Department of Medicaid

Ohio medicaid enterprise system (OMES), Electronic data interchange (EDI)

HIPAA transaction standard companion guide

Refers to the implementation guides based on ASC X12 version 005010

834 Benefit enrollment and maintenance

20240405 v12.0

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 - 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.

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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 ODM has something additional or 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.

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/005010X220A1 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.

This Companion Guide contains the format and establishes the data contents of the Enrollment Transaction Set (834) for use within the context of an EDI environment. The 834 is used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy to a payer. The intent of this implementation guide is to meet the health care industry's specific need for the initial enrollment and subsequent maintenance of individuals who are enrolled in a Managed Care Entity (MCE). This implementation guide specifically addresses the enrollment and maintenance of health care products only.

As utilized by the ODM, this transaction is designed to accomplish the function of sending enrollment information to Managed Care Entities (licensed as Health Insuring Corporations [HICs] through the Department of Insurance) participating in the Ohio Medicaid Managed Care Program.

The 834 X12 is the Enrollment Roster for the MCE. There are 2 file types that are sent – the full and the changes file.

834 Full File: This is a full file extract of the members enrolled with a health care provider at a specific point in time each month. It contains the most current information related to that member. This file is used to keep the MCE's system in sync with Ohio Medicaid. As a result, INS03 in Loop 2000 (Member Level Detail) as well as HD01 in Loop 2300 (Health Coverage) will be set to 030.

834 Changes File: This file reflects any changes made to a member's status or demographic information. It is generated five days a week (Monday through Friday). The MCE should not assume that new membership results in the automatic termination of prior coverage. There will be multiple member level details (Loop 2000) to indicate movement from the old to the new coverage. Membership spans should not be used to process changes (INS01 = 001).

Loop 2300 is also used to indicate coverage such as Supplemental Income, Physician Coordinated Service Program and Pharmacy Coordinated Service Programs. In the changes file, there could be up to 10 changes listed per day per coverage for each recipient id if the information in the 2300 loop is updated. When multiple changes to a specific coverage appear, they are sorted in descending order of date and time.

The 834 file comprises of separate transaction sets (ST-SE) for each 7-digit Medicaid Provider ID. Within each set, the member details are grouped in the following sequence: ADD records (INS01 = 021) are followed by CHANGE (INS01 = 001) and finally by TERMINATION (INS01 = 024).

Address demographic changes on future date PMP ID will not be sent to the future PMP ID's 834 Changes file but will be sent on their 834 Full file. However, any future address change will appear on the current PMP ID's

834 Changes file.

When the 834 file is downloaded and processed, please be cognizant of these details.

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

1.4 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 ControlHeader			
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	MMISODJFS		Value assigned to the Sender of this file. 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	0021920 0002937 0004202 0003150 0021919 0007316 0007610 0021457 0021914		This is a fixed-length field and should be left justified and filled with spaces to meet the minimum length requirement of 15. 0021920 = AmeriHealth Caritas Ohio, Inc. 0002937 = Anthem Blue Cross Blue Shield 0004202 = Buckeye Community Health Plan 0003150 = CareSource 0021919 = Humana Health Plan of Ohio, Inc. 0007316 = Molina Healthcare of Ohio 0007610 = United Healthcare Community Plan of Ohio, Inc 0021457 = Aetna Better Health of Ohio Inc. 0021914 = Aetna Better Health of Ohio Inc.
C.5		ISA13	Interchange Control Number			Must be identical to the associated interchange control trailer IEA02

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
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 Trailer			
C.7		GS02	Application Sender's Code	MMISODJFS		MMISODJFS = Ohio Department of Medicaid Fee-for-Service
C.7		GS03	Application Receiver's Code			
C.7		GS04	Date			Date when the X12 file was generated
C.8		GS05	Time			Time when the X12 file was generated. Format used - HHMMSS
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 Header			
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
31		ST	Transaction Set Header			
31		ST02	Transaction Set Control Number			Identical to the value in SE02

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
184		SE	Transaction Set Trailer			
184		SE01	Number of Included Segments			Total number of segments included in a transaction set including ST and SE segments
184		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 conduct claim status requests using the 834 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 Usage of REF segment for recipient IDs

There is guidance around the various recipient identifiers provided using the REF (Member Supplemental Identifier) segment in the 2000 loop.

- When REF01 = 17, this is the newborn mother's id. It comprises of a Prefix (C) + Medicaid ID. This is transmitted as the newborn is auto assigned.
  Format Used - CXXXXXXXXXXX

- When REF01 = 23, this is the recipient's existing aid category and effective start date. Format Used - XXXX CCYYMMDD

- When REF01 = 3H, this comprises of the IE Case Number + Category + Sequence. The category is the aid category which is 3-4 characters long. Also, the sequence is generally set to 01. Format used - CCCCCCCCCCXXXX01
  If the IE Case Number is 7 characters in length, then the format used is – CCCCCCCXXXX01

- When REF01 = 6O, this is the recipient's Alternate ID. The Alternate ID is usually the recipient ID the recipient had prior to being placed in Foster Care. This is the ID that we receive from SACWIS which is usually an Active ID in MITS. MCEs are supposed to use this ID to associate a recipient's claims and encounters history with the new SACWIS ID when the recipient is placed in Foster Care.

- When REF01 = F6, this is the recipient's Medicare ID. This is provided when the recipient has Medicare. Where possible, this is the new Medicare Beneficiary ID. In other instances, it is still the recipient's HIC Number.

- When REF01 = DX, this is the recipient's county of eligibility.

- When REF01 = Q4, this is the recipient's linked (or secondary) id. This is an Inactive ID in MITS that is linked to the recipient's primary ID. The secondary ID is usually a historical ID for the recipient. If the recipient is found to have multiple IDs, the recipient IDs are linked and only one ID remains as primary, all other linked IDs become secondary. The 834 will have the most recent linked ID (secondary ID) in the chain when a recipient has multiple linked IDs.

7.2 Usage of the 2300 loop

The following is supplemental information related to the ODM usage of the 2300 Loop HD01 – Maintenance Type Code and the HD04 – Plan Coverage Description for the following benefit programs:

- Money Follows Person
- Nursing Homes
- Patient Liability
- Restricted Medicaid
- Special Conditions
- Waivers
- ABD/CFC HMO Coverage to OhioRISE MCP
- OhioRISE HMO Coverage to ABD/CFC MCP

When these coverages are reported on the 834 Change File, they will be reported using the 001. This code will be used when reporting any spans which partially or completely overlap the plan enrollment.

On the 834 Full File, these coverages will be reported using 030 when reporting any spans which partially or completely overlap the plan enrollment.

These programs will never be reported using 002, 021, or 024 qualifiers.

8 Acknowledgements and/or reports

The 834 is an outbound transaction and there are no associated responses.

8.1 Report inventory

This section contains a listing/inventory of all applicable acknowledgement reports

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 bedetailed 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
32		BGN	Beginning Segment			
32		BGN01	Transaction Set Purpose Code	00		Original
33		BGN03	Date			Date when the X12 file was generated
33		BGN04	Time			Time when the X12 file was generated.Format used - HHMM
35		BGN08	Action Code	2, 4		2 = Change (Update) 4 = Verify (Full file)
36		REF	Transaction Set Policy Number			
36		REF01	Reference Identification Qualifier	38		Master Policy Number
36		REF02	Reference Identification			7-digit Medicaid Provider ID
37		DTP	File Effective Date			
37		DTP01	Date/Time Qualifier	007		Effective
37		DTP03	Date Time Period			File Effective Date. Date when the X12 file was generated. Format YYYYMMDD.
39	1000A	N1	Sponsor Name			
39	1000A	N101	Entity Identifier Code	P5		Plan Sponsor
39	1000A	N102	Name	OMES		
40	1000A	N103	Identification Code Qualifier	FI		Federal Taxpayer's Identification Number

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
40	1000A	N104	Identification Code	311334825		ODM Tax ID
41	1000B	N1	Payer			
41	1000B	N101	Entity Identifier Code	IN		Insurer
41	1000B	N102	Name			Name of Managed Care Entity
42	1000B	N103	Identification Code Qualifier	FI		Federal Taxpayer's Identification Number
42	1000B	N104	Insurer Identification Code			Federal Tax ID of Managed Care Entity
47	2000	INS	Member Level Detail			A single 834 transaction will have a maximum of 10,000 INS segments. As most Managed Care Entities receiving this roster have a larger population, they will have multiple transaction sets (ST-SE).
48	2000	INS01	Member Indicator	Y		Subscriber (Each Medicaid Managed Care enrollee is a considered a subscriber)
48	2000	INS02	Individual Relationship Code	18		Self
49	2000	INS03	Maintenance Type Code	001, 021, 024, 030		001 = Change 021 = Addition 024 = Cancellation or Termination030 = Audit or Compare **001**, **021** and **024** are used with the 834 Change file. **030** is used with the monthly 834 Full file.
49	2000	INS04	Maintenance Reason Code			See Appendix A for more information. When INS04=03, the date of death is indicated as the Medicaid end date in the 2000 loop
51	2000	INS05	Benefit Status Code	A		Active
52	2000	INS08	Employment Status Code	FT, TE		FT = Full Time TE = Terminated
54	2000	INS12	Date Time Period			Date of death from eligibility system. A death reported by MCE (INS04=03) may not always have a date in this element
55	2000	REF	Subscriber Identifier			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
55	2000	REF01	Reference Identification Qualifier	0F		Subscriber Number
55	2000	REF02	Reference Identification			Medicaid Recipient Identification Number Medicaid IDs originating from the IE system will have a “9” in the first character. Similar to the current IDs, they will still be 12 characters in length.
57	2000	REF	Member Supplemental Identifier			
57	2000	REF01	Reference Identification Qualifier	17, 3H, 6O, F6, DX, Q4, 23		17 = Client Reporting Category 3H = Case Number 6O = Alternate Recipient ID F6 = Medicare ID DX = Recipient’s County of Eligibility Q4 = Recipient’s Linked (Secondary) ID 23 = Recipient’s Aid Category
58	2000	REF02	Member Supplemental Identifier			When REF01 = 17, this is the newborn mother’s id. When REF01 = 3H, this comprises of the IE Case Number + Category + Sequence. When REF01 = 6O, this is the recipient’s Alternate ID. When REF01 = F6, this is the recipient’s Medicare ID. When REF01 = DX, this is the recipient’s county of eligibility. When REF01 = Q4, this is the recipient’s linked (or secondary) id. When REF01 = 23, this is the

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						recipient's aid category and effective start date. Additional details are provided in Section 7 (Payer specific Business Rules and Limitations)
59	2000	DTP	Member Level Dates			
59	2000	DTP01	Date/Time Qualifier	300, 473, 474		300 = Enrollment Signature Date. The re-determination date contains any re- determination of eligibility for assistance (i.e., food stamps, Temporary Assistancefor Needy Families (TANF), and Medicaid). Re-determination is a process conducted by the CDJFS to review a consumer's eligibility. The re-determination is scheduled based on federally mandated timelines for each type of assistance or is scheduled when any type of change in the household financial status occurs. 473 = Medicaid Begin 474 = Medicaid End The qualifiers 473 and 474 are used for reporting the member's eligibility effective date and end date associated with that specific PMP. Therefore, the eligibility effective and end dates apply to that specific PMP's membership/coverage only.
61	2000	DTP03	Date Time Period			Date specified by DTP01
62	2100A	NM1	Member Name			
64	2100A	NM108	Identification Code Qualifier	34		Social Security Number
64	2100A	NM109	Identification Code			Member's Social Security Number
65	2100A	PER	Member Communications Numbers			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
66	2100A	PER03	Communication Number Qualifier	TE, CP, HP, WP, EM		TE = Telephone CP = Cell Phone HP = Home Phone WP = Work Phone EM = Email
66	2100A	PER05	Communication Number Qualifier	TE, CP, HP, WP, EM		
67	2100A	PER07	Communication Number Qualifier	EM		
69	2100A	N4	Member City, State, Zip Code			If the member's address is outside the US, then the following address will be sent using the N3 and N4 segments. Please contact Ohio Department ofMedicaid 50 W. Town St, Suite 400 Columbus, OH 43215
70	2100A	N405	Location Qualifier	CY		County
70	2100A	N406	Location Identifier			Contains 2-digit county code
71	2100A	DMG	Member Demographics			
73	2100A	DMG05-1	Race or Ethnicity Code	7, A, B, C, D, E, F, G, H, I, J, N, O, P		If multiple codes are sent, then they areseparated by the repetition character "^" identified in ISA11. For example, A^B^C^D indicates 4 separate codes arebeing sent. 7 = Not provided A = Asian or Pacific Islander B = Black C = Caucasian D = Subcontinent Asian American E = Other Race or Ethnicity F = Asian Pacific American G = Native American H = Hispanic I = American Indian or

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Alaskan Native J = Native Hawaiian N = Black (Non-Hispanic) O = White (Non-Hispanic) P = Pacific Islander
86	2100B	NM1	Incorrect Member Name			
87	2100B	NM108	Identification Code Qualifier	34		Social Security Number
88	2100B	NM109	Identification Code			Member's Incorrect Social SecurityNumber
123	2100G	NM1	Responsible Person			The Responsible Party is the person(s) assisting the consumer with the Medicaid application.
123	2100G	NM101	Entity Identifier Code	S1, LR, E1, QD		S1 = Parent LR = Personal Representative E1 = Placement Provider QD = Authorized Representative
124	2100G	NM102	Identification Code	1		Person
124	2100G	NM103	Responsible Party Last or Organization Name			If the responsible person's name is notavailable, this will be the name of the agency.
126	2100G	PER	Responsible Person Communication Numbers			
127	2100G	PER01	Contact Function Code	RP		Responsible Person
127	2100G	PER03	Communication Number Qualifier	TE, CP, HP, WP, EM		TE = Telephone CP = Cell Phone HP = Home Phone WP = Work Phone EM = Email
127	2100G	PER05	Communication Number Qualifier	TE, CP, HP, WP, EM		
128	2100G	PER07	Communication Number Qualifier	EM		
130	2100G	N4	Responsible Person City, State, Zip Code			If the responsible person's address isoutside the US, then the following address will be sent using the N3 and N4 segments. Please contact Ohio

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Department ofMedicaid 50 W. Town St, Suite 400 Columbus, OH 43215
140	2300	HD	Health Coverage			
140	2300	HD01	Maintenance Type Code	001, 002, 021, 024, 025, 030		001 = Change 002 = Delete 021 = Addition 024 = Cancellation or Termination 025 = Reinstatement 030 = Audit or Compare **001**, **002**, **021**, **024** and **025** are usedwith the 834 Change file. **030** is used with the monthly 834 Full file.
141	2300	HD03	Insurance Line Code	HMO, AG, AH, AJ, AK, EPO, HLT, MM, PDG, POS, LTC, LTD		HMO = Health Maintenance Organization AG = Preventative Care/Wellness (for Special Conditions) AH = 24 Hour Care (for Waivers) AJ = Medicare Risk (for Medicare) AK = Mental Health (for Specialized Recovery Services Program – SRSP, Assertive Community Treatment (ACT), Intensive Home-Based Treatment (IHBT), and Behavioral Health Care Coordination (BHCC)) EPO = Exclusive Provider Organization (for Restricted Medicaid) HLT = Health (for Physician CSP), Comprehensive

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Addiction & Recovery Act (CARA) MM = Major Medical (for Patient Liability) PDG = Prescription Drug (for Pharmacy CSP) POS = Point of Service (for Money Follows Person) LTC = Long-Term Care (for Nursing Homes – both CRISE and MCE entered; also for Hospice Benefit Plan) LTD = Long-Term Disability (for SI)
141	2300	HD04	Plan Coverage Description			Used to provide additional information related to the coverage specified in HD03. See Appendix B for more information.
143	2300	DTP	Health Coverage Dates			This DTP segment is used to indicate date spans related to the program reported in the HD segment.
143	2300	DTP01	Date/Time Qualifier	348, 349		348 = Benefit Begin 349 = Benefit End
144	2300	DTP03	Date Time Period			Date specified by DTP01 When 2300:DTP01 = 348 and this is an MCE entered Nursing Home span: • 2300:HD04 = NH-MCE – DTP03 is the Threshold Date • 2300:HD04 = NH-MCADMIT – DTP03 is the Admission Date
145	2300	AMT	Health Coverage Policy			This AMT segment is used to indicate the amount for Patient Liability.
145	2300	AMT01	Amount Qualifier	D2		Deductible Amount

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Code			
145	2300	AMT02	Monetary Amount			Patient Liability Amount
146	2300	REF	Health Coverage Policy Number			
146	2300	REF01	Reference Identification Qualifier	1L		Group or Policy Number
147	2300	REF02	Reference Identification			Capitation Rate Indicator The indicator is a composite of the program, region, gender, and age. “XXXXXXXXXX” occurs if there are timing issues with eligibility/demographic changes. IE will have 6 characters for the capitation rate indicator. For ICDS, the indicator will be 7 or 8 characters.
152	2310	LX	Provider information			Used for Health Maintenance Organization, Physician Coordinated Service Program, Pharmacy Coordinated Service Programs, Assertive Community Treatment, Intensive Home-Based Treatment, Nursing Homes (both CRISE and MCP entered), Behavioral Health Care Coordination, and Medicare Part C & Part D.
152	2310	LX01	Assigned Number	1		Single iteration of 2310 loop is used tosend information about the provider.
153	2310	NM1	Provider Name			Used for Health Maintenance Organization, Physician Coordinated Service Program, Pharmacy Coordinated Service Programs, Assertive Community Treatment, Intensive Home-Based Treatment, Nursing Homes

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						(both CRISE and MCP entered), Behavioral Health Care Coordination, and Medicare Part C & Part D.
153	2310	NM101	Entity Identifier Code	FA, QA, Y2		FA = Facility QA = Pharmacy (for Medicare Part D) Y2 = Managed Care Organization
154	2310	NM102	Entity Type Qualifier	2		Non-Person Entity (NM103 contains the name of the entity)
155	2310	NM108	Identification Code Qualifier	XX, SV		XX = National Provider Identifier(provided in NM109) SV = Service Provider Number (provided in NM109)
155	2310	NM109	Identification Code			When NM108 = XX, this is the NPI usedfor Physician CSP, Pharmacy CSP, ACT,IHBT, Nursing Homes, and BHCC. When NM108 = SV, this is the Medicaid Provider ID (No NPI available) used for HMO, Physician CSP, Pharmacy CSP, ACT, IHBT, Nursing Homes, and BHCC or the H Number (Medicare Part C).
155	2310	NM110	Entity Relationship Code	25		Established Patient
159	2310	PER	Provider Communication Numbers			
160	2310	PER03	Communication Number Qualifier	TE		Telephone
160	2310	PER04	Communication Number			Provider's Telephone Number
164	2320	COB	Coordination of Benefits			
164	2320	COB01	Payer Responsibility Sequence Number Code	P		Primary
164	2320	COB03	Coordination of Benefits Code	1		Coordination of Benefits
166	2320	REF	Additional Coordination of Benefits Identifiers			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
166	2320	REF01	Reference Identification Qualifier	6P, SY		6P = Group Number SY = Social Security
167	2320	REF02	Reference Identification			Value based on code entered in REF01
169	2330	NM1	Coordination of Benefits Related Entity			
169	2330	NM101	Entity Identifier Code	IN		Insurer (NM103 contains the name of theinsurer)
178	2750	N1	Reporting Category			
178	2750	N102	Member Reporting Category Name	Living Arrangement Pregnant		Different reporting categories
179	2750	REF	Reporting Category Reference			
179	2750	REF01	Reference Identification Qualifier	LU, XX1, ZZ		LU = Living Arrangement XX1 = Special Program Code ZZ = Mutually Defined - used for reporting pregnancies.
180	2750	REF02	Member Reporting Category Reference ID	Two-character Living Arrangement Code, Work Requirement – MANDATORY, Estimated Due Date, End Date, No Date Available		For **reporting living arrangements**, this is the two-character living arrangement code. See Appendix C for the entire list of codes and their description. For **reporting work requirements**, this element will be set to WORK REQUIREMENT - MANDATORY For **reporting pregnancies**, this elementcontains one of these three values – ESTIMATED DUE DATE, END DATE or NO DATE AVAILABLE.
181	2750	DTP	Reporting Category Dates			
181	2750	DTP01	Date/Time Qualifier	007		Effective
182	2750	DTP03	Member Reporting Category Effective Dates			For reporting living arrangements, this element contains the Start and End Dates of Living

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Arrangement. When DTP02 = D8, DTP03 contains the start date in the format CCYYMMDD. When DTP02 = RD8, both start and end dates are present in the format CCYYMMDD-CCYYMMDD. For reporting pregnancies, this is either the ESTIMATED DUE DATE or the END DATE based on the REF segment in this loop.

11 Appendices

This section contains one or more appendices.

11.1 Assignment reason codes

INS04 Value	Assignment Reason
Add	**(Start) Assignment Reason**
28	Member added due to Auto-Enrollment in MITS: Member enrolled with same MCE for next effective monthwhen same MCE is within the previous 3 months. (ABD, MAGI or MyCare Ohio) Member is newborn and enrolled from date of birth on Mother's MCE. (ABD, MAGI) Member is added for the next month to same MCE as case members. (ABD, MAGI)
14	Member was assigned an MCE by enrollment broker since member did not voluntarily select. (ABD, MAGIor MyCare Ohio)
15	Member enrollment addition performed by ODM managed care staff. (ABD, MAGI or MyCare Ohio)
16	Member selected their MCE through the enrollment broker (ABD, MAGI or MyCare Ohio) or ODM managedcare staff added a MyCare Ohio enrollment that needed to send a DTR to CMS.
17	Member is retroactively re-enrolled by MITS for up to 3 months due to restoration of retroactive eligibilityand/or managed care enrollment criteria. (ABD, MAGI or MyCare Ohio)
AJ	Member has been assigned effective the first day of the current month per Managed Care Day 1rules. (ABD or MAGI)
Change & Delete	**(Stop) Assignment Reason**
1	Member lost Medicaid eligibility due to not completing reapplication (ABD, MAGI). Member is no longerMedicaid eligible. (MyCare Ohio)
2	Member has a Nursing Facility (NF), Individual w/Intellectual Disability (IID), or Home and Community-Based (HCBS) Waiver Level of Care. (MyCare Ohio)
3	Member has a Date of Death. (ABD, MAGI or MyCare Ohio)
5	Member's 12-digit billing ID is not active. Sometimes referenced by ODM staff as a "Secondary" ID. (ABD,MAGI or MyCare Ohio)
6	Member disenrollment action performed by ODM managed care staff. (ABD, MAGI or MyCare Ohio)
7	Member is no longer Medicaid eligible. (ABD, MAGI or MyCare Ohio)
9	Member is incarcerated. (ABD, MAGI or MyCare Ohio)
10	Member no longer resides in the MCE's service area i.e. the consumer moved outside of Ohio (ABD,MAGI). Member no longer resides in the MCOP's service area. (MyCare Ohio)
11	Member is exempt from managed care enrollment due to an ODM Just Cause Determination. (ABD, MAGIor MyCare Ohio)
18	Member has voluntarily changed Managed Care Entity. (ABD, MAGI or MyCare Ohio)
29	Member is enrolled in the PACE program (MyCare Ohio only) or action by ODM staff on ABD/MAGImember. ABD/MAGI member enrolled in PACE prospectively will disenroll with reason AA.
37	Member has an invalid living arrangement code for Managed Care. (ABD, MAGI or MyCare Ohio)
38	Member has a special condition that excludes them from managed care enrollment. (ABD, MAGI or MyCareOhio)
40	Member has Medicaid aid category, which is not eligible for their managed care program. (ABD, MAGI orMyCare Ohio)
43	Member lost Medicare A and/or B (MyCare Ohio)
AA	Member has a benefit plan which is mutually exclusive for managed care enrollment. An example is thePACE program. You cannot be enrolled in PACE & Managed Care (ABD, MAGI or MyCare Ohio)
AB	OhioRISE Disenrollment

INS04 Value	Assignment Reason
AD	Medicaid Aid Category is appropriate for managed care but member's age is invalid. For example, a person 75 years old on extension. This prevents determination of capitation rate cell. Capitation paymentcannot be made or is made incorrectly. (MyCare Ohio/MAGI Extension).
EC	Member has Third Party Liability coverage (MyCare Ohio only)
XT	Member is enrolled in Medicare Part A and/or Medicare Part B. (ABD, MAGI)
System	**Assignment Reason**
25	System default value for 001 - Change transactions. Signifies change in identifying data elements
AI	System default assignment reason code. MCE will receive when a reason not listed above is used by thesystem. Please contact ODM if you receive this dis-enrollment reason. (ABD, MAGI or MyCare Ohio)
XN	System default assignment reason code that is sent ONLY on the HIPAA 834 Full file. (ABD, MAGI orMyCare Ohio)

11.2 HD04 code list

Coverage	HD04	Description
Assertive Community Treatment	ACT	ASSERTIVE COMMUNITY TREATMENT
Behavioral Health Care Coordination	BH-SUD	BEHAVIORAL HEALTH – SUBSTANCE USE DISORDERS
	BH-SPMI	BEHAVIORAL HEALTH – SERIOUS AND PERSISTENT MENTALILLNESS
Comprehensive Addiction & RecoveryAct	CARA	COMPREHENSIVE ADDICTION & RECOVERY ACT
Health Maintenance Organization **NOTE:** Used to indicate ABD/CFC coverage to the OHR Managed Care Entity (MCE) and OHR coverage to the ABD/CFC MCE	ABD	AGED, BLIND OR DISABLED
	CFC	COVERED FAMILIES AND CHILDREN
	OHR	OHIORISE (RESILIENCE THROUGH INTEGRATED SYSTEMS AND EXCELLENCE)
Hospice	HSBP	HOSPICE BENEFIT PLAN
Intensive Home-Based Treatment	IHBT	INTENSIVE HOME-BASED TREATMENT
Medicare	MEDICARE-A	MEDICARE PART A
	MEDICARE-B	MEDICARE PART B
	MEDICARE-C	MEDICARE PART C
	MEDICARE-D	MEDICARE PART D
Money Follows Person	MFP-N	MONEY FOLLOWS PERSON - NO
	MFP-Y	MONEY FOLLOWS PERSON - YES
Nursing Homes	NH-CRISE	CRISE NURSING SPAN
	NH-MCE	MCE ENTERED NURSING SPAN
	NH-MCADMIT	MCE ENTERED NURSING SPAN BASED ON ADMISSION DATE
Patient Liability	PL-F	PACE – NF
	PL-C	PACE - COMMUNITY
	PL-G	PRO-RATED PACE COMMUNITY
	PL-H	HOSPITAL
	PL-I	PRO-RATED HOSPITAL

Coverage	HD04	Description
	PL-N	LTCF
	PL-R	PRO-RATED LTCF
	PL-W	WAIVER
	PL-P	PRO-RATED WAIVER
Special Conditions –EXM (Exclude from Managed Care)	951	EXCLUDE SHARED DEMOGRAPHIC DATA
	AGE	AGE NOT VALID FOR AID CATEGORY
	BCM	BUREAU FOR CHILDREN WITH MEDICAL HANDICAPS
	CIC	CHILD IN CUSTODY
	DDR	DISABILITY DETERMINATION REDESIGN
	DDW	DDW-DEVELOPMENTAL DISABILITIES WAIVER ENROLLEE
	DEF	INPATIENT DEFERMENT
	DOD	DATE OF DEATH
	DVS	DEATH RECORD FROM VITAL STATISTICS
	E01	EXEMPT/EXCLUDE FROM MANAGED CARE ENROLLMENT
	ELG	INELIG CORRECTION - SEPT. 2012
	GHO	BENEFICIARY GROUP HEALTH ORGANIZATION - MYCARE OHIO
	IAH	INDEPENDENCE AT HOME DEMONSTRATION - MYCARE OHIO
	IDD	IDD DIAGNOSIS
	INC	INCARCERATION
	IVE	TITLE IV-E
	JC	JUST CAUSE EXEMPTION OR CHANGE
	LIS	LOW INCOME SUBSIDY - MYCARE OHIO
	MUL	MULTIPLE ID EXCLUDE
	N4E	OHIO BENEFITS FOSTER/ADOPT
	NUR	NURSING HOME FACILITY
	OAC	OAC RULES EXEMPTION-(ABD UNDER 21; INDIAN TRIBE;INSTITUTIONALIZED; ET AL.)
	PBP	PLAN BENEFIT PACKAGE NUMBER - MYCARE OHIO
	RDS	RETIREE DRUG SUBSIDY - MYCARE OHIO
Special Conditions – Informational Type	CC1	BCMH MEMBER
	CC2	BCMH SERVICE COORDINATION
	I01	INFORMATIONAL ONLY
	IMD	IMD EXTENDED STAY
	O42	OPT-OUT - UNSOLICITED OPT-OUT
	O51	OPT OUT - UNSOLICITED CMS DISENROLLMENT
	O54	OPT OUT - UNSOLICITED DISENROLLMENT
	OOD	OPT OUT BY DTRR
	OOH	OPT OUT BY HOTLINE
	OOM	OPT OUT BY CMS (is being replaced with O42 and O54)
	OOR	OPT OUT BY RETRO REENROLLMENT.
	OOV	OPT OUT - MEDICAID ONLY PASSIVE ENROLLMENT
	ORW	OHIORISE WAIVER
	PRE	PRE-RELEASE
Specialized Recovery Services Program	SRSP	SPECIALIZED RECOVERY SERVICES PROGRAM
Supplemental Income	SI-UNE	SUPPLEMENTAL INCOME
Waivers	WVR-A1	A1 – OHIO HOME CARE

Coverage	HD04	Description
	WVR-A4	A4 – TRANSITIONS CARVE-OUT
	WVR-A	A – PASSPORT
	WVR-9	9 – CHOICES
	WVR-P3	P3 – ASSISTED LIVING
	WVR-ICDS	ICDS WAIVER
	WVR-10	10 – SELF WAIVER
	WVR-P	P – TRANSITIONS DD WAIVER
	WVR-B	B – INDIVIDUAL OPTIONS WAIVER
	WVR-0	0 – LEVEL ONE WAIVER
	WVR-OR	OR - OHIORISE HCBS WAIVER

11.3 Living arrangement codes

Code	Description
01	INDEPENDENT (HOME/APART/TRLR)
02	PUBLIC INSTITUTION
03	REST HOME
04	BOARDING HOME
05	HOME OF ANOTHER(1/3 REDUCTION)
06	FOSTER FAMILY HOME
07	ADULT FAMILY HOME
09	NURSING HOME/GROUP HOME
10	NURSING HOME (LTCF)
11	GROUP HOME
12	BATTERED WOMAN SHELTER
13	HOMELESS
15	SPONSOR LIVING IN HOME
16	SPONSOR NOT LIVING IN HOME
17	SPONSOR SPOUSE IN HOME
18	SPONSOR SPOUSE NOT IN HOME
19	MENTAL INSTITUTION (MRDD)
20	MENTAL HEALTH CENTER
21	DRUG ALCOHOL TREATMENT CENTER
22	DEATH
23	LIVE-IN ATTENDANT
24	UNDER 21 YEARS, IN CUSTODY
25	SHELTER
26	HOSPITAL - OVER 30 DAYS
27	ADULT FOSTER HOME
28	ODADAS RESIDENTIAL FACILITY
29	ADULT COMMUNITY ALTERNATIVE
30	ADULT RESIDENTIAL FACILITY
31	ADULT MENTAL HEALTH HOUSING
32	PRISON NURSERY PROGRAM
33	TEMP ABSENT CHILD (PCSA)
DF	DETENTION FACILITY
EC	EMERGENCY CARE
EF	EMERGENCY SHELTER CARE FACILITY
HA	HOSPITAL ADMISSION
HH	HALFWAY HOUSE
HS	HISTORICAL IV-E SERVICE
IL	INDEPENDENT LIVING
IP	INPATIENT PSYCHIATRIC
KC	KINSHIP CARE

Code	Description
NH	NURSING HOME
NS	NON-REIMBURSABLE SERVICE
PH	PRE-ADOPTIVE INFANT HOME
S1	NON-INSTITUTION
S3	COUNTY HOME
S4	VENDOR PAY NURSING HOME
S9	REST HOME
SA	EMERGENCY FOSTER CARE
SB	TREATMENT FOSTER HOME
SC	CHILDREN'S RESIDENTIAL CENTER
SD	CHILDREN'S RESIDENTIAL CENTER - PUBLIC
SE	GROUP HOME
SF	FAMILY FOSTER HOME
SG	MEDICALLY FRAGILE FOSTER HOME
SH	TREATMENT FOSTER HOME SPECIAL NEEDS
SI	TREATMENT FOSTER HOME EXCEPTIONAL
SJ	GROUP HOME - PUBLIC
SK	FOSTER CARE-RELATIVE'S HOME
SL	RESIDENTIAL PARENTING HOME
SM	HOME
SN	H/HA PROJECT
SO	ADC-MED UNDER 21 RECEIVING GA
SP	PFFC-PURCHASED FAMILY FOSTER CARE
SR	CUBAN OR HAITIAN RRP
TV	TRIAL HOME VISIT
UF	UNLICENSED FACILITY

11.4 X12 segments used

Loop	Segment	Name	Ohio Specific Guidance
	ISA	Interchange Control Header	**Yes**
	GS	Functional Group Header	**Yes**
	ST	Transaction Set Header	**Yes**
	BGN	Beginning Segment	**Yes**
	REF	Transaction Set Policy Number	**Yes**
	DTP	File Effective Date	**Yes**
1000A	N1	Sponsor Name	**Yes**
1000B	N1	Payer	**Yes**
2000	INS	Member Level Detail	**Yes**
2000	REF	Subscriber Identifier	**Yes**
2000	REF	Member Supplemental Identifier	**Yes**
2000	DTP	Member Level Dates	**Yes**
2100A	NM1	Member Name	**Yes**
2100A	PER	Member Communications Numbers	**Yes**
2100A	N3	Member Residence Street Address	**No**
2100A	N4	Member City, State, Zip Code	**Yes**
2100A	DMG	Member Demographics	**Yes**
2100A	LUI	Member Language	**Yes**
2100B	NM1	Incorrect Member Name	**Yes**
2100B	DMG	Incorrect Member Demographics	**No**

Loop	Segment	Name	Ohio Specific Guidance
2100C	NM1	Member Mailing Address	**No**
2100C	N3	Member Mail Street Address	**No**
2100C	N4	Member Mail City, State, Zip Code	**No**
2100G	NM1	Responsible Person	**Yes**
2100G	PER	Responsible Person Communications Numbers	**Yes**
2100G	N3	Responsible Person Street Address	**No**
2100G	N4	Responsible Person City, State, Zip Code	**Yes**
2300	HD	Health Coverage	**Yes**
2300	DTP	Health Coverage Dates	**Yes**
2300	AMT	Health Coverage Policy	**Yes**
2300	REF	Health Coverage Policy Number	**Yes**
2300	LX	Provider Information	**Yes**
2310	NM1	Provider Name	**Yes**
2310	PER	Provider Communications Numbers	**Yes**
2320	COB	Coordination of Benefits	**Yes**
2320	REF	Additional Coordination of Benefits Identifiers	**Yes**
2320	DTP	Coordination of Benefits Eligibility Dates	**No**
2330	NM1	Coordination of Benefits Related Entity	**Yes**
2330	N3	Coordination of Benefits Related Entity Address	**No**
2330	N4	Coordination of Benefits Other Insurance Company City, State, Zip Code	**No**
2330	PER	Administration Communications Contact	**No**
2700	LS	Additional Reporting Categories	**No**
2710	LX	Member Reporting Categories	**No**
2750	N1	Reporting Category	**Yes**
2750	REF	Reporting Category Reference	**Yes**
2750	DTP	Reporting Category Date	**Yes**
2700	LE	Additional Reporting Categories Loop Termination	**No**
	SE	Transaction Set Trailer	**Yes**
	GE	Functional Group Trailer	**Yes**
	IEA	Interchange Control Trailer	**Yes**

NOTE: *Ohio Medicaid sends the segments listed above on the 834. For segments where additional notes are provided in this Companion Guide,the* ***Ohio Specific Guidance*** *column indicates "****Yes****". For all other segments, there are no additional notes provided. In such cases, this column indicates "****No****" and the details are in* ***blue*** *color.*

11.5 Implementation checklist

See Trading Partner Information Guide found here: Trading Partners | Medicaid (ohio.gov) .

11.6 Frequently asked questions

See Trading Partner website for FAQs.

12 Change summary

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

12/21/2021:

- Added EDI helpdesk email address to Section 5 Contact Information
- Added 0021914 = Aetna OhioRISE in ISA08
- Removed details from GS03

3/4/2022:

- Added in Section 7 Payer Specific Business Rules and Limitations “When REF01 = 23, this is the recipient’s existing aid category and effective start date. Format Used - XXXX CCYYMMDD”

04/22/2022:

- Replaced DRAFT with OMES disclaimer

06/17/2022:

- Changes to align the guide for FI file structure changes to be consistent with MITS
- Updates to Sections 6.1, 7.2, 10, 11.1 and 11.2 with OhioRISE information

01/17/2023:

- Updated comments in DTP Date Time Period on page 20

01/24/2023

- Updated EDI Support in Section 5, Contact Information.

05/16/2023

- Added “7 = Not provided” on page 24 for DMG05-1

07/19/2023

- Added HH – Halfway House to Section 11.3 Living Arrangement Codes

02/09/2024

- Removed disclaimer from cover page

04/05/2024

- Applied new ODM style guide
- Added February 1, 2023 date (clarified the Go-Live date in the tables under Section 7.6)