Ohio | Department of Medicaid

HIPAA Transaction Standard Companion Guide

Refers to the Implementation Guides Based on ASC X12 version 005010

837 Post-Adjudicated Claims Data Reporting (PACDR): Institutional

This Companion Guide has been developed in coordination with the new Ohio Medicaid Enterprise System (OMES) and provides trading partners information needed to meet future OMES EDI requirements. Trading Partners should not use the instructions in this Companion Guide to submit production files until the official implementation of the new OMES.

20230124 v10.0

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 - Trading Partners | Medicaid (ohio.gov).

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.

EDITOR'S NOTE:
This page is blank because major sections of a book should begin on a right-hand page.

Table of Contents

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 ODM has something additional, over and above, the information in the IGs. That information can:

1 Limit the repeat of loops, or segments
2 Limit the length of a simple data element
3 Specify a sub-set of the IGs internal code listings
4 Clarify the use of loops, segments, composite, and simple data elements
5 Any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with ODM

In addition to the row for each segment, one or more additional rows are used to describe ODM's usage for composite and simple data elements and for any other information. Notes and commentsshould 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 hasbegun. 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 thelength of the specified data element.
196	2100C	REF	Subscriber Additional Identificatio n			
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 isrequired. 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 rowimmediately 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 onlyone 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 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/005010X299A1 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 Post-Adjudicated Claims Data Reporting (PACDR): 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 Enterprise System (OMES). In order to create a HIPAA compliant transaction, you must first meet the requirements of the ASC X12 HIPAA 837 PACDR: Institutional Implementation Guide and then incorporate the ODM specific requirements.

To properly process 837 transactions, OMES 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.

The page reference to the ASC X12 837 PACDR: Institutional TR3 (HIPAA TR3) 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 PACDR: Institutional Implementation Guide, the Implementation Guide is the final authority.

1.3 REFERENCES

In addition to the resources available on the ODM Trading Partner Website (Trading Partners | Medicaid (ohio.gov)), 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.gov
- Answers to Frequently Asked Questions: HIPAA, Administrative Simplification, and ACA FAQs | CMS
- HHS Office for Civil Rights (Privacy): http://www.hhs.gov/ocr/hipaa/
- WEDI SNIP: Workgroup for EDI, Strategic National Implementation Process: 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/

- American National Standards Institute: http://ansi.org/
- Accredited Standards Committee: http://www.x12.org

1.3.4 ADDITIONAL INFORMATION

For additional information, the Trading Partner Information Guide can be found here: Trading Partners | Medicaid (ohio.gov).

2 GETTING STARTED

To get started, the Trading Partner Information Guide, can be found here:
Trading Partners | Medicaid (ohio.gov).

3 TESTING WITH THE PAYER

Details related to testing are in the Trading Partner Information Guide, which can be found here:Trading Partners | Medicaid (ohio.gov).

4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

Connectivity information is in the Trading Partner Information Guide, which can be found here: Trading Partners | Medicaid (ohio.gov).

5 CONTACT INFORMATION

5.1 EDI CUSTOMER SERVICE

Days Available: Monday through Friday
Time Zone: Eastern Time (ET)
Time Available: 8:00 am to 4:30pm
Phone: 800-686-1516, option 4.
Email: omesedisupport@medicaid.ohio.gov

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: 800-686-1516, option 4.
Email: omesedisupport@medicaid.ohio.gov

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		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			This is a fixed-length field and should be left justified and filled with spaces to meet the minimum length requirement of 15. Use OMES assigned Trading Partner ID. All ODM Trading Partner IDs should be 7-digits which include leading zeros.
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 ControlNumber			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 sentand how ODM will send functional groups. These discussions will describe how similar transaction sets will be packaged and ODM's 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'sCode			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 GroupTrailer			
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 SetHeader			
67		ST02	Transaction SetControl Number			Identical to the value in SE02

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

7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

In order to send 837 PACDR: Institutional X12 transactions, Trading Partners must be certified by Ohio Medicaid and in active status. These details are documented in the Trading Partner Information Guide which can be found at this link - Trading Partners | Medicaid (ohio.gov).

7.1 LIN/CPT

- 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 **CPT (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

7.2 Payment Arrangement Information

ODM considers a capitation payment arrangement to include those arrangements for which a sub-contracted entity to the Managed Care Entity (MCE) 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 MCE must provide approximate payment information as follows:

1. If an MCE sub-contracts with another entity to pay claims on the MCEs 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 MCE paid the benefit manager.
2. For payments arrangements for which the MCE pays a per member per month rate to a provider or group of providers, the MCE must shadow price the encounter to be the amount that the MCE would have paid to the provider if the capitation arrangement did not exist.
   a. If the MCE also maintains a contractual arrangement on a fee-for-service basis with the provider, the MCE must submit the amount that the MCE'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 MCE does not maintain a contractual arrangement on a fee-for-service basis with the provider, the MCE must submit the amount that the MCE'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).

7.3 CARCs/RARCs

Managed Care Entities (MCE) must send all CARCs / RARCs which were sent to providers on the 835 ERA. If providers did not receive an 835 ERA the MCE must crosswalk any proprietary EOB/EOP codes to the appropriate CARC/RARC and include those codes on their PACDR Encounter submission.

7.4 FI Clearinghouse Tracking ID

The FI Clearinghouse Tracking ID for claims/encounters will use the following mask:

YYJJJIGC#######

YY = year
JJJ = Julian day
IGC = static value
 # = 7-digit number

Example: REF*D9*21327IGC0000024

Note: The FI Clearinghouse Tracking ID for claims will use the same mask but the static value will be "IGC". Also please note, the Tracking ID added to the claim is to be returned in the encounter. Gainwell FI will not be adding a new Tracking ID to the encounters.

7.5 Tracking IDs

- FI Assigned Tracking ID should be returned by the MCE in the 2300 loop
  - REF – Claim Identifier for Transmission Intermediaries
  - REF*D9*12A34B56C789 (must match exactly what was sent to the MCE)
- The MCE should report their own unique claim identifier (ICN/TCN) in the 2330B
  - REF – Other Payer Claim Control Number
  - REF*F8*ABC123QTY321 (this is just an example. Each MCE will have their own configuration)

7.6 Adjustment/Void Reporting

- For an Adjustment or Void Initiated by the provider, the MCE should report the adjustment or void with the following in the 2330B:
  - REF – Other Payer Claim Adjustment Indicator
  - REF*T4*Y
  - REF – Other Payer Claim Control Number
  - REF*F8*ABC123LMN001 (this would be the NEW unique claim identifier created by the MCE (ICN/TCN) when the adjustment or void was processed)
  - REF – Other Payer Claim Adjusted Claim Control Number
  - REF*BP*ABC123QTY321 (this would be the FI Assigned tracking ID of the original claim sent to the MCE)
  - REF*D9*12A34B56C789 in the 2300 – (this would be the FI Assigned tracking ID of the adjustment/void claim sent to the MCE)

- For an Adjustment or Void Initiated by the MCE, the MCE should report the adjustment or void with the following in the 2330B:
  - REF – Other Payer Claim Adjustment Indicator
  - REF*T4*Y
  - REF – Other Payer Claim Control Number
  - REF*F8*ABC123LMN001 (this would be the NEW unique claim identifier created by the MCE (ICN/TCN) when the adjustment or void was processed)
  - REF – Other Payer Claim Adjusted Claim Control Number
  - REF*BP*ABC123QTY321 (this would be the FI Assigned tracking ID of the original claim sent to the MCE)
  - REF*D9*12A34B56C789 in the 2300 – (this would be the NEW unique claim identifier created by the MCE (ICN/TCN) when the adjustment or void was processed. So the same value as in the 2330B REF*F8)

PACDR Adjustments/Voids submitted after Go Live					
837 Location	**837 Description**	**837 Value**	**PACDR Location**	**PACDR Description**	**PACDR Value**
Scenario:	**837 original submitted by Provider**				
2300 REF*D9	FI Tracking ID	22030IGC0000005	2300 REF*D9	FI Tracking ID	22030IGC0000005
			2330B REF*F8	MCE assigned claim ID	MCE12345
Scenario:	**837 Adjustment/Void submitted by Provider**				
2300 REF*D9	FI Tracking ID for adjustment/void	22030IGC0000022	2300 REF*D9	FI Tracking ID for adjustment/void	22030IGC0000022
2300 REF*F8	MCE assigned claim ID to adjust/void	MCE12345	2330B REF*F8	MCE assigned claim ID for adjusted claim	MCE56789
			2330B REF*BP	FI Tracking ID for claim being adjusted	22030IGC0000005
Scenario:	**Subsequent 837 Adjustment/Void submitted by Provider**				
2300 REF*D9	FI Tracking ID for adjustment/void	22030IGC0000033	2300 REF*D9	FI Tracking ID for adjustment/void	22030IGC0000033
2300 REF*F8	MCE assigned claim ID to adjust/void	MCE56789	2330B REF*F8	MCE assigned claim ID for adjusted claim	MCE98989
			2330B REF*BP	FI Tracking ID for claim being adjusted	22030IGC0000022
Scenario:	**Subsequent Adjustment/Void initiated by MCE**				
N/A	N/A	N/A	2300 REF*D9	MCE assigned claim ID for adjusted claim	MCE55512
N/A	N/A	N/A	2330B REF*F8	MCE assigned claim ID for adjusted claim	MCE55512
			2330B REF*BP	FI Tracking ID for claim being adjusted	22030IGC0000033
Scenario:	**Subsequent 837 Adjustment/Void submitted by Provider**				
2300 REF*D9	FI Tracking ID for adjustment/void	22030IGC0000044	2300 REF*D9	FI Tracking ID for adjustment/void	22030IGC0000044
2300 REF*F8	MCE assigned claim ID to adjust/void	MCE55512	2330B REF*F8	MCE assigned claim ID for adjusted claim	MCE21544
			2330B REF*BP	value submitted in the REF*D9 of the previous adjustment	MCE55512
Scenario:	**Subsequent Adjustment/Void initiated by MCE**				
N/A	N/A	N/A	2300 REF*D9	MCE assigned claim ID for adjusted claim	MCE00225
N/A	N/A	N/A	2330B REF*F8	MCE assigned claim ID for adjusted claim	MCE00225
			2330B REF*BP	FI Tracking ID for claim being adjusted	22030IGC0000044
Scenario:	**Subsequent Adjustment/Void initiated by MCE**				
N/A	N/A	N/A	2300 REF*D9	MCE assigned claim ID for adjusted claim	MCE98002
N/A	N/A	N/A	2330B REF*F8	MCE assigned claim ID for adjusted claim	MCE98002
			2330B REF*BP	value submitted in the REF*D9 of the previous adjustment	MCE00225

PACDR Adjustments/Voids submitted after Go Live for Encounters submitted in MITS					
837 Location	**837 Description**	**837 Value**	**PACDR Location**	**PACDR Description**	**PACDR Value**
Scenario:	**837 Adjustment/Void submitted by Provider**				
2300 REF*D9	FI Tracking ID for adjustment/void	22030IGC0000321	2300 REF*D9	FI Tracking ID for adjustment/void	22030IGC0000321
2300 REF*F8	MCE assigned claim ID to adjust/void	MCE12989	2330B REF*F8	MCE assigned claim ID for adjusted claim	MCE55442
			2330B REF*BP	MITS assigned Claim ID	MITS7654
Scenario:	**Subsequent Adjustment/Void initiated by MCE**				
N/A	N/A	N/A	2300 REF*D9	MCE assigned claim ID for adjusted claim	MCE23456
N/A	N/A	N/A	2330B REF*F8	MCE assigned claim ID for adjusted claim	MCE23456
			2330B REF*BP	FI Tracking ID for claim being adjusted	22030IGC0000321

PACDR Adjustments/Voids submitted after Go Live for MYCARE Encounters					
837 Location	**837 Description**	**837 Value**	**PACDR Location**	**PACDR Description**	**PACDR Value**
Scenario:	**Original PACDR encounter submitted by MCE**				
N/A	N/A	N/A	2300 REF*D9	MCE assigned claim ID for original claim	MCE24445
			2330B REF*F8	MCE assigned claim ID for original claim	MCE24445
Scenario:	**Subsequent Adjustment/Void initiated by MCE**				
N/A	N/A	N/A	2300 REF*D9	MCE assigned claim ID for adjusted claim	MCE55333
N/A	N/A	N/A	2330B REF*F8	MCE assigned claim ID for adjusted claim	MCE55333
			2330B REF*BP	value submitted in the REF*D9 of the original encounter	MCE24445

8 ACKNOWLEDGEMENTS AND/OR REPORTS

8.1 The TA1 Technical Acknowledgement

The TA1 allows the receiver of a file to notify the sender that an invalid interchange structure was received or that problems were encountered. The TA1 verifies only the interchange header (ISA/GS) and trailer (IEA/GE) segments of the file envelope.

For batch and real-time transactions, if ISA or GS errors were encountered then the generated TA1 report with the Interchange Header errors will be returned for pickup.

8.2 The 999 Implementation Acknowledgement

For batch transactions, each time a properly formatted 5010 X12 file is submitted to Ohio Medicaid, an accepted 999 acknowledgement is returned to the submitter. If the file submitted is rejected, a negative 999 is produced and returned to the submitter.

8.3 824 Application Advice

For batch transactions, the 824 transaction set is used to report the rejection of a transaction that does not meet WEDI SNIP Type 7 compliance.

8.4 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

9.1 TRADING PARTNERS

These details can be found in the Trading Partner Information Guide which can be found at this link - Trading Partners | Medicaid (ohio.gov).

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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Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		BHT	Beginning of Hierarchical Transaction			
		BHT02	Transaction Set Purpose Code	00		Original
		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.
		BHT06	Claim Identifier	RP		Reporting
	1000A	NM1	Submitter Name			
	1000A	NM109	Submitter Identifier			7-digit Ohio Medicaid Trading Partner ID assigned by ODM
	1000B	NM1	Receiver Name			
	1000B	NM103	Receiver Name	ODM		ODM
	1000B	NM109	Receiver Primary Identifier	MMISODJFS		
	2000A	PRV	Billing Provider Specialty Information			If the adjudicated taxonomy is different than the provider-submitted taxonomy, the preferred value is the provider-submitted taxonomy.

						ODM strongly encourages the collection and submission of this data.
	2010AA	NM1	Billing Provider Name			An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
	2010AA	NM109	Billing Provider Identifier			Provider NPI
	2010AA	REF	Billing Provider Secondary Identification			
	2010AA	REF01	Reference Identification Qualifier	G2		Provider Commercial Number
	2010AA	REF02	Billing Provider Secondary Identifier			7-digit OMES Provider ID must be used.
	2000B	HL	Subscriber Hierarchical Level			For Ohio Medicaid, the “insured”, “subscriber”, and the “patient” are always the same person.
	2000B	HL04	Hierarchical Child Code	0		No subordinate HL segment in this hierarchical structure.
	2010BA	NM1	Subscriber Name			
	2010BA	NM108	Identification Code Qualifier	MI		
	2010BA	NM109	Subscriber Primary Identifier			Medicaid member ID assigned by ODM.
	2010BB	NM1	Data Receiver			
	2010BB	NM103	Payer Name	ODM		ODM
	2300	CLM	Claim Information			
	2300	CLM01	Claim Submitter’s Identifier			
	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.
	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
	2300	DTP	Discharge Hour			ODM strongly encourages the collection and submission of this data.
	2300	DTP	Admission Date/Hour			ODM strongly encourages the collection and submission of this data.
	2300	DTP02	Date Time Period Format Qualifier	D8, DT		D8 = CCYYMMDD DT = CCYYMMDDHHMM
	2300	DPT03	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.
	2300	CN1	Contract Information			MCE payment arrangement at the claim level.
	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 05 = Capitated 06 = Percent 09 = Other
	2300	CN102	Contract Amount			
	2300	CN103	Contract Percentage			Allowance or charge percent
	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
	2300	CN106	Contract Version Identifier	VAS		Value Added Service
	2300	AMT	Patient Estimated Amount Due			Patient Co-Pay Amount DO NOT Use for Nursing Facility Patient Liability deduction
	2300	AMT02	Patient Responsibility Amount			Report any co-payment charged and collected by the MCE.
	2300	REF	Payer Claim Control Number			Use this REF segment when submitting a reversal/correction to the original encounter.
	2300	REF01	Reference Identification Qualifier	F8		
	2300	REF02	Payer Claim Control Number			MCE assigned claim ID
	2300	NTE	Billing Note			
	2300	NTE01	Note Reference Code	ADD		Additional Information
	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.
	2300	CRC	EPSDT Referral			Required by HIPAA for EPSDT claims. Used for Federal Reporting requirements.
	2300	CRC01	Code Qualifier	ZZ		Mutually Defined EPSDT Screening referral information
	2300	CRC02	Certification Condition Code Applies Indicator	Y, N		Y = Yes N = No
	2300	CRC03	Condition Indicator	S2, ST		S2 = Under Treatment ST = New Services Requested Required if CRC02 = Y
	2300	HI	Patient's Reason for Visit			ODM strongly encourages the collection and submission of this

						data.
	2300	HI02-HI12	Patient's Reason for Visit			Required when it is necessary to report an additional patient's reason for visit code and the preceding HI data elements have been used to report other patient's reason for visit codes.
	2300	HI	External Cause of Injury			ODM strongly encourages the collection and submission of this data.
	2300	HI02-HI12	External Cause of Injury			Required when it is necessary to report an additional external cause of injury code and the preceding HI data elements have been used to report other external cause of injury codes.
	2300	HI	Diagnosis Related Group (DRG) Information			
	2300	HI01-1	Code List Qualifier Code	DR		Diagnosis Related Group (DRG) Required when the MCE pays the claim by DRG.
	2300	HI01-02	Diagnosis Related Group			ODM expects to receive the APR-DRG that is a four-digit numeric DRG code that combines the DRG code (3 digits) and the Severity of Illness (SOI) indicator (1 digit). In cases where the MS-DRG (3 digits) is being reported. The MS-DRG should be left justified and an SOI indicator of zero should be added.
	2300	HI	Other Diagnosis Information			ODM strongly encourages the collection and submission of this data.
	2300	HI02-HI12	Other Diagnosis Information			Required when it is necessary to report an additional other diagnosis code and the preceding HI data elements have been used to report other diagnosis codes.
	2300	HI	Other Procedure Information			ODM strongly encourages the collection and submission of this data.
	2300	HI02-HI12	Other Procedure Information			Required when it is necessary to report an additional other procedure code and the preceding HI data elements have been used to report other procedure codes.
	2300	HI	Occurrence Span Information			ODM strongly encourages the collection and submission of this data
	2300	HI02-HI12	Occurrence Span Information			Required when it is necessary to report an additional occurrence span code and the preceding HI data elements

						have been used to report other occurrence span codes.
	2300	HI	Occurrence Information			ODM strongly encourages the collection and submission of this data.
	2300	HI02-HI12	Occurrence Information			Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes.
	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.
	2300	HI01-1	Code List Qualifier Code	BE		Value
	2300	HI01-2	Value Code	54		Newborn birth weight, in grams
	2300	HI01-5	Value Code Amount			Birth weight in grams
	2300	HI02-HI12	Value Information			Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes.
	2300	HI	Condition Information			ODM strongly encourages the collection and submission of this data.
	2300	HI02-HI12	Condition Information			Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes.
	2300	HCP	Claim Pricing/Repricing Information			
	2300	HCP01	Pricing Methodology			
	2300	HCP06	Approved DRG Code			Include the DRG or EAPG when the claim was adjudicated using a grouper
	2300	HCP07	Approved DRG Amount			
	2310A	NM1	Attending Provider Name			An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
	2310A	NM109	Attending Provider Primary Identifier			Provider NPI
	2310A	PRV	Attending Provider Specialty Information			If the adjudicated taxonomy is different than the provider-submitted

						taxonomy, the preferred value is the provider-submitted taxonomy. ODM strongly encourages the collection and submission of this data.
	2310A	REF	Attending Provider Secondary Identification			
	2310A	REF01	Reference Identification Qualifier	G2		G2
	2310A	REF02	Attending Provider Secondary Identifier			7-digit OMES Provider ID must be used.
	2310B	NM1	Operating Physician Name			An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
	2310B	NM109	Operating Physician Primary Identifier			Provider NPI
	2310B	REF	Operating Physician Secondary Identification			
	2310B	REF01	Reference Identification Qualifier	G2		G2
	2310B	REF02	Operating Physician Secondary Identifier			7-digit OMES Provider ID must be used.
	2310C	NM1	Other Operating Physician Name			An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
	2310C	NM109	Other Operating Physician Identifier			Provider NPI
	2310C	REF	Other Operating Physician Secondary Identification			
	2310C	REF01	Reference Identification Qualifier	G2		G2
	2310C	REF02	Other Provider Secondary Identifier			7-digit OMES Provider ID must be used.
	2310D	REF	Rendering Provider Secondary Identification			
	2310D	REF01	Reference Identification Qualifier	G2		G2
	2310D	REF02	Rendering Provider Secondary Identifier			7-digit OMES Provider ID must be used.
	2310E	REF	Service Facility Location Secondary Identification			
	2310E	REF01	Reference Identification Qualifier	G2		G2
	2310E	REF02	Laboratory or Facility Secondary Identifier			7-digit OMES Provider ID must be used.
	2310F	NM1	Referring Provider Name			
	2310F	NM109	Referring Provider Identifier			Provider NPI
	2310F	REF	Referring Provider Secondary Identification			
	2310F	REF01	Reference Identification Qualifier	G2		G2

	2310F	REF02	Referring Provider Secondary Identifier			7-digit OMES Provider ID must be used.
	2320	CAS	Line Adjustment			
	2320	CAS01	Claim Adjustment Group Code			For Nursing Facility Patient Liability, use PR (Patient Responsibility)
	2320	CAS02	Adjustment Reason Code			For Nursing Facility Patient Liability, use 142 (Monthly Medicaid Patient Liability). For Nursing Facility Patient Liability, Use 142 (Monthly Medicaid Patient Liability) MCEs must submit all claim adjustment reasons codes (CARCs) that post to claims in the MCEs claims adjudication system in this segment. If MCEs post proprietary EOBs, these must be cross-walked to the best HIPAA Compliant CARC available and submit it in the encounter data in this segment.
	2320	AMT	Coordination of Benefits (COB) Payer Paid Amount			
	2320	AMT01	Amount Qualifier Code	D		
	2320	AMT02	Payer Paid Amount			
	2330A	NM1	Other Subscriber Name			
	2330A	NM108	Identification Code Qualifier	MI		Member Identification Number
	2330A	NM109	Other Insured Identifier			Must match the value in Loop 2010BA, NM109.
319	2330B	NM1	Other Payer Name			
	2330B	NM108	Identification Code Qualifier	XV		Centers for Medicare and Medicaid Services Plan ID.
	2330B	NM109	Other Payer Primary Identifier			MCE or other entity's Contract ID Number.
325	2330B	REF01	Reference Identification Qualifier	F8		
	2330B	REF02	Other Payer's Claim Control Number			MCE assigned claim ID
328	2330B	REF	Adjudicated DRG			
		REF01	Diagnosis Related Group (DRG) Number	1N		

	2330B	REF04	Reference Identifier			
	2330B	REF04-01	Reference Identification Qualifier	V0		
	2330B	REF04-02	DRG Grouper Version			
358	2410	LIN	Drug Identification			
	2410	LIN02	Product or Service ID Qualifier	N4		See Section 7.
	2410	LIN03	National Drug Code			See Section 7.
	2410	CTP	Drug Pricing			See Section 7.
	2410	CTP04	National Drug Unit Count			See Section 7.
	2410	CTP05-1	Unit or Basis for Measurement Code	GR, ML, UN		GR = Gram ML = Milliliter UN = Unit
	2420A	NM1	Operating Physician Name			An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
	2420A	NM109	Operating Physician Primary Identifier			Provider NPI
	2420A	REF	Operating Physician Secondary Identification			
	2420A	REF01	Reference Identification Qualifier	G2		G2
	2420A	REF02	Operating Physician Secondary Identifier			7-digit OMES Provider ID must be used.
	2420B	NM1	Other Operating Physician Name			An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
	2420B	NM109	Other Operating Physician Identifier			Provider NPI
	2420B	REF	Other Operating Physician Secondary Identification			
	2420B	REF01	Reference Identification Qualifier	G2		G2

	2420B	REF02	Other Provider Secondary Identifier			7-digit OMES Provider ID must be used.
	2420D	NM1	Referring Provider Name			
	2420D	NM109	Referring Provider Identifier			Provider NPI
	2420D	REF	Referring Provider Secondary Identification			
	2420D	REF01	Reference Identification Qualifier	G2		G2
	2420D	REF02	Referring Provider Secondary Identifier			7-digit OMES Provider ID must be used.
	2430	SVD	Line Adjudication Information			Should contain the MCE paid amount of the line level.
	2430	SVD01	Other Payer Primary Identifier			
	2430	SVD02	Service Line Paid Amount			
	2430	CAS	Line Adjustment			
	2430	CAS02	Adjustment Reason Code			MCEs must submit all claim adjustment reasons codes (CARCs) that post to claims in the MCEs claims adjudication system in this segment. If MCEs post proprietary EOBs, these must be cross-walked to the best HIPAA Compliant CARC available and submit it in the encounter data in this segment.
	2430	DTP	Line Check or Remittance Date			
	2430	DTP01	Date Time Qualifier	573		Date claim was paid by the Managed Care Entity.
	2430	DTP02	Date Time Period Format Qualifier	D8		Date Expressed in Format CCYYMMDD
	2430	DTP03	Adjudication or Payment Date			

11 APPENDICES

This section contains one or more appendices.

11.1 Implementation Checklist

See Implementation Checklist found here: Trading Partners | Medicaid (ohio.gov).

11.2 Frequently Asked Questions

See Trading Partner website: Trading Partners | Medicaid (ohio.gov).

12 Change Summary

This section describes the differences between the current Companion Guide and previous guide(s).

12/21/2021:

- Added the text “Complete only if Provider does not have an NPI.” To all REF rows in the table in Section 10 that refer to secondary identification.
- Added EDI helpdesk email address to Section 5 Contact Information
- Updated revision number in filename
- Added Sender IDs in the ISA06
- Added Section 7.3 FI Clearinghouse Tracking ID information

12/22/2021

- Removed the text “Complete only if Provider does not have an NPI” from all REF rows in the table in Section 10 that refer to secondary identification as this is not applicable to PACDR transactions

1/28/2022:

- Added Section 7.5 Tracking ID information
- Added Section 7.6 Adjustment/Void Reporting

2/11/2022

- Removed comments from Section 10, 2300 AMT Patient Estimated Amount Due, no changes made
- Removed notes from Section 10, 2300 CN102 Contract Amount
- Added Paramount’s Sender ID 0003258 in Section 6, ISA06

3/4/2022

- Added additional scenario information on adjustments and voids in Section 7.6

04/22/2022:

- Replaced DRAFT with OMES disclaimer
- Updated in Section 1.1 ASC X12N/005010X299**A1**
- Updated ISA06 Sender ID with “Use ODM assigned Trading Partner ID”
- Removed HCP02 Allowed Amount requirement in 2300 loop Section 10

10/14/2022

- Added In Section 10, Contract Version Identifier VAS for CN106

12/28/2022

- Clarified in Section 10, 2300 loop where REF01=F8, REF02= MCE assigned claim ID
- Clarified in the 2330B loop where REF01=F8, REF02= MCE assigned claim ID
- Removed REF loop with REF02 with D9 qualifier as this information is not applicable
- Added REF segment for Adjudicated DRG information with REF02 with 1N qualifier

01/24/2023

- Updated EDI Support in Section 5, Contact Information.