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

837 Post-adjudicated claims data reporting (PACDR): dental

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).

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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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EDITOR'S NOTE:
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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, 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 ofthe 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.

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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/005010X300A1 Technical Report Type (TR3)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 TR3in 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 Post-Adjudicated Claims Data Reporting: Dental 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 Post-Adjudicated Claims Data Reporting: Dental 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 Post-Adjudicated Claims Data Reporting: Dental Implementation Guide (HIPAATR3) 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 Post-Adjudicated Claims Data Reporting: Dental 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/

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- 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).

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2 Getting started

To get started, the Trading Partner Information Guide, can be found here:

Trading Partners | Medicaid (ohio.gov)

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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).

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4 Connectivity with the payer/communication

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

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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

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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 InformationQualifier	00		No Security Information Present (No Meaningful Information in ISA04)
C.4		ISA05	Interchange IDQualifier	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 ODM 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 Control Number			Must be identical to the associated interchange control trailer IEA02
C.6		ISA14	Acknowledgment Requested	0		No Interchange Acknowledgment Requested

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.10		IEA	Interchange Control Trailer			
C.10		IEA01	Number of Included Functional Groups			Number of included functional groups.
C.10		IEA02	Interchange Control Number			The control number assigned by the interchange sender. Must be identical to the value in ISA13.

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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'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's Code			7-digit Trading Partner ID assigned by ODM
C.7		GS03	Application Receiver's Code	MMISODJFS		
C.8		GS06	Group Control Number			Must be identical to the value in GE02

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.9		GE	Functional Group Trailer			
C.9		GE01	Number of Transaction Sets Included			Number of included transaction sets
C.9		GE02	Group Control Number			The functional group control number. Must be the same value as GS06.

6.3 ST-SE

This section describes how ODM uses transaction set control numbers. ODM limits the number of inquiries per ST-SE to 5,000.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
65		ST	Transaction Set Header			
65		ST02	Transaction Set Control Number			Identical to the value in SE02

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

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7 Payer specific business rules and limitations

In order to send 837 PACDR: Dental 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 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).

7.2 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.

7.3 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.

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7.4 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)

7.5 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)

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PACDR Adjustments/Voids submitted after Go Live (February 1, 2023)					
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 (February 1, 2023) 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 (February 1, 2023) 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

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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.

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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) .

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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
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 pertinentto trading electronically with ODM

In addition to the row for each segment, one or more additional rows are used to describe ODM's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
36		BHT	Beginning of Hierarchical Transaction			
		BHT02	Transaction Set Purpose Code	00		Original
		BHT06	Claim Identifier	RP		Reporting
38	1000A	NM1	Submitter Name			
	1000A	NM109	Submitter Identifier			7-digit Ohio Medicaid Trading Partner ID assigned by ODM
43	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.
52	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.

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Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						For group professional practices which are submitted as the billing provider, the individual rendering provider should be submitted in the 2310B loop. An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
	2010AA	NM109	Billing Provider Identifier			Provider NPI
61	2010AA	REF	Billing Provider Secondary Identification			
	2010AA	REF01	Reference Identification Qualifier	G2		G2
	2010AA	REF02	Billing Provider Secondary Identifier			7-digit OMES Provider ID must be used.
62	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.
66	2010BA	NM1	Subscriber Name			
	2010BA	NM108	Identification Code Qualifier	MI		
	2010BA	NM109	Subscriber Primary Identifier			Medicaid member ID assigned by ODM
77	2010BB	NM1	Payer Name			
	2010BB	NM103	Receiver Name	ODM		ODM
94	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.
147	2300	CLM05-3	Claim Frequency Code	1, 7, 8		1 = Original 7 = Replacement - Replacement of prior claim

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Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						8 = Void - Void/cancel of prior claim.
99	2300	DTP	Date - Accident Date			ODM strongly encourages the collection and submission of this data.
100	2300	DTP	Date - Appliance Placement			ODM strongly encourages the collection and submission of this data. It is critical to the intended analytics anticipated to be part of quality measures.
101	2300	DTP	Date - Service Date			ODM strongly encourages the collection and submission of this data. It is critical to the intended analytics anticipated to be part of quality measures.
102	2300	DN1	Orthodontic Total Months of Treatment			ODM strongly encourages the collection and submission of this data.
	2300	DN101	Orthodontic Treatment Quantity			ODM strongly encourages the collection and submission of this data
	2300	DN102	Orthodontic Treatment Remaining Quantity			ODM strongly encourages the collection and submission of this data.
104	2300	DN2	Tooth Status			ODM strongly encourages the collection and submission of this data.
106	2300	CN1	Contract Information			MCE payment arrangement at the claim level.
	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
	2300	CN102	Monetary 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
108	2300	AMT	Patient Amount Paid			
	2300	AMT01	Amount Qualifier Code	F5		

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Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2300	AMT02	Monetary Amount			
111	2300	REF	Claim Identifier			
	2300	REF01	Reference Identification Qualifier	D9		Claim Number
	2300	REF02	Payer Claim Control Number			See Section 7
115	2300	HI	Health Care Diagnosis Code			ODM strongly encourages the collection and submission of this data.
	2300	HI	Primary Diagnosis Code			
	2300	HI02-HI04	Health Care Diagnosis Code			Required when it is necessary to report an additional diagnosis code and the preceding HI data elements have been used to report diagnosis codes.
120	2310A	NM1	Referring Provider Name			An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
	2310A	NM109	Referring Provider Identifier			Provider NPI
123	2310A	PRV	Referring 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.
125	2310A	REF	Referring Provider Secondary Identification			
	2310A	REF01	Reference Identification Qualifier	G2		G2
	2310A	REF02	Referring Provider Secondary Identifier			7-digit OMES Provider ID must be used.
127	2310B	NM1	Rendering Provider Name			An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
	2310B	NM109	Rendering Provider Identifier			Provider NPI
130	2310B	PRV	Rendering 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

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Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						collection and submission of this data.
132	2310B	REF	Rendering Provider Secondary Identification			
	2310B	REF01	Reference Identification Qualifier	G2		G2
	2310B	REF02	Rendering Provider Secondary Identifier			7-digit OMES Provider ID must be used.
134	2310C	NM1	Service Facility Location Name			An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
	2310C	NM102	Entity Type Qualifier	2		Non-Person Entity
	2310C	NM109	Laboratory or Facility Primary Identifier			Provider NPI
140	2310C	REF	Service Facility Location Secondary Identification			
	2310C	REF01	Reference Identification Qualifier	G2		G2
	2310C	REF02	Laboratory or Facility Secondary Identifier			7-digit OMES Provider ID must be used.
142	2310D	NM1	Assistant Surgeon Name			An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
	2310D	NM109	Assistant Surgeon Primary Identifier			Provider NPI
147	2310D	REF	Assistant Surgeon Secondary Identification			
	2310D	REF01	Reference Identification Qualifier	G2		G2
	2310D	REF02	Assistant Surgeon Secondary Identifier			7-digit OMES Provider ID must be used.
154	2320	SBR	Other Subscriber Information			.
	2320	SBR01	Payer Responsibility Sequence Number Code			
	2320	SBR02	Individual Relationship Code			
	2320	SBR06	Coordination of Benefits Code	1, 6		1 = TPL 6 = MCE
	2320	SBR09	Claim Filing Indicator Code	HM		

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Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2320	AMT01	Amount Qualifier Code	D		Payor Amount Paid
	2320	AMT02	Payer Paid Amount			
170	2330A	NM1	Other Subscriber Name			
	2330A	NM109	Subscriber Primary Identifier			
178	2330B	NM1	Other Payer Name			
	2330B	NM109	Other Payer Primary Identifier			This information must match the information in SVD01. This should be the 7-digit Medicaid provider number of the MCE.
180	2330B	DTP	Claim Check or Remittance Date			
	2330B	DTP01	Date Time Qualifier	573		This is the date claim was paid by the MCE.
	2330B	DTP02	Date Time Period Format Qualifier	D8		Date Expressed in Format CCYYMMDD
	2330B	DTP03	Adjudication or Payment Date			
	2330B	REF01	Original Reference Number	F8		
	2330B	REF02	Other Payer Claim Control Number			ODM expects to receive MCEs Transaction Control Number (TCN) or MCE claim number
187	2330C	NM1	Other Patient Name			
	2330C	NM109	Other Insured Identifier			Required when ID is different than 2330A NM109
195	2400	LX	Service Line Number			
202	2400	TOO	Tooth Information			ODM strongly encourages the collection and submission of this data.
204	2400	DTP	Date - Service Date			ODM strongly encourages the collection and submission of this data
205	2400	DTP	Date - Prior Placement Date			ODM strongly encourages the collection and submission of this data.
206	2400	DTP	Date - Appliance Placement			ODM strongly encourages the collection and submission of this data.

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Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
207	2400	DTP	Date - Replacement			ODM strongly encourages the collection and submission of this data.
208	2400	DTP	Date - Treatment Start			ODM strongly encourages the collection and submission of this data.
209	2400	DTP	Date - Treatment Completion			ODM strongly encourages the collection and submission of this data.
210	2400	CN1	Contract Information			MCE payment arrangement at the line level.
	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
	2400	CN102	Contract Amount			
	2400	CN103	Contract Percentage			Allowance or charge percent
	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.
	2400	CN106	Contract Version Identifier	VAS		Value Added Service
216	2420A	NM1	Rendering Provider Name			An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
	2420A	NM109	Rendering Provider Identifier			Provider NPI
221	2420A	REF	Rendering Provider Secondary Identification			
	2420A	REF01	Reference Identification Qualifier	G2		When the provider's NPI is not applicable or unknown, ODM expects to receive "G2" – Provider Commercial Number.
	2420A	REF02	Rendering Provider Secondary Identifier			The ODM is expecting the provider's NPI. When the

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Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						provider's NPI is not applicable or unknown, the 7-digit OMES Provider ID must be used.
223	2420B	NM1	Assistant Surgeon Name			The provider information An encounter that contains an NPI that does not pass check digit validation WILL REJECT.
	2420B	NM109	Assistant Surgeon Primary Identifier			Provider NPI
226	2420B	PRV	Assistant Surgeon Specialty Information			ODM strongly encourages the collection and submission of this data.
228	2420B	REF	Assistant Surgeon Secondary Identification			
	2420B	REF01	Reference Identification Qualifier	G2		When the provider's NPI is not applicable or unknown, ODM expects to receive "G2" – Provider Commercial Number.
	2420B	REF02	Assistant Surgeon Secondary Identifier			The ODM is expecting the provider's NPI. When the provider's NPI is not applicable or unknown, the 7-digit OMES Provider ID must be used. .
235	2430	SVD	Line Adjudication Information			
	2430	SVD01	Other Payer Primary Identifier			This number should match NM109 in Loop ID-2330B identifying Other Payer
	2430	DTP01	Date Time Qualifier	573		Date claim was paid by the Managed Care Plan.
	2430	DTP02	Date Time Period Format Qualifier	D8		Date Expressed in Format CCYYMMDD
	2430	DTP03	Adjudication or Payment Date			

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11 Appendices

This section contains one or more appendices.

11.1 Implementation checklist

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

11.2 Frequently asked questions

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

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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 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:

- Added Paramount’s Sender ID 0003258 in Section 6, ISA06

3/04/2022:

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/005010X300**A1**
- Updated ISA06 Sender ID with “Use ODM assigned Trading Partner ID”

10/14/2022

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

01/24/2023

- Updated EDI Support in Section 5, Contact Information.

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)

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