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 institutional fee-for-service claims

20240405 v12.0

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 v5010 ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with ODM. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N 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 Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that inany way exceeds the requirements or usages of data expressed in the 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 hassomething 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.

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/005010X223 Implementation Guide (IG). It provides supplementation instructions not included in the IG that must be followed for implementation and conducting the transaction with ODM. It does not change the requirements of the IG in any way.

1.2 Overview

The Health Insurance Portability and Accountability Act (HIPAA) require all Providers, Trading Partners and Payers in the United States to comply with the Electronic Data Interchange (EDI) Standards for Health Care.

The ASC X12 HIPAA 837 Institutional Implementation Guide presents the basic requirements for planning and implementing an EDI-based system for the exchange of ASC X12 HIPAA compliant transactions with the Ohio Medicaid Enterprise System (OMES). In order to create a HIPAA compliant transaction, you must first meet the requirements of the ASC X12 HIPAA 837 Institutional Implementation Guide and then incorporate the ODM specific requirements.

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

1.3 References

In addition to the resources available on the ODM Trading Partner Website (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 EDI contact information

5.1 Integrated help desk (IHD)

Questions about the status of EDI submissions (837, 270, and 276 transactions) and questions about EDI SNIP rejections from TA1, 999, and 824 transactions) should be directed to OMES EDI:

OMES EDI
Days Available: Monday through Friday
Time Zone: Eastern Time (ET)
Time Available: 8:00 am to 4:30pm
Phone: 800-686-1516, option 4, sub-option 1
Email: omesedisupport@medicaid.ohio.gov

Questions about legacy EDI (MITS/OXI) transactions, fee-for-service (FFS) claim adjudication results, results for 270/271, 276/277, 277CA, and 835 transactions for FFS should be directed to the Ohio Fiscal Intermediary (FI).

Ohio fiscal intermediary (FI)
Days Available: Monday through Friday
Time Zone: Eastern Time (ET)
Time Available: 8:00 am to 4:30pm
Phone: 800-686-1516, option 4, sub-option 2
Email: OH_FI_EDI_Helpdesk@gainwelltechnologies.com

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		ISA02	Authorization Information			Populate with 10 spaces
C.4		ISA03	Security Information Qualifier	00		No Security Information Present (No Meaningful Information in ISA04)
C.4		ISA04	Security Information			Populate with 10 spaces
C.4		ISA05	Interchange ID Qualifier	ZZ		Mutually Defined
C.4		ISA06	Interchange Sender ID			7-digit Trading Partner ID assigned by ODM. This is a fixed-length field and should be left justified and filled with spaces to meet the minimum length requirement of 15.
C.4		ISA07	Interchange ID Qualifier	ZZ		Mutually Defined
C.4		ISA08	Interchange ReceiverID	MMISODJFS 0021920 0002937 0004202 0003150 0021919 0007316 0007610 0021914		This is a fixed-length field and should be left justified and filled with spaces to meet the minimum length requirement of 15. All ODM Trading Partner IDs should be 7-digits which include leading zeros. MMISODJFS = Ohio Dept of Medicaid Fee for Service 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.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						0007316 = Molina Healthcare of Ohio 0007610 = United Healthcare Community Plan of Ohio, Inc 0021914 = Aetna OhioRISE
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 ControlTrailer			
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 GroupHeader			
C.7		GS02	Application Sender'sCode			7-digit Trading Partner ID assigned by ODM. Must equal ISA06
C.7		GS03	Application Receiver'sCode			Must equal ISA08
C.8		GS06	Group ControlNumber			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 ControlNumber			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 receive 837 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).

Medicaid is the payer of last resort. The claim must first be adjudicated by all payers submitted in the 2330B loop before submitting the claim to ODM, unless an exception set forth in Rule 5160-1-05 or 5160-1-08 Coordination of benefits of the Ohio Administrative Code (OAC) applies. The total amount paid by the payer in 2330B for all services on the claim must be submitted (AMT 2320). If the payer in 2330B adjudicated the claim at the claim/header level, the associated Adjustment Code Group (s), Adjustment Reason Code(s) and Amount(s) must be submitted in this loop/segment. If the payer in 2330B adjudicated the claim at the detail level (i.e., made line payments and/or made line adjustments that caused the line payment to differ from the line billed charges), the 2430 loop must be completed. If the payer in 2330B adjudicated the claim at the detail but made some adjustments at the header/claim level that caused the claim payment to differ from the sum of the line payments, the 2320 CAS must be submitted in addition to the appropriate adjustments made in 2430 CAS.

Most inpatient institutional claims are adjudicated at the header/claim level.

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

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

0821-Hemodialysis

0831-IPD

0841-CAPD

0851-CCPD

0825-Hemodialysis Support Services

0835-IPD Support Service

0845-CAPD Support Services

0855-CCPD Support Services0829-Hemodialysis Training

0839-IPD Training

0849-CAPD Training

0859-CCPD Training

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

0304 - Clinical Laboratory

0310 - Pathological Laboratory

0730 - Diagnostic Services

0634 - Erythropoietin (EPO) less than 10,000 units

0635 - Erythropoietin (EPO) 10,000 units or greater

0636 - Separately billable drugs / injections / immunizations

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

0101 - All-inclusive room and board0160 - All-inclusive room and board for a short-term stay for waiver consumer

0183 - Therapeutic leave

0185 - Hospitalization leave

0220 - Flat Fee: Full Day (relates to RCC 0101) for a PA1/PA2

0169 - Flat Fee: Short-term NF stay for Waiver consumer (relates to RCC 0160) for a PA1/PA2

0189 - Flat Fee Leave Days (relates to RCC 0183 & 0185) for a PA1/PA2

0419 - All-inclusive room and board for ventilator-dependent resident (in approved Vent NF)

0410 – All-inclusive room and board for ventilator weaning resident (in approved Vent NF)

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

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

0101 – All-inclusive room and board

0160 - All-inclusive room and board for a short-term stay for waiver consumer

0182 - Patient Convenience (Visits with Friends and Family Leave)

0183 - Therapeutic Leave

0185 - Hospitalization

0410 - Respiratory Services (Ventilator add-on)

Dates of Service and the Submission of Claims

EDI claims with dates of service on 2/1 or greater must be submitted to the new OMES EDI administered by Deloitte. Claims with service dates prior to 2/1 have two options:

They can be submitted to the current path, or they can be submitted to the new OMES EDI

ODM has stated that trading partners should direct claims with services dates prior to 2/1 to the current

location as a precaution so that all claims are not caught up in any go-live challenges. ODM recognizes that not every trading partner will be able to split between two system and the new OMES EDI and downstream processing will be capable of handling all service date ranges.

MCE Payer IDs in 2010BB NM109:

MCE	837 2010BB NM109	DESCRIPTION
UNITED HEALTH CARE	88337	United Healthcare Ohio Medicaid
	83572	United Healthcare Ohio Medicaid Vision
	83244	United Healthcare Ohio Medicaid Dental * For Dates of Service 04/30/2024 and prior
	OHMD3	UnitedHealthcare Ohio Medicaid Dental *For Dates of service beginning 5/1/2024
AMERIHEALTH	35374	AmeriHealth Caritas Ohio
AETNA OhioRISE	45221	Aetna OhioRISE
CARESOURCE	0003150	CareSource OH Medicaid
	CSVIS001	CareSource OH Vision
	CSDEN001	CareSource OH Dental
BUCKEYE	0004202	Buckeye Ohio Medicaid
	V004202	Buckeye Envolve Vision
	D004202	Buckeye Envolve Dental
MOLINA	0007316	Molina Ohio Medicaid
	D007316	Molina SkyGen
	V007316	Molina March Vision
HUMANA	61103	Humana Ohio Medicaid
	D021919	Humana DentaQuest
	V021919	Humana EyeMed
ANTHEM BCBS	0002937	Anthem Medical
	V002937	Anthem EyeMed Vision
	D002937	Anthem DentaQuest Dental

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 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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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 comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
68		BHT	Beginning of Hierarchical Transaction			
68		BHT02	Transaction Set Purpose Code	00		Original
69		BHT06	Claim Identifier	CH		Chargeable
71	1000A	NM1	Submitter Name			
72	1000A	NM109	Submitter Identifier			7-digit Ohio Medicaid Trading Partner ID assigned by ODM
76	1000B	NM1	Receiver Name			
77	1000B	NM109	Receiver PrimaryIdentifier			
84	2010AA	NM1	Billing Provider Name			
86	2010AA	NM109	Billing Provider Identifier			Provider NPI
107	2000B	HL	Subscriber Hierarchical Level			For Ohio Medicaid, the "insured", "subscriber" and the "patient" are always the same person.
108	2000B	HL04	Hierarchical Child Code	0		No subordinate HL segment in this hierarchical structure.
109	2000B	SBR	Subscriber Information			
110	2000B	SBR09	Claim Filing Indicator Code	MC		

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
112	2010BA	NM1	Subscriber Name			
113	2010BA	NM108	Identification Code Qualifier	MI		
114	2010BA	NM109	Subscriber Primary Identifier			Medicaid member ID assigned by ODM
122	2010BB	NM1	Payer Name			
123	2010BB	NM108	Identification Code Qualifier	PI		
123	2010BB	NM109	Payer Identifier			For FFS = MMISODJFS. For Managed Care members, see Section 7".
144	2300	CLM	Claim Information			
144	2300	CLM	Patient Account Number			The maximum number of characters to be supported for this field is '20". Trading partners can submit up to 38 characters in the EDI CLM01, but the response in the 277CA and 835 will only have the first 20 characters.
145	2300	CLM05-3	Claim Frequency Code	1, 2, 3, 4, 7, 8		1 = Original claim submission 2 = Interim – First Claim 3 = Interim – Continuing Claim 4 = Interim – Last Claim 7 = Replacement (adjustment) 8 = Void/cancel of prior claim.
156	2300	PWK02	Report Transmission Code	AA, EL, FT		
160	2300	AMT	Patient Estimated Amount Due			
160	2300	AMT01	Amount Qualifier Code	F3		Patient Responsibility - Estimated
160	2300	AMT02	Patient Responsibility Amount			
174	2300	REF	Demonstration Project Identifier			Used for vendor approved resubmissions.
174	2300	REF01	Reference Identification Qualifier	P4		Project Code
174	2300	REF02	Demonstration Project Identifier			Original ICN
178	2300	NTE	Billing Note			
178	2300	NTE01	Note Reference Code	ADD		ADD – when the non-emergency emergency co-payment applies (See NTE02 comments) ADD – will be used by providers

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						to denote timely filing exemption (See NTE02 Comments)
178	2300	NTE02	Billing Note Text			For hospitals, when the non-emergency emergency co-payment applies, the 10-character code (COPAY NEMR) must be the first item listed in the NTE02. There must always be a single space between the word COPAY and NEMR. Example: NTE*ADD*COPAY NEMR When a claim could not be filed within the normal claim filing limit due to the pendency of an administrative hearing decision by ODM or an eligibility determination by a County Department ofJob and Family Services (CDJFS) the (1)or (2) below applies. For appeals/hearings, report the appeals/hearing number and date (The XXXXXXX is the hearing number) in thisformat: **APPEALS XXXXXXX CCYYMMDD** For a delayed eligibility determination,enter the eligibility determination decision notice date in this format: **DECISION CCYYMMDD** Example (1): NTE*ADD*APPEALS 123456A 20110906 Example (2): NTE*ADD*DECISION 20110831
258	2300	HI	Occurrence Span Information			This is required when there is an occurrence span code that

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						applies to the claim.
258	2300	HI01-1	Code List Qualifier Code	BI		Occurrence Span
258	2300	HI01-2	Occurrence Span Code			
259	2300	HI01-3	Date Time Period Format Qualifier	RD8		Format: CCYYMMDD-CCYYMMDD
259	2300	HI01-4	Occurrence Span Code Date			For ICF-IID claims, this indicates the date range of ventilator services for the recipient.
284	2300	HI	Value Information			
284	2300	HI01-1	Code List Qualifier Code	BE		Value
284	2300	HI01-2	Value Code	24, 31, 54, 80, 81, 82, 83		24 – Medicaid Rate Code 31 – Patient Liability Amount 54 – Newborn birth weight, in grams 80 – Covered Days 81 – Non-covered Days 82 – Co-insurance Days 83 – Lifetime Reserve Days
285	2300	HI01-5	Value Code Amount	5, 6		When HI01-2 = 24, this is the acuity level code. When HI01-2 = 31, this is the lump sum payment amount on nursing facility room and board claims. When HI01-2 = 54, this is the birth weight in grams.
319	2310A	NM1	Attending Provider Name			
321	2310A	NM109	Attending Provider Primary Identifier			Provider NPI
324	2310A	REF	Attending Provider Secondary Identification			Complete only if Provider does not have an NPI.
324	2310A	REF01	Reference Identification Qualifier	G2		Provider Commercial Number
325	2310A	REF02	Attending Provider Secondary Identifier			7-digit OMES Provider ID must be used.
354	2320	SBR	Other Subscriber Information			
356	2320	SBR09	Claim Filing IndicatorCode	MA, MB, 16, CI,		MA – For Original Medicare Part A claims MB – For Original Medicare Part B claims

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
				BL		16 – When other payer is a Medicare HMO / Part C plan CI – When other payer is commercial insurance (other than Blue Cross) BL – When other payer is Blue Cross/ Blue Shield Plan Any other appropriate value except MC (MC should only be used in 2000B loop)
358	2320	CAS	Claim Level Adjustments			See Section 7
424	2400	SV2	Institutional Service Line			
424	2400	SV201	Service Line Revenue Code			Specific guidance is provided in Section 7 (Payer specific Business Rules and Limitations)
427	2400	SV203	Line-Item Charge Amount			When submitting an Institutional Service Line for a covered day within a Nursing Facility or ICF-IID, please enter covered charge amount. For non-covered days within a Nursing Facility or ICF-IID room and board claim, the SV203 must be set to zeros. Use the SV207 to enter the non-covered charge amount.
428	2400	SV204	Unit or Basis for Measurement Code	DA, UN		DA – Days: For ESRD Clinics, only one date of service may be submitted for a RCC. UN – Units: Multiple units may be billed by Independent Free-standing ESDR Dialysis Clinics only for certain CPT/ HCPCS codes itemized with certain RCCs.
428	2400	SV205	Service Unit Count			For Nursing Facility & ICF-IID room and board claims, enter the number of units (days) associated with each occurrence of a Revenue Code.
428	2400	SV207	Line Item DeniedCharge or Non-Covered ChargeAmount			When submitting an Institutional Service Line for a non-covered day within a Nursing Facility or ICF-IID room and board claim, the SV207 must contain the amount of

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						non-covered charges, and the SV203 must be set to zeros.
433	2400	DTP	Date - Service Date			
434	2400	DTP02	Date Time Period Format Qualifier	D8		D8 – Format CCYYMMDD
449	2410	LIN	Drug Identification			
451	2410	LIN03	National Drug Code			National Drug Code
480	2430	CAS	Line Adjustment			See Section 7

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 Business scenarios

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

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

11.3 Transmission examples

This appendix contains actual data streams linked to the business scenarios from Appendix 2.

11.4 Frequently asked questions

See Trading Partner Information Guide found here: 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:

- Updated the revision number in the filename
- Added EDI helpdesk email address to Section 5 Contact Information
- Added 0021914 = Aetna OhioRISE in ISA08
- Removed GS03 Application Receiver's Code information
- 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
- Removed 1000B NM109 Receiver Primary Identifier information
- Removed 2010BB NM109 Payer Identifier information

03/4/2022:

- Added MCE Payer IDs in 2010BB NM109 in Section 7

03/25/2022:

- Added "AA" qualifier to PWK02 in Section 10
- Updated MCE Payer IDs in Section 7

04/22/2022:

- Replaced DRAFT with OMES disclaimer
- Removed 0021457 Aetna Better Health of Ohio from ISA08 Receiver ID
- Created table and updated MCE Payer IDs in 2010BB NM109 in Section 7

09/16/2022:

- Updated Section 7 MCE Payer ID table

12/23/2022

- Added clarification for the data required in the ISA02 & ISA04 in Section 6
- Added comment GS02 must equal ISA06 and GS03 must equal ISA08 in Section 6
- Added language about the February 1st, 2023, hard cut-over date on page 17

01/11/2023

- Updated MCE Payer IDs in 2010BB NM109 in Section 7
- Added clarifying language on dates of service and claims submission in Section 7
- Updated EDI support email contact address

01/24/2023

- Updated EDI Support in Section 5, Contact Information.
- Updated Section 10, Reference NM109

06/30/2023

- Updated Section 5 EDI Contact Information
- Removed AmeriHealth Payer IDs for radiology and transportation in Section 7
- Added CLM01 clarification comments in Section 10

02/09/2024

- Removed disclaimer from cover page

04/05/2024

- Updated MCE Payer IDs in 2010BB NM109 in Section 7
- Applied new ODM style guide