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 Professional health care claim for fee-for-service

20240405 v.15.0

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, over, and above, the information in the IGs. That information can:

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

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

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

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comment about the segment itself goes in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P,HJ, N6		These are the only codes transmitted by ODM.
			Plan Network Identification Number	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first 3 columns makes it clear that the code value belongs to the row immediately above it
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also, how to specify that only one code value is applicable.

1.1 Scope

ODM developed 5010 Companion Guides to supplement each 5010 Transaction Implementation Guide, based on Version 5, Release 1, with regards to:

- Specific Codes and/or Values that ODM will default on Outbound Transactions
- Specific Codes and/or Values that are unique to ODM to accept an Inbound Transaction

ODM Companion Guides will not create a Non-Compliant Transaction

This companion guide is intended to be used in conjunction with the ASC X12N/005010X222A1 Implementation Guide (IG). It provides supplementation instructions not included in the IG that must be followed for implementation and conducting the transaction with ODM. It does not change the requirements of the IG in any way.

1.2 Overview

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

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

The segments and elements used in this document are necessary for the ODM adjudication system for Professional 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.hhs.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).
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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).

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 Control Header			
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 Receiver ID	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 Department 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 Control Trailer			
C.10		IEA01	Number of Included Functional Groups			Number of included functional groups.
C.10		IEA02	Interchange Control Number			The control number assigned by the interchange sender. Must be identical to the value in ISA13.

6.2 GS-GE

This section describes ODM's use of the functional group control segments. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how ODM expects functional groups to be sentand how ODM will send functional groups. These discussions will describe how similar transaction sets will be packaged and ODM's use of functional group control numbers.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.7		GS	Functional Group Header			
C.7		GS02	Application Sender's Code			7-digit Trading Partner ID assigned by ODM. Must equal ISA06
C.7		GS03	Application Receiver's Code			Must equal ISA08
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
70		ST	Transaction Set Header			
70		ST02	Transaction Set Control Number			Identical to the value in SE02

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

7 Payer specific business rules and limitations

In order to submit 837 Professional 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).

Effective July 1st, 2018, based on the CMS rule (CMS-6010-F) titled "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements", ODM requires FQHCs (provider type 12), RHCs (provider type 5), OHFs (provider type 4), AHCCs (provider type 50), and freestanding birth centers (provider type 11) to submit claims with the NPI of the individual rendering provider. At the claim header level, this information is reported in the 2310B loop while at the detail level, it is the 2420A loop.

Behavioral Health (BH) Reimbursement Rule, OAC 5160-27-03 claims for dates of service prior to 7/1/22 must include the following:

1. The PWK segment in the 2300 loop of the 837 Professional claim. Use form identifier ODM99999. A certification statement uploaded via the MITS provider portal found here: https://portal.ohmits.com/public/Providers/tabid/43/Default.aspx.
2. The MOA segment in the 2320 loop with Remittance Advice Remark Codes (RARC) – M32 and N215.
3. The CAS segment in the 2320 loop must include the following Claim Adjustment Reason Code (CARC):

CARC 209 - Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)

The CMS authority governing this temporary TPL bypass is ending effective 7/1/2022. All claims attempting to utilize this bypass with dates of service subsequent to this date will be denied.

Rendering provider submissions

Effective February 1st, 2023, **ODM will require one rendering provider per claim at the header level, rather than the detail level, for professional claims** for both fee-for-service (FFS) and managed care recipients in order to ensure claims can be properly priced and paid.

Examples of claims submissions with the rendering practitioner are as follows:

- A client receives one service during the visit. The rendering practitioner's NPI is recorded in the header field on the claim. The service is recorded at the detail level on the claim without the rendering practitioner's NPI.
- A client receives multiple services from the same rendering practitioner during the visit. The rendering practitioner's NPI is recorded in the header field on the claim. Each service is recorded at a separate detail level without a rendering practitioner NPI.
- The client receives multiple services, each from a different rendering practitioner during the visit. The billing provider must create separate claims for each service provided by each rendering practitioner during the visit. Each claim must record the rendering practitioner NPI at the header level on each claim, and the service they rendered to the client is recorded at the detail level.

There is one exception to this rule for services provided by FFS Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) providers. FQHC/RHC claims submitted to ODM for payment may include multiple rendering providers at the detail level because ODM pays FQHC/RHC providers based on an encounter. In these specific scenarios multiple rendering providers on a claim will not cause a pricing/paying issue because

the rendering providers are not utilized in determining payment for FFS FQHC/RHC wraparound claims. For additional guidance related to FQHC/RHC providers, please review the Medicaid Advisory Letter located here: Letterhead | Administration (ohio.gov).

Claims for Wraparound Payments for Services Provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

To submit a wraparound claim successfully via EDI, providers must include the following information on the claim:

1. The Medicaid provider ID number for the Medicaid Managed Care Plan (MCP) must be reported as the "Other Payer Primary Identifier" in the 2330B loop in the NM1 09 data element (See chart below).
2. In the 2320 SBR 09 'HM' must be selected as the "Claim Filing Indicator".
3. The approved/allowed amount specified by the MCP must be reported in the 2320 loop AMT – Coordination of Benefits (COB) Payer Paid Amount. MCPs pay the same amounts to FQHCs and RHCs as they pay to similar providers for the same services.
4. If the provider's total billed charge is greater than the payment made by the MCP, then an amount equal to the difference must be reported on the claim, along with Claim Adjustment Reason Code (CARC) returned on the remittance by the MCP. For example, if billed charges are $100, and the MCP paid $25, then the difference of $75 must be reported.
5. All other required coordination-of-benefits (COB) information (such as the policy holder's name and relationship to the consumer) must also be reported in the appropriate loops/segments/data elements.
6. It is only necessary to report COB payment information at the detail level if another payer, which paid at the detail level, is the primary payer while the MCP is the secondary payer. Information about every payer must be reported in the 2320 and 2330 loops.

Managed Care Entity	ABD Medicaid Provider ID	CFC Medicaid Provider ID	OhioRISE Medicaid Provider ID
Buckeye Community Health Plan	0077145	0077148	N/A
CareSource	0077191	0077193	N/A
Molina Healthcare of Ohio Inc.	0077182	0077186	N/A
Paramount Advantage	0077188	0077190	N/A
United Healthcare Community Plan of Ohio, Inc.	0077110	0077115	N/A

Managed Care Entity	ABD Medicaid Provider ID	CFC Medicaid Provider ID	OhioRISE Medicaid Provider ID
Aetna Better Health OhioRISE	N/A	N/A	0445886
Comm. Ins. Co. DBA Anthem Blue Cross Blue Shield (effective 12/1/2022)	0464227	0464229	N/A
Humana Health Plan of Ohio, Inc. (effective 12/1/2022)	0461038	0462285	N/A
AmeriHealth Caritas (effective 12/1/2022)	0461036	0462293	N/A

Provider handbooks, billing instructions, and other provider communications are available on the Department's electronic manual site at: http://medicaid.ohio.gov/PROVIDERS.aspx

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

Each time a properly formatted 5010 X12 file is submitted to Ohio Medicaid, a 999 acknowledgement is returned to the submitter.

8.3 824 – application advice

For batch transactions, the 824-application advice 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

The Trading Partner Agreement can be found at this link -
Required Forms & Technical Letters (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
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. Notesand 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
71		BHT	Beginning of Hierarchical Transaction			
71		BHT02	Transaction Set Purpose Code	00		Original
72		BHT06	Claim or Encounter Identifier	CH		Chargeable
74	1000A	NM1	Submitter Name			
75	1000A	NM109	Submitter Identifier			7-digit Ohio Medicaid Trading Partner ID assigned by ODM
79	1000B	NM1	Receiver Name			
80	1000B	NM109	Receiver Primary Identifier			
87	2010AA	NM1	Billing Provider Name			
90	2010AA	NM109	Billing Provider Identifier			Provider NPI
114	2000B	HL	Subscriber Hierarchical Level			For Ohio Medicaid, the "insured", "subscriber" and the "patient" are always the same person.
115	2000B	HL04	Hierarchical Child Code	0		No subordinate HL segment in this hierarchical structure.
116	2000B	SBR	Subscriber Information			
118	2000B	SBR09	Claim Filing Indicator Code	MC, HM		MC = Medicaid HM = Health Maintenance Organization

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
121	2010BA	NM1	Subscriber Name			
122	2010BA	NM108	Identification Code Qualifier	MI		
123	2010BA	NM109	Subscriber Primary Identifier			Medicaid member ID assigned by ODM
133	2010BB	NM1	Payer Name			
134	2010BB	NM108	Identification Code Qualifier	PI		Payor Identification
134	2010BB	NM109	Payer Identifier			For FFS = MMISODJFS. For Managed Care members, see Section 7".
140	2010BB	REF	Billing Provider Secondary Identification			Complete only if Provider does not have an NPI.
140	2010BB	REF01	Reference Identification Qualifier	G2		Provider Commercial Number.
141	2010BB	REF02	Billing Provider Secondary Identifier			The 7-digit OMES Provider ID must be used.
158	2300	CLM	Claim Information			
158	2300	CLM01	Patient Control 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.
182	2300	PWK	Claim Supplemental Information			Follow these instructions when an EDI claim requires an attachment. Completion of this information indicates an attachment is being sent. The claim will be suspended waiting for the attachment.
183	2300	PWK01	Attachment Report Type Code			
184	2300	PWK02	Attachment Transmission Code	AA, EL, FT		Use when sending the attachment
185	2300	PWK06	Attachment Control Number			
188	2300	AMT	Patient Amount Paid			
188	2300	AMT01	Amount Qualifier Code	F5		Patient Amount Paid
188	2300	AMT02	Patient Amount Paid			Report Patient Liability amounts whenever applicable (e.g., Hospice room and board, waiver claims).

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						Never report Medicaid copayment amounts collected (or incurred) or the copayments will be deducted twice.
205	2300	REF	Demonstration Project Identifier			Used for vendor-approved resubmissions.
205	2300	REF01	Reference Identification Qualifier	P4		Project Code
205	2300	REF02	Demonstration Project Identifier			Original ICN
209	2300	NTE	Claim Note			
209	2300	NTE01	Note Reference Code	ADD, CER		ADD - will be used by providers to denote a copayment exemption applies (see NTE02 Comments) ADD - will be used by providers to denote timely filing exemption (See NTE02 Comments) CER - required if Billing Provider is a Medicaid School Program (MSP) Provider (See NTE02 Comments)
210	2300	NTE02	Claim Note Text			When a Medicaid co-payment exclusion applies, the 10-character code (see Application Value List below) must be the first item listed in the NTE02. There must always be a single space between the word COPAY and the four-character exclusion code. Application Value List (Select one): COPAY EMER (Emergency) COPAY HSPC (Hospice) COPAY PREG (Pregnancy) Example: NTE*ADD*COPAY EMER 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 of Job and Family Services (CDJFS) the (1) or (2) below applies.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						(1) For appeals/hearings, report the appeals/hearing number and date (The XXXXXXX is the hearing number) in this format APPEALS XXXXXXX CCYYMMDD (2) For a delayed eligibility determination, enter the eligibility determination decision date in this format. DECISION CCYYMMDD Example (1): NTE*ADD*APPEALS 123456A 110906 Example (2): NTE*ADD*DECISION 110831 (3) When a Medicaid Schools Program claim is submitted, the 10-character code (see Application Value List below) must be the first item listed in the NTE02. There must always be a single space between the word ATTEST and the three character exclusion code. Application Value List: ATTEST NAY ATTEST YES Example: NTE*CER*ATTEST YES
257	2310A	NM1	Referring Provider Name			Provider must be enrolled with Ohio Medicaid. When a Medicaid School Program (MSP) provider is billing for a therapy service, either an Ordering or Referring provider is required.
259	2310A	NM109	Referring Provider Identifier			Provider NPI
260	2310A	REF	Referring Provider Secondary Identification			Complete only if Provider does not have an NPI.
260	2310A	REF01	Reference Identification Qualifier	G2		Provider Commercial Number
261	2310A	REF02	Referring Provider Secondary Identifier			The 7-digit OMES Provider ID must be used

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
262	2310B	NM1	Rendering Provider Name			
264	2310B	NM109	Rendering Provider Identifier			Provider NPI
267	2310B	REF	Rendering Provider Secondary Identification			Complete only if Provider does not have an NPI.
267	2310B	REF01	Reference Identification Qualifier	G2		Provider Commercial Number.
268	2310B	REF02	Rendering Provider Secondary Identifier			The 7-digit OMES Provider ID must be used.
280	2310D	NM1	Supervising Provider Name			Provider must be enrolled with Ohio Medicaid
282	2310D	NM109	Supervising Provider Identifier			Provider NPI
283	2310D	REF	Supervising Provider Secondary Identification			Complete only if Provider does not have an NPI.
283	2310D	REF01	Reference Identification Qualifier	G2		Provider Commercial Number.
284	2310D	REF02	Supervising Provider Secondary Identifier			The 7-digit OMES Provider ID must be used.
295	2320	SBR	Other Subscriber Information			
296	2320	SBR09	Claim Filing Indicator Code	HM, MA, MB, 16, CI, BL		HM- Health Maintenance Organization MA - For Original Medicare Part A claims MB - For Original Medicare Part B claims 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
299	2320	CAS	Claim Level Adjustments			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 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

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						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. COB balancing rules apply and may be enforced (See IG Balancing).
301	2320	CAS01	Claim Adjustment Group Code	CO, OA, PI, PR		CO – Contractual Obligations OA - Other adjustments PI - Payer Initiated Reductions PR - Patient Responsibility
310	2320	MOA	Outpatient Adjudication Information			
311	2320	MOA03	Claim Payment Remark Code			M32 or N215 to meet OAC 5160-27-03 for BH claims.
311	2320	MOA04	Claim Payment Remark Code			M32 or N215 to meet OAC 5160-27-03 for BH claims.
320	2330B	NM1	Other Payer Name			
321	2330B	NM109	Other Payer Primary Identifier			The Medicaid provider ID number for the Managed Care Entity (see list in Section 7, page 17 and 18)
423	2410	LIN	Drug Identification			
425	2410	LIN03	National Drug Code			National Drug Code. Enter the code without dashes or hyphens.
430	2420A	NM1	Rendering Provider Name			
432	2420A	NM109	Rendering Provider Identifier			Provider NPI
434	2420A	REF	Rendering Provider Secondary Identification			Complete only if Provider does not have an NPI.
434	2420A	REF01	Reference Identification Qualifier	G2		Provider Commercial Number.
435	2420A	REF02	Rendering Provider Secondary Identifier			The 7-digit OMES Provider ID must be used.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
449	2420D	NM1	Supervising Provider Name			Provider must be enrolled with Ohio Medicaid
451	2420D	NM109	Supervising Provider Identifier			Provider NPI
452	2420D	REF	Supervising Provider Secondary Identification			Complete only if Provider does not have an NPI.
452	2420D	REF01	Reference Identification Qualifier	G2		Provider Commercial Number.
453	2420D	REF02	Supervising Provider Secondary Identifier			The 7-digit OMES Provider ID must be used.
454	2420E	NM1	Ordering Provider Name			Provider must be enrolled with Ohio Medicaid. Required when an MSP provider is billing for a nursing service. When an MSP provider is billing for a therapy service, either an Ordering or Referring provider is required.
456	2420E	NM109	Ordering Provider Identifier			Provider NPI
460	2420E	REF	Ordering Provider Secondary Identification			Complete only if Provider does not have an NPI.
460	2420E	REF01	Reference Identification Qualifier	G2		Provider Commercial Number.
461	2420E	REF02	Ordering Provider Secondary Identifier			The 7-digit OMES Provider ID must be used.
465	2420F	NM1	Referring Provider Name			Provider must be enrolled with Ohio Medicaid. When an MSP provider is billing for a therapy service, either an Ordering or Referring provider is required.
467	2420F	NM109	Referring Provider Identifier			Provider NPI
468	2420F	REF	Referring Provider Secondary Identification			Complete only if Provider does not have an NPI.
468	2420F	REF01	Reference Identification Qualifier	G2		Provider Commercial Number.
469	2420F	REF02	Referring Provider Secondary Identifier			The 7-digit OMES Provider ID must be used.
484	2430	CAS	Line Adjustment			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 of the Ohio Administrative Code applies. The total amount paid by the payer in 2330B for all

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						services on the claim must be submitted (AMT 2320). 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. COB balancing rules will be enforced (
485	2430	CAS01	Claim Adjustment Group Code	CO, OA, PI, PR		CO - Contractual Obligations OA - Other adjustments PI - Payer Initiated Reductions PR - Patient Responsibility

11 Appendices

This section contains one or more appendices.

11.1 Implementation checklist

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

11.2 Frequently asked questions

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

12 Change summary

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

12/21/2021:

- Updated the revision number in the filename
- Added EDI helpdesk email address to Section 5 Contact Information
- Added 0021920 = Aetna OhioRISE in ISA08
- Removed details from GS03 in GS03
- 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 Receiver Primary Identifiers in the 1000B NM109
- Removed Payer Identifiers in the 2010BB NM109

3/4/2022:

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

3/25/2022:

- 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

09/30/2022

- Added “for Fee-For-Service” on the title/cover page

12/05/2022

- Added clarification for the data required in the ISA02 & ISA04 in Section 6
- Added details in regard to the submission of rendering provider information in Section 7

12/23/2022

- Added comment GS02 must equal ISA06 and GS03 must equal ISA08 in Section 6
- Added language about the February 1, 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

08/13/2023

- Added information about wraparound payments for services provided by FQHCs and RHCs in Section 7, page 17 and 18
- Added 2330B, NM109 notes in Section 10, page 29

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