



MyCare Ohio
277 Unsolicited Claim/Encounter Status
Notification

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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 - <http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>.

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.

Table of Contents

1	INTRODUCTION.....	1
1.1	Scope.....	2
1.2	Overview	2
1.3	References	3
1.3.1	EDI Basics	3
1.3.2	Government and Other Associations.....	3
1.3.3	ASC X12 Standards	3
1.4	Additional Information	3
2	GETTING STARTED	4
3	TESTING WITH THE PAYER	5
4	CONNECTIVITY WITH THE PAYER/COMMUNICATIONS	6
5	CONTACT INFORMATION.....	7
5.1	EDI Customer Service.....	7
5.2	EDI Technical Assistance	7
5.3	Provider Service Number	7
5.4	Applicable Websites/Email	7
6	CONTROL SEGMENTS/ENVELOPES	8
6.1	ISA-IEA.....	8
6.2	GS-GE	8
6.3	ST-SE.....	9
7	PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS.....	10
8	ACKNOWLEDGEMENTS AND/OR REPORTS.....	11
9	TRADING PARTNER AGREEMENTS.....	12
10	TRANSACTION SPECIFIC INFORMATION	13
	APPENDICES	17
A.	EOB Codes.....	17
B.	Implementation Checklist.....	20
C.	Frequently Asked Questions.....	20

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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 the Ohio Department of Medicaid 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 the Ohio Department of Medicaid.

In addition to the row for each segment, one or more additional rows are used to describe ODM, 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
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/005010X212 Implementation Guide (IG). It provides supplementation instructions not included in the IG that must be followed for implementation and conducting the transaction with ODM. It does not change the requirements of the IG in any way.

1.2 Overview

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

This is not a HIPAA 'mandated' Transaction, and the only change noted was the name to the 277U Health Care Claim Pending Status Information to meet the original intent of the Transaction. This was documented in the 277 ERRATA.

The new name does not reflect the ODM use of the Transaction.

This outbound transaction is not checked for compliance by ODM. Thus the inbound transaction should not be checked for compliance.

ODM returns the 277U once a claim/encounter passes compliance and the EDI edit process. The EDI edit process can 'reject' any claim/encounter that does not pass the edit criteria. The 'rejected' claims/encounters will not be loaded into MITS, whereas those that do pass the edit process will be loaded into MITS. Once adjudication has occurred, the 277U will be generated for every claim/encounter, listing the adjudication status of 'Accepted' (including suspended) or 'Denied'.

Encounters denied by MITS in this transaction set may be corrected and the encounter resubmitted according to the MCP encounter data submission companion guides and submission schedule. Denied claims should also be corrected and resubmitted as original claims.

The 277U X12 Transaction was created as a non-mandated Transaction to accommodate Medicaid States that report 'Suspended/Pended' Claims to their TP/Providers.

Since it is not a HIPAA Mandated Transaction it can be customized and used to suit the needs of each Payer.

This EDI Companion Guide provides the Trading Partners with a Status of 'Accepted' (includes Suspended/Pended claims) or 'Rejected' for each claim when an 837 file is adjudicated.

ODM has elected to utilize the 5010 277 as a point of reference to update their 277U.

1.3 References

In addition to the resources available on the ODM Trading Partner Website (<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>), 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: <https://questions.cms.gov>
- HHS Office for Civil Rights (Privacy) <http://www.hhs.gov/ocr/hipaa>
- WEDI - Workgroup for Electronic Data Interchange: <http://www.wedi.org>
- CMS website for NPI: <http://www.cms.hhs.gov/NationalProvIdentStand>

1.3.3 ASC X12 Standards

- Washington Publishing Company: <http://www.wpc-edi.com>
- Data Interchange Standards Association: <http://disa.org>
- 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:
<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>

2 GETTING STARTED

To get started, the Trading Partner Information Guide can be found here:
<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>

3 TESTING WITH THE PAYER

Details related to testing are in the Trading Partner Information Guide which can be found here:

<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>

4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

Connectivity information is in the Trading Partner Information Guide which can be found here:

<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>

5 CONTACT INFORMATION

5.1 EDI Customer Service

Days Available: Monday through Friday

Time Zone: Eastern Time (ET)

Time Available: 8:00 am to 5:00 pm

Phone: (614) 387-1212

Email: DAS-EDI-Support@das.ohio.gov

5.2 EDI Technical Assistance

Days Available: Monday through Friday

Time Zone: Eastern Time (ET)

Time Available: 8:00 am to 5:00 pm

Phone: (614) 387-1212

Email: DAS-EDI-Support@das.ohio.gov

5.3 Provider Service Number

Provider Assistance Unit 1-800-686-1516. Please listen to the entire message before making your selection.

Web URL: <http://medicaid.ohio.gov/PROVIDERS.aspx>

5.4 Applicable Websites/Email

Ohio Medicaid Website: <http://medicaid.ohio.gov>

The Trading Partner web page can be found by following: Providers > Billing > Trading Partners

(<http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>)

To contact Ohio Medicaid for assistance, use the link - <http://medicaid.ohio.gov/CONTACT.aspx>

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		ISA03	Security Information Qualifier	00		No Security Information Present (No Meaningful Information in ISA04)
C.4		ISA05	Interchange ID Qualifier	ZZ		Mutually Defined
C.4		ISA06	Interchange Sender ID	MMISODJFS		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			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.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 sent and how ODM will send functional groups. These discussions will describe how similar

transaction sets will be packaged and ODM 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	MMISODJFS		
C.7		GS03	Application Receiver's Code			7 digit Trading Partner ID assigned by ODM
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.

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

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
213		SE	Transaction Set Trailer			
213		SE01	Number of Included Segments			Total number of segments included in a transaction set including ST and SE segments
213		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 receive 277U X12 transactions, trading partners must be authorized by Ohio Medicaid and in active status. These details are documented in the Trading Partner Information Guide which can be found at this link - <http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>.

8 ACKNOWLEDGEMENTS AND/OR REPORTS

The 277U is an outbound transaction and there are no associated responses.

9 TRADING PARTNER AGREEMENTS

These details can be found in the Trading Partner Information Guide which can be found at this link - <http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>.

10 TRANSACTION SPECIFIC INFORMATION

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that ODM has something additional, over and above, the information in the IGs. That information can:

1. Limit the repeat of loops, or segments.
2. Limit the length of a simple data element.
3. Specify a sub-set of the IGs internal code listings.
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 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
107		BHT	Beginning of Hierarchical Transaction			
107		BHT01	Hierarchical Structure Code	0010		Information Source, Information Receiver, Provider of Service, Subscriber, Dependent
107		BHT02	Transaction Set Purpose Code	08		Status
107		BHT03	Originator Application Transaction Identifier			Concatenation of Trading Partner ID and System Date
108		BHT06	Transaction Type Code	DG		Response
109	2000A	HL	Information Source Level			
110	2000A	HL03	Hierarchical Level Code	20		Information Source
110	2000A	HL04	Hierarchical Child Code	1		Additional Subordinate HL Data Segment in This Hierarchical Structure.
111	2100A	NM1	Payer Name			
111	2100A	NM101	Entity Identifier Code	PR		Payer
111	2100A	NM102	Entity Type Qualifier	2		Non-Person Entity
111	2100A	NM103	Name Last or Organization Name	ODJFS		Payer Name
112	2100A	NM108	Identification Code Qualifier	PI		Payor Identification

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
112	2100A	NM109	Identification Code	MMISODJFS		
137	2200D	TRN	Claim Status Tracking Number			
137	2200D	TRN01	Trace Type Code	2		Referenced Transaction Trace Numbers
137	2200D	TRN02	Reference Identification			For Encounters, this will be the MCP's Transaction Control Number (TCN). For FFS Claims, this will be the original Patient Control Number (CLM01) from the 837 Claim.
138	2200D	STC	Claim Level Status Information			
138	2200D	STC01-1	Industry Code	A2, A7		A2 = Encounters/FFS – Adjudication Status of 'Accepted' A7 = Encounter/FFS – Adjudication Status of 'Rejected'
138	2200D	STC01-3	Entity Identifier Code	03, 2D, 71, 72, 82, DN, MSC, PRP, QC, SEP, TL, TTP		03 = Dependent 2D = Miscellaneous Health Care Facility 71 = Attending Physician - Used with Status Code 26 72 = Operating Physician - Used with Status Code 26 82 = Rendering Provider. Used with Status Code 26 DN = Referring Provider. Used with Status Code 26 MSC = Mammography Screening Center PRP = Primary Payer QC = Patient - Used with Status Code 21 and 478 SEP = Secondary Payer TL = Testing Laboratory TTP = Tertiary Payer
138	2200D	STC12	Free-Form Message Text			This element is for Encounter Claims only. This will be the 4 digit Error (EOB) Codes regarding Encounter Transactions for both informational and critical Errors. Please see Appendix A for more information on the EOB Code(s). The Error Codes will appear as a continuous string of numbers. For example, the Error Codes of 201, 203, 269, and 3047 will be displayed as 0201020302693047

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
149	2200D	REF	Payer Claim Control Number	1K		Value used for Claims/Encounters accepted into MITS.
149	2200D	REF01	Reference Identification Qualifier			
149	2200D	REF02	Reference Identification			ODM assigned Internal Control Number (ICN). ICNs are assigned to every Claim/Encounter that has been accepted into MITS for adjudication.
155	2200D	DTP	Claim Service Date			
155	2200D	DTP02	Date Time Period Format Qualifier	D8, RD8		D8 = Date Expressed in Format CCYYMMDD RD8 = Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
156	2200D	DTP03	Date Time Period			Dates of service for the Institutional, Dental, and Professional Claim/Encounter.
157	2220D	SVC	Service Line Information			
157	2220D	SVC01-1		AD, ER, HC, HP, IV, N4, NU, WK		AD = American Dental Association Codes (ADA) ER = Jurisdiction Specific Procedure and Supply Codes HC = Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes HP = Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code IV = Home Infusion EDI Coalition (HIEC) Product/Service Code N4 = National Drug Code in 5-4-2 Format NU = National Uniform Billing Committee (NUBC) UB92 Codes WK = Advanced Billing Concepts (ABC) Codes
161	2220D	STC	Service Line Status Information			
161	2220D	STC01-1	Industry Code	A2, A7		A2 = Encounter/Claim Adjudication Status of 'Accepted'

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						A7 = Encounter/Claim Adjudication Status of 'Rejected'
170	2220D	STC12	Free-Form Message Text			<p>This element is for Encounter Claims only.</p> <p>This will be the 4 digit Error (EOB) Codes regarding Encounter Transactions for both informational and critical Errors.</p> <p>Please see Appendix A for more information on the EOB Code(s) for MCPs.</p> <p>The Error Codes will appear as a continuous string of numbers.</p> <p>For example, the Error Codes of 201, 203, 269, and 3047 will be displayed as 0201020302693047.</p>
172	2220D	DTP	Service Line Date			
172	2220D	DTP01	Date/Time Qualifier	472		Service – Begin and end dates of the service being rendered.
172	2220	DTP02	Date time Period Format Qualifier	D8, RD8		<p>D8 = Date Expressed in Format CCYYMMDD</p> <p>RD8 = Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD</p>
172	2220	DTP03	Date Time Period			Service Line Date

APPENDICES

This section contains one or more appendices.

A. EOB Codes

EOB Code	EOB Description
30	MILEAGE RATE MISSING OR ZEROS
50	CLAIM DENIED. PLEASE CORRECT COVERED DAYS FIELD AND RESUBMIT
51	PATIENT CONDITION/STATUS CODE MISSING, INVALID
62	CLAIM DENIED. THE HOUR OF ADMISSION IS MISSING OR INVALID.
124	INVALID DATE OF SERVICE
132	HEADER TOTAL/SUBMITTED CHARGE MISSING OR INVALID
133	SUBMITTED CHARGES/TOTAL CLAIM CHARGE CONFLICT
136	REVENUE CENTER CODE IS MISSING/INVALID
138	TYPE OF BILL IS INVALID
167	PATIENT STATUS MISSING OR INVALID
170	PLACE OF SERVICE IS INVALID
184	DETAIL TOTAL/SUBMITTED CHARGE MISSING OR INVALID
254	FOR COMPOUND DRUGS, 2 OR MORE NDC CODE DTLS NEEDED
321	PROCEDURE CODE NOT ON FILE
361	PROCEDURE CODE NOT ALLOWED FOR DATE OF SERVICE
482	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.
872	FIRST DIAGNOSIS CODE NOT ON FILE
873	SECOND DIAGNOSIS CODE NOT ON FILE
875	THIRD DIAGNOSIS CODE NOT ON FILE
878	FOURTH DIAGNOSIS CODE NOT ON FILE
885	FIFTH DIAGNOSIS CODE NOT ON FILE
888	SIXTH DIAGNOSIS CODE NOT ON FILE
892	SEVENTH DIAGNOSIS CODE NOT ON FILE
898	EIGHTH DIAGNOSIS CODE NOT ON FILE
1027	FIRST SURGICAL PROCEDURE CODE NOT ON FILE
1028	SECOND SURGICAL PROCEDURE NOT ON FILE
1029	THIRD SURGICAL PROCEDURE NOT ON FILE
1030	4TH SURGICAL PROCEDURE NOT FOUND
1031	5TH SURGICAL PROCEDURE NOT FOUND
1032	6TH SURGICAL PROCEDURE NOT FOUND
1090	1ST SURGICAL PROCEDURE DATE IS MISSING OR ZEROS
1091	2ND SURGICAL PROCEDURE DATE IS MISSING OR ZEROS
1092	3RD SURGICAL PROCEDURE DATE IS MISSING OR ZEROS
1093	4TH SURGICAL PROCEDURE DATE INVALID
1094	5TH SURGICAL PROCEDURE DATE INVALID
1095	6TH SURGICAL PROCEDURE DATE INVALID
1152	CREDIT/ADJUSTMENT REQUIRES ICN
1157	CLAIM NOT ON HISTORY
2047	THE ENCOUNTER CLAIM PMP ID/CONTRACT ID DOES NOT MATCH THE PMP ID ASSOCIATED WITH THE RECIPIENT ON THE CLAIM HEADER FROM DOS. (NOTE: INPATIENT CLAIM = DISCHARGE DATE)
2048	THE CONTRACT ID SUBMITTED ON THE MYCARE OHIO ENCOUNTER DOES NOT FIND A MATCH TO OHIO MEDICAID PMP ID.
2049	THE CMS CONTRACT ID REPORTED ON THE MYCARE OHIO ENCOUNTER CLAIMS FOR THE PROGRAM SPECIFIC MCP PROVIDER ID MUST BE A VALID MYCARE MCP ID.

EOB Code	EOB Description
2050	FOR MYCARE OHIO ENCOUNTERS, IN THE FIRST OCCURRENCE OF THE OTHER PAYER THE CLAIM FILING INDICATOR MUST BE SUBMITTED WITH 16 - HEALTH MAINTENANCE ORGANIZATION (HMO) MEDICARE RISK.
2051	ON THE MYCARE OHIO ENCOUNTERS, THE OTHER PAYER CONTACT ID MUST BE REPORTED IN THE PAYER ID AT THE CLAIM HEADER, THE INSURED GROUP #, AND PAYER ID AT THE CLAIM DETAIL.
2053	THE ENCOUNTER CLAIM PMP ID/CONTRACT ID DOES NOT MATCH THE PMP ID ASSOCIATED WITH THE RECIPIENT ON THE CLAIM DETAIL FROM DATE OF SERVICE.
2063	THE MYCARE OHIO INSTITUTIONAL ENCOUNTER CLAIMS CAN ONLY BE SUBMITTED WITH A CLAIM FREQUENCY INDICATOR OF 1-4 OR 7-9.
2064	THE CMS ICN IS REQUIRED ON ALL MYCARE OHIO ENCOUNTERS EXCEPT FOR PHARMACY PART D MYCARE OHIO ENCOUNTERS.
2065	THE CMS ICN FORMAT MUST BE 13 CHARACTERS WHEN REPORTING ON ALL MYCARE OHIO ENCOUNTERS EXCEPT FOR PHARMACY PART D MYCARE OHIO ENCOUNTERS.
2066	THE OTHER PAYER PATIENT RESPONSIBILITY PAYMENT AMOUNT MUST BE \$0 OR GREATER ON MYCARE OHIO PHARMACY CLAIMS.
2067	THE OTHER PAYER PATIENT RESPONSIBILITY PAYMENT AMOUNT MUST BE VALID ON MYCARE OHIO PHARMACY CLAIMS.
2091	RECIPIENT SERVICES COVERED BY HMO PLAN
2126	FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV
2168	INVALID SOURCE OF ADMISSION
2183	MISSING UNITS OF SERVICE
2199	DATE OF SURGERY IS MISSING
2200	INVALID TYPE OF ADMISSION
2313	DIAGNOSIS CODE MISSING/NOT ON FILE
2314	SURGICAL PROCEDURE CODE NOT FOUND
2317	PROCEDURE CODE/MODIFIER CONFLICT
2321	PROCEDURE CODE IS NO LONGER VALID
4252	DIAGNOSIS CODE 10-24 NOT ON FILE
4893	NDC CODE MISSING
4897	NDC SHOULD NOT REPEAT FOR CLAIM DETAIL
5000	THIS IS A DUPLICATE OF ANOTHER CLAIM
8884	MCP PROVIDER NUMBER/NPI BILLED INCORRECTLY
8885	MCP PROVIDER NUMBER NOT ON FILE
8886	RECIPIENT IS NOT ENROLLED IN MCO
8887	INVALID MCP RECIPIENT ID
8888	NO MEDICAID ELIGIBILITY FOR MCP RECIPIENT
8889	PROCEDURE CODE REQUIRED AT DETAIL LEVEL FOR ENCOUNTERS
8890	MISSING OR INVALID MCP PAID DATE
8891	MCP PAID DATE IS LESS THAN DETAIL DOS
8892	MODIFIER NOT ON FILE
8893	LMP REQUIRED FOR DELIVERY OR PRENATAL PROCEDURE
8894	INVALID LMP DATE
8895	LMP DATE MUST BE LESS THAN FIRST DOS
8896	EPSDT REFERRAL INDICATOR REQUIRED
8897	INVALID ADMIT HOUR MINUTES
8898	MCP CLAIM NUMBER REQUIRED
8899	MCP CLAIM NUMBER MUST BE BETWEEN 1 AND 18 BYTES IN LENGTH AND ONLY CONTAINS ALPHANUMERIC CHARACTERS
8900	MISSING HEADER MCP AMOUNT
8901	CAPITATION INDICATOR REQUIRED AT THE DETAIL LEVEL
8902	CAPITATION INDICATOR REQUIRES AMOUNT >\$0 AT THE CLAIM LEVEL
8903	CAPITATION INDICATOR ON ALL DETAILS REQUIRES AMOUNT > \$0 AT THE CLAIM LEVEL
8904	HEADER MCP CAPITATION PAYMENT MUST BE SUM OF DETAIL MCP CAPITATION PAYMENTS

EOB Code	EOB Description
8906	INVALID DETAIL CAPITATED AMOUNT SUBMITTED WITH NINE 9'S AND A DECIMAL
8907	INVALID BIRTH WEIGHT
8908	INVALID MCP PAID DATE AT LINE LEVEL WHEN FINAL PER TYPE OF BILL
8909	INVALID DISCHARGE HOUR
8910	MISSING MCP PAID DATE AT LINE LEVEL WHEN FINAL PER TYPE OF BILL
8911	MCP PAID DATE AT LINE LEVEL WHEN FINAL PER TYPE OF BILL LESS THAN FIRST AND LAST DATES OF SERVICE
8912	INVALID HEADER MCP PAYMENT AMOUNT
8913	MISSING DETAIL MCP PAYMENT AMOUNT
8914	INVALID DETAIL MCP PAYMENT AMOUNT
8915	CAPITATION INDICATOR REQUIRES \$0 AT THE DETAIL LEVEL
8916	QUALIFIER MUST BE EI OR SY
8917	INVALID EIN/SSN FOR QUALIFIERS EI/SY/24/34
8918	INVALID HEADER MCP PAYMENT AMOUNT
8919	VALUE MUST BE 1, 7 OR 8 IN 2300-CLM05-3
8920	DATE QUALIFIER MUST BE D8
8921	CONTRACT TYPE CODE INVALID ON HEADER
8922	RECIPIENT ID NOT ON FILE
8923	QUALIFIER MUST BE 'XX'/24/'34/'46/'MI/'EI/SY/PI'
8924	INVALID CHECK DIGIT FOR NPI
8925	FIRST OCCURRENCE MUST BE 'P'
8926	FIRST OCCURRENCE MUST BE 18
8929	FIRST OCCURRENCE MUST BE 'D'
8930	MISSING HEADER MCP PAYMENT AMOUNT
8932	FIRST OCCURRENCE MUST BE '573'
8933	VALUE MUST BE D8 AT DETAIL
8934	CONTRACT TYPE CODE INVALID ON DETAIL
8935	QUALIFIER MUST BE XX AT DETAIL
8936	INVALID NPI CHECK DIGIT AT DETAIL
8938	INVALID REGION/PROGRAM SPECIFIC MCP PROVIDER NUMBER AT DETAIL LEVEL
8939	FIRST OCCURRENCE OF MCP AMOUNT IS REQUIRED AT DETAIL
8940	FIRST OCCURRENCE OF DATE/TIME QLFR MUST BE 573 AT DETAIL
8941	FIRST OCCURRENCE OF DATE/TIME FMT QLFR MUST BE D8 AT DETAIL
8943	DRG CODE NOT SUPPLIED FOR INPATIENT
8944	MISSING INDICATOR ON PAID BY DRG CLAIM
8945	DRG PD MUST HAVE 1ST DTL MCP AMT=0 OR MCP HDR AMT
8946	DRG CODE NOT ON FILE FOR INPATIENT
8947	INVALID TRADING PARTNER ID
8954	MCP ATTENDING PROVIDER NUMBER/NPI BILLED INCORRETLY
8955	DETAIL LEVEL MCP ATTENDING PROVIDER NUMBER/NPI NOT ON FILE
8956	MCP OPERATING PROVIDER NUMBER/NPI NOT ON FILE
8957	INVALID CHECK DIGIT FOR OTHER PHYSICIAN NPI
8958	INVALID CHECK DIGIT FOR MCP ATTENDING PROVIDER NPI
8959	MCP OTHER PHYSICIAN NUMBER/NPI NOT ON FILE
8963	ON ENCOUNTERS, MCP PAYER ID / CONTRACT ID NOT ALLOWED ON SUBSEQUENT OTHER PAYER OCCURRENCES.
8980	CLMCN1 SEGMENT IS NOT FOUND
8981	OTHER PAYER INFORMATION MISSING OR INVALID

B. Implementation Checklist

See Trading Partner Information Guide found here: <http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>.

C. Frequently Asked Questions

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