federal Reporting requirements. |
| 223 | 2300 | CRC01 | Code Qualifier | ZZ | | Mutually Defined
EPSDT Screening referral information |
| 224 | 2300 | CRC02 | Certification Condition Code Applies Indicator | Y, N | | Y = Yes
N = No |
| 224 | 2300 | CRC03 | Condition Indicator | S2, ST | | S2 = Under Treatment
ST = New Services Requested
Required if CRC02 = Y |
257	2310A	NM1	Referring Provider Name			
259	2310A	NM109	Referring Provider Identifier			Provider NPI
260	2310A	REF	Referring Provider Secondary Identification			Complete only if Provider does not have an NPI.
260	2310A	REF01	Reference Identification Qualifier	G2		Provider Commercial Number
261	2310A	REF02	Referring Provider Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
262	2310B	NM1	Rendering 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.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						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.
264	2310B	NM109	Rendering Provider Identifier			Provider NPI
267	2310B	REF	Rendering Provider Secondary Identification			Complete only if Provider does not have an NPI.
267	2310B	REF01	Reference Identification Qualifier	G2		Provider Commercial Number
268	2310B	REF02	Rendering Provider Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
280	2310D	NM1	Supervising 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. 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.
282	2310D	NM109	Supervising Provider Identifier			Provider NPI
283	2310D	REF	Supervising Provider Secondary Information			Complete only if Provider does not have an NPI.
283	2310D	REF01	Reference Identification Qualifier	G2		Provider Commercial Number
284	2310D	REF02	Supervising Provider Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
287	2310E	N3	Ambulance Pick-Up Location Address			
287	2310E	N301	Ambulance Pick-up Address Line			Provide the address line for the Rendering Provider if the true ambulance pick-up address line is not available. Provide the address line for the Billing Provider if the Rendering Provider is

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						the same as the Billing Provider and the true ambulance pick-up address line is not available.
288	2310E	N4	Ambulance Pick-Up Location City, State, and Zip Code			
289	2310E	N402	Ambulance Pick-up State or Province Code			Provide the state name for the Rendering Provider if the true ambulance pick-up state name is not available. Provide the state name for the Billing Provider if the Rendering Provider is the same as the Billing Provider and the true ambulance pick-up state name is not available.
289	2310E	N403	Ambulance Pick-up Postal Zone or Zip Code			Provide the Zip code for the Rendering Provider if the true ambulance pick-up Zip code is not available. Provide the Zip code for the Billing Provider if the Rendering Provider is the same as the Billing Provider and the true ambulance pick-up Zip code is not available
292	2310F	N3	Ambulance Drop-off Location Address			
292	2310F	N301	Ambulance Drop-off Address Line			Provide the address line for the Rendering Provider if the true ambulance drop-off address line is not available. Provide the address line for the Billing Provider if the Rendering Provider is the same as the Billing Provider and the true ambulance drop-off address line is not available.
293	2310F	N4	Ambulance Drop-off Location City, State, and Zip Code			
293	2310F	N401	Ambulance Drop-Off City Name			Provide the city name for the Rendering Provider if the true ambulance drop-off city name is not available. Provide the city name for the Billing Provider if the Rendering Provider is the same as the Billing Provider and the true ambulance drop-off city name is not available.
294	2310F	N402	Ambulance Drop-off State or Province Code			Provide the state name for the Rendering Provider if the true ambulance drop-off state name is not

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						available. Provide the state name for the Billing Provider if the Rendering Provider is the same as the Billing Provider and the true ambulance drop-off state name is not available.
295	2310F	N403	Ambulance Drop-off Postal Zone or Zip Code			Provide the Zip code for the Rendering Provider if the true ambulance drop-off Zip code is not available. Provide the Zip code for the Billing Provider if the Rendering Provider is the same as the Billing Provider and the true ambulance drop-off Zip code is not available
295	2320	SBR	Other Subscriber Information			This is required for the first occurrence and subsequent occurrences when there is other payer information.
296	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)
296	2320	SBR02	Individual Relationship Code	18		This is the only option for Professional 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.**
297	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
298	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.**
299	2320	CAS	Claim Level Adjustments			
301	2320	CAS02	Adjustment Reason Code			If a claim is denied in the MCP or other entity's adjudication system, the denial reason must be populated
305	2320	AMT	Coordination of Benefits (COB) Payer			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Paid Amount			
305	2320	AMT01	Amount Qualifier Code	D		Payor Amount Paid
305	2320	AMT02	Payer Paid Amount			For the first occurrence, the element will always contain the amount the MCP, or the MCP's subcontracted Benefit Manager, paid on the Encounter. 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 Encounter for the Provider. 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 the CN102 identifying the contract amount in the 2300 loop. It must equal the sum of the CN102 values in the 2400 loop.
308	2320	OI	Other Insurance Coverage Information			
308	2320	OI03	Benefits Assignment Certification Indicator			Must match the value in Loop 2300.CLM08
310	2320	MOA	Outpatient Adjudication Information			
311	2320	MOA03	Claim Payment Remark Code			During the pay and post period, place the Remark Code N363 here to denote an EVV claim that would have been denied.
313	2330A	NM1	Other Subscriber Name			
315	2330A	NM108	Identification Code Qualifier	MI		Member Identification Number
315	2330A	NM109	Other Insured Identifier			Must match the value in Loop 2010BA, NM109
320	2330B	NM1	Other Payer Name			This is required for the first occurrence on all Encounter claims.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
321	2330B	NM108	Identification Code Qualifier	XV		Centers for Medicare and Medicaid Services Plan ID
321	2330B	NM109	Other Payer Primary Identifier			MCP or other entity's Contract ID Number.
322	2330B	N3	Other Payer Address			
322	2330B	N301	Other Payer Address Line			MCP or other entity's Address
323	2330B	N4	Other Payer City, State, Zip Code			
323	2330B	N401	Other Payer City Name			MCP or other entity's City Name
323	2330B	N402	Other Payer State Code			MCP or other entity's State
324	2330B	N403	Other Payer Postal Zone or Zip Code			MCP or other entity's Zip Code
325	2330B	DTP	Claim Check or Remittance Date			Use only if the Line Check or Remittance Date is not sent in Loop 2430.
325	2330B	DTP01	Date Time Qualifier	573		Date claim was paid by the MCP.
325	2330B	DTP02	Date Time Period Format Qualifier	D8		Date Expressed in Format CCYYMMDD
325	2330B	DTP03	Adjudication or Payment Date			Use only if the Line Check or Remittance Date is not sent in Loop 2430.
351	2400	SV1	Professional Service			
357	2400	SV111	EPSDT Indicator	Y		Required if Medicaid services are the result of a screening referral. Must be completed for all referrals made under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program.
357	2400	SV112	Family Planning Indicator	Y		Must be completed on all family planning related procedures.
366	2400	PWK	Durable Medical Equipment Certificate of Medical Necessity Indicator			
366	2400	PWK01	Attachment Report Type Code	CT		Certification
367	2400	PWK02	Attachment Transmission Code	NS		Not Specified = Paperwork is available on request MCPs and other entities must not submit supplemental forms
380	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

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						information.
380	2400	DTP01	Date Time Qualifier	472		Service
380	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. Date Expressed in Format CCYYMMDD
380	2400	DTP03	Service Date			
395	2400	CN1	Contract Information			MCP payment arrangement at the line level.
395	2400	CN101	Contract Type Code	02, 03, 04, 05, 06, 09		02 = Per Diem 03 = Variable Per Diem 04 = Flat 05 = Capitated 06 = Percent 09 = Other
395	2400	CN102	Contract Amount			
396	2400	CN103	Contract Percentage			Allowance or charge percent
396	2400	CN104	Contract Code	P, D		P = Paid D = Denied Please indicate what service lines were denied by placing a D on each line that was denied. Submitting P on paid lines is acceptable, but not required.
423	2410	LIN	Drug Identification			**Required for MyCare Ohio Medicaid Encounters.** Specific details are provided in Section 7 (Payer specific Business Rules and Limitations)
425	2410	LIN02	Product or Service ID Qualifier	N4		National Drug Code in 5-4-2 Format
425	2410	LIN03	National Drug Code			National Drug Code. Enter the code without dashes or hyphens.
426	2410	CTP	Drug Quantity			**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
426	2410	CTP04	National Drug Unit Count			
427	2410	CTP05-1	Code Qualifier	GR, ML, UN		GR = Gram ML = Milliliter UN = Unit
430	2420A	NM1	Rendering 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. 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.
432	2420A	NM109	Rendering Provider Identifier			Provider NPI
434	2420A	REF	Rendering Provider Secondary Identification			Complete only if Provider does not have an NPI.
434	2420A	REF01	Reference Identification Qualifier	G2		Provider Commercial Number
435	2420A	REF02	Rendering Provider Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
449	2420D	NM1	Supervising Provider Name			
451	2420D	NM109	Supervising Provider Identifier			Provider NPI
452	2420D	REF	Supervising Provider Secondary Identification			
452	2420D	REF01	Reference Identification Qualifier	G2		Provider Commercial Number
453	2420D	REF02	Supervising Provider Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM. Enter Provider ID assigned by MCP, if Provider does not have an ID assigned by ODM.
454	2420E	NM1	Ordering Provider Name			
456	2420E	NM109	Ordering Provider Identifier			Provider NPI
460	2420E	REF	Ordering Provider Secondary Identification			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
460	2420E	REF01	Reference Identification Qualifier	G2		Provider Commercial Number
461	2420E	REF02	Ordering Provider Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
465	2420F	NM1	Referring 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. 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.
467	2420F	NM109	Referring Provider Identifier			Provider NPI
468	2420F	REF	Referring Provider Secondary Identification			Complete only if Provider does not have an NPI.
468	2420F	REF01	Reference Identification Qualifier	G2		Provider Commercial Number
469	2420F	REF02	Referring Provider Secondary Identifier			Enter 7-digit Medicaid Provider ID Assigned by ODM.
480	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.
480	2430	SVD01	Other Payer Primary Identifier			Must match the value in Loop 2330B, NM109.
481	2430	SVD02	Service Line Paid Amount			This is required for the first occurrence and 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 Amount Allowed at the Line Level. Subsequent occurrences may contain COB payment amounts.
484	2430	CAS	Line Adjustment			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
486	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
490	2430	DTP	Line Check or Remittance Date			This is required for the first occurrence on all Encounter claims. Use only if the Claim Check or Remittance Date is not sent in Loop 2330B.
490	2430	DTP01	Date Time Qualifier	573		Date claim was paid by the Managed Care Plan.
490	2430	DTP02	Date Time Period Format Qualifier	D8		Date Expressed in Format CCYYMMDD
490	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.