

The logo for the state of Ohio, featuring a red outline of the state's shape to the left of the word "Ohio" in a bold, dark red serif font.

Department of  
Job and Family Services

**Ohio Companion Guide  
837 Encounter Dental Claim**

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## Document Information

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<http://jfs.ohio.gov/OHP/tradingpartners/info.stm>

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## Amendment History

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1.0		HP EDI Team	DRAFT Version
2.0		HP EDI Team	Initial Production version

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## EDI SUPPORT INFORMATION

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## DISCLOSURE STATEMENT

This Companion Guide documents the ODJFS specific requirements to submit Encounters in an EDI X12 Format from the Managed Care Plans.

This following documentation was referenced for this Transaction:

- ODJFS 4010 CG – 837D Encounter Companion Guide
- ODJFS 837D Gap Analysis and Mapping based on the 5010 837D Gap Analysis.
- 5010 837D Version 5, Release1 Health Care Claim: Implementation Guide.

The ODJFS Companion Guides are subject to change without prior notice.

Managed Care Plans are responsible for periodically checking for Companion Guide updates on the ODJFS Trading Partner website. <http://jfs.ohio.gov/OHP/tradingpartners/info.stm>

Each Managed Care Plan has the ultimate responsibility to adhere to any Ohio State laws that are applicable including the Ohio Administrative Code.

<http://codes.ohio.gov/>

This is not a HIPAA Mandated Transaction.

## PURPOSE

ODJFS developed this Companion Guide to accomplish the following:

- Identify and document Specific Codes and/or Values that ODJFS will accept in the 837D Encounter Transactions from the Managed Care Plans.

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## INTRODUCTION

ODJFS has elected to use the base 837D HIPAA Transaction as a means for Managed Care Plans to submit their Encounters via EDI to ODJFS.

This Inbound Transaction is not checked for Compliance when the Transactions are received by ODJFS.

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## GENERAL INFORMATION

This is not a HIPAA mandated Transaction.

Since this is not a HIPAA Mandated Transaction, ODJFS has the option to customize this Transaction to suit the needs of the ODJFS Adjudication process for Encounters.

In order to create a HIPAA compliant transaction, you must first meet the requirements of the ASC X12 HIPAA Implementation Guide and then incorporate the ODJFS specific requirements.

To properly process 837 transactions, the Ohio MITS requires only ONE transaction type in each transmission file beginning with the Interchange Control Header (ISA) and ending with the Interchange Control Trailer (IEA) envelope segments. A separate file for each transaction type should be submitted – for example, one file containing only the 837P professional data, one file containing only 837I institutional data, and one file containing only 837D dental data.

In the examples given in this Companion Guide, a period (“.”) denotes a blank space.

The page reference to the ASC X12 837 Dental Implementation Guide (HIPAA IG) is provided at the beginning of each Element section.

Every effort has been made to prevent errors in this document. However, if discrepancies exist between the EDI Companion Guide and the ASC X12 837 Dental Implementation Guide, the Implementation Guide is the final authority.

### Provider Information Flow

Loop 2010 contains information about entities that apply to all claims in Loop 2300. For example, these entities may include billing provider, insurer, primary administrator, contract holder, or claimant.

Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.

Loop 2420A is required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is carried at the Billing loop level (2010AA) and this particular service line has a different Rendering Provider than what is given in the 2010AA loop. The identifying payer-specific numbers are those that belong to the destination payer identified in loop 2010BB.

### **Payment Arrangement Information**

ODJFS considers a capitation payment arrangement to include those arrangements for which a sub-contracted entity to the MCP assumes a risk. If any part of the encounter is part of capitation payment arrangement, the line-level item contract type should reflect whether the service is part of a capitation payment arrangement and the claim-level amount must be recorded as with a contract type of capitation. For encounters which have a capitation payment arrangement, the MCP must provide approximate payment information as follows:

1. For sub-contracted payment arrangements in which a vendor directly pays particular claims (e.g., an MCP's sub-contractor pays all claims to vision providers), the MCP must submit the amounts paid by to the provider at the claim- and line-level.
2. For payments arrangements for which the MCP pays a per member per month rate to a provider or group of providers, the MCP must shadow price the encounter to be the amount that the MCP would have paid to the provider if the capitation arrangement did not exist.
  - a. If the MCP also maintains a contractual arrangement on a fee-for-service basis with the provider, the MCP must submit the amount that the MCP's claims system would have priced the claim at the claim and line-level per the adjudication process specific to that provider.
  - b. If the MCP does not maintain a contractual arrangement on a fee-for-service basis with the provider, the MCP must submit the amount that the MCP's claims system would have priced the claim at the claim and line-level per the adjudication process that is for the same provider type and specialty (if appropriate) which is within the either county, region, and/or state (prioritized in this order per the information that is available).

## DATA FORMATTING

All objects including \*.837, \*.999 files can either be wrapped or unwrapped, which means the files must contain carriage return/line feed control characters at the end of every line or the data in the files must be streamed to be processed. The method chosen must be consistent throughout the entire file.

### American National Standards Institute (ANSI) X12 Formatting

The EDI objects must strictly adhere to the structure, syntax, and semantic requirements as specified in each Transaction Implementation Guide.

### American Standard Code for Information Exchange Formatting

ODJFS does not accept Extended Binary Coded Decimal Interchange Code (EBCDIC) Transactions.

All HIPAA Inbound and Outbound Transactions will be in the American Standard Code for Information Exchange (ASCII) format.

For additional information, see the EDI Trading Partner Information Guide found on the ODJFS Trading Partner website <http://jfs.ohio.gov/OHP/tradingpartners/info.stm>

## REFERENCES

In addition to the resources available on the ODJFS Trading Partner website there are additional websites that contain helpful information to assist with the 5010 Implementation of HIPAA Mandated Transactions.

### Government and Other Association Links

- Center for Medicare and Medicaid Services(CMS)
  - <http://www.cms.hhs.gov>
- Answers to Frequently Asked Questions
  - [https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std\\_alp.php?p\\_sid=GiSFk8jj](https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=GiSFk8jj)
- Health and Human Services (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/snip/>
- CMS website for National Provider Identifier (NPI)
  - <http://www.cms.gov/NationalProvIdentStand/>

### ASC X12 Standards Links

- 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>

#### **Ohio Department of Job and Family Services Links**

- ODJFS website
  - <http://jfs.ohio.gov>
- Ohio Health Plans (OHP) website
  - <http://jfs.ohio.gov/ohp/>

## SEGMENT INFORMATION

### ISA - Interchange Control Header

Segment Repeat: 1

Usage: Required

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/ Max	Data Type		
ISA01	Authorization Information Qualifier	R	2/2	ID	00	
ISA03	Security Information Qualifier	R	2/2	ID	00	
ISA05	Interchange ID Qualifier	R	2/2	ID	ZZ	
ISA06	Interchange Sender ID	R	15/15	AN		7 digit Trading Partner ID. Fixed-length field, left justified and filled with spaces to meet the minimum length requirement of 15.
ISA07	Interchange ID Qualifier	R	2/2	ID	ZZ	
ISA08	Interchange Receiver ID	R	15/15	AN	MMISODJFS	Fixed-length field, left justified and filled with spaces to meet the minimum length requirement of 15.

		ATTRIBUTES				
Element	Name	Usage	Min/ Max	Data Type	Codes/ Values	Comments
ISA14	Acknowledgment Requested	R	1/1	ID	0	

## GS – Functional Group Header

**Segment Repeat:** 1

**Usage:** Required

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/ Max	Data Type		
GS02	Application Sender's Code	R	2/15	AN		7-digit Ohio Medicaid Trading Partner ID assigned by ODJFS
GS03	Application Receiver's Code	R	2/15	AN	MMISODJFS	

## BHT – Beginning of Hierarchical Transaction

**Segment Repeat:** 1

**Usage:** Required

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/ Max	Data Type		
BHT02	Transaction Set Purpose Code	R	2/2	ID	00	
BHT06	Transaction Type Code	S	2/2	ID	RP	

### Loop 1000A: NM1 – Submitter Name

**Loop Repeat:** 1

**Segment Repeat:** 1

**Usage:** Required

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/ Max	Data Type		
NM109	Submitter Identifier	R	2/80	AN		This is the seven-digit number ODJFS assigned to the Medicaid Trading Partner. Medicaid numbers assigned to identify healthcare providers (e.g. Physicians) are not valid. Medicaid Trading Partners with a test status may only submit test EDI transactions. Medicaid Trading Partners with an active status may submit business transactions to ODJFS. A Medicaid Trading Partner is given an active status when they have passed the testing phase and have met all of the criteria specified by ODJFS.

**Loop 1000B: NM1 – Receiver Name****Loop Repeat:** 1**Segment Repeat:** 1**Usage:** Required

		ATTRIBUTES				
Element	Name	Usage	Min/ Max	Data Type	Codes/ Values	Comments
NM109	Receiver Primary Identifier	R	2/80	AN	MMISODJFS	

**Loop 2000B: HL – Subscriber Hierarchical Level****Loop Repeat:** >1**Segment Repeat:** 1**Usage:** Required

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/ Max	Data Type		
HL04	Hierarchical Child Code	S	1/1	ID	0	

## Loop 2000B: SBR – Subscriber Information

**Loop Repeat:** >1

**Segment Repeat:** 1

**Usage:** Required

**NOTE:** Depends on the value in the first occurrence in the 2320 SBR.”. For example, if in the 2320 SBR the MCP payer is Primary, then the Destination Payer must be Secondary in the 2000B SBR.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/ Max	Data Type		
SBR01	Payer Responsibility Sequence Number Code	R	1/1	ID	S T A	Secondary Tertiary Payer Responsibility Four
SBR09	Claim Filing Indicator Code	S	1/2	ID	MC	

## Loop 2010AA: NM1 – Billing Provider Name

**Loop Repeat:** 1

**Segment Repeat:** 1

**Usage:** Situational

**NOTES:** Any Billing Provider that has an NPI must submit it with this segment.

The provider information submitted in this loop should be for a Medicaid billing provider that provides services. It should not be Trading Partner information.

For group professional practices which are submitted as the billing provider, the individual rendering provider should be submitted in the 2310B loop.

If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error.

An encounter that contains an NPI that does not pass check digit validation WILL REJECT.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/ Max	Data Type		
NM109	Billing Provider Identifier	S	2/80	AN		Provider NPI

**Loop 2010BA: NM1 – Subscriber Name**

**Loop Repeat:** 1

**Segment Repeat:** 1

**Usage:** Required

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/ Max	Data Type		
NM108	Identification Code Qualifier	R	1/2	ID	MI	
NM109	Subscriber Primary Identifier	R	2/80	AN		12-digit Medicaid recipient billing number.

**Loop 2010BB: NM1 – Payer Name****Loop Repeat:** 1**Segment Repeat:** 1**Usage:** Required

		ATTRIBUTES				
Element	Name	Usage	Min/ Max	Data Type	Codes/ Values	Comments
NM109	Payer Identifier	R	2/80	AN	MMISODJFS	

## Loop 2010BB: REF – Billing Provider Secondary Information

**Loop Repeat:** 1

**Segment Repeat:** 2

**Usage:** Situational

**NOTE:** Complete only if Provider does not have an NPI.

Element	Name	ATTRIBUTES				Codes/ Values	Comments
		Use	Min/ Max	Data Type			
REF01	Reference Identification Qualifier	R	2/3	AN	G2	Commercial Provider ID or ODJFS Medicaid Reporting/ Provider ID	
REF02	Reference Identification	R	1/50	AN		Enter Reporting or Provider ID Assigned by ODJFS. Enter Provider ID assigned by MCP, if Provider does not have an ID assigned by ODJFS.	

### Loop 2300: CLM – Claim Information

**Loop Repeat:** 100

**Segment Repeat:** 1

**Usage:** Required

		ATTRIBUTES				
Element	Name	Usage	Min/Max	Data Type	Codes/Values	Comments
CLM01	Claim Submitter's Identifier	R	1/38	AN		This field should contain the MCP generated Transaction Control Number (TCN)
CLM02	Total Claim Charge Amount	R	1/18	R		Total claim charges must be equal to the sum of all line item charges. For Third Party Liability (TPL) claims total charges must balance.
CLM05-3	Claim Frequency Code	S	1/1	ID	1	Original – Admit thru Discharge
					7	Replacement – Replacement of Prior Claim
					8	Void – Void/Cancel of Prior Claim

## Loop 2300: CN1 – Contract Information

**Loop Repeat:** 1

**Segment Repeat:** 1

**Usage:** Required

**NOTE:** MCP payment arrangement at the claim level. . On a Dental encounter, MCP payment arrangement information must come in at both the claim and the line level; exception: if there is only one line item, the information must come in at either the claim or line level, but not both. The information cannot be duplicate information,

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
CN101	Contract Type code	R	2/2	ID	02 03 04 05 06 09	Per Diem Variable Per Diem Flat Capitated Percent Other
CN102	Monetary Amount	O	1/18	R		This amount must match AMT02 identifying the MCP paid amount in the first occurrence of the 2320 loop. It must equal the sum of the CN102 values in the 2400 loop.
CN103	Percent	O	1/6	R		Allowance or charge percent

CN104	Reference Identification	O	1/30	AN		
CN105	Terms Discount Percent	O	1/6	R		
CN106	Version Identifier	O	1/30	AN		

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### Loop 2300: AMT – Patient Amount Paid

**Loop Repeat:** 40

**Segment Repeat:** 30

**Usage:** Situational

**NOTE:** Patient Co-Pay Amount.

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
AMT01	Amount Qualifier Code	R	1/3	ID	F5	Patient Co-Pay Amount
AMT02	Monetary Amount	R	1/18	R		Report any co-payment charged and collected by the MCP.

## Loop 2300: REF – Payer Claim Control Number

**Loop Repeat:** 100

**Segment Repeat:** 1

**Usage:** Situational

**NOTE:** Use this REF segment when submitting a reversal/correction to the original encounter. The value is the unique 13-digit InterChange control number (ICN) assigned to the original encounter. The format of this 13-digit ICN should not include any spaces or hyphens.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/ Max	Data Type		
REF02	Payer Claim Control Number	R	1/50	AN		13 digit InterChange Control Number (ICN) assigned to the original Encounter by ODJFS without any dashes or spaces.

## Loop 2310A: NM1 – Referring Provider Name

**Loop Repeat:** 2

**Segment Repeat:** 1

**Usage:** Situational

**NOTE:** Any Referring Provider that has an NPI must submit it with this segment.

The provider information submitted in this loop should be for a Medicaid billing provider that provides services. It should not be Trading Partner information.

If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error.

An encounter that contains an NPI that does not pass check digit validation WILL REJECT.

Element	Name	ATTRIBUTES			Code/Values	Comments
		Use	Min/Max	Data Type		
NM109	Referring Provider Identifier	S	2/80	ID		Provider NPI

## Loop 2310A: REF – Referring Provider Secondary Information

**Loop Repeat:** 1

**Segment Repeat:** 2

**Usage:** Situational

**NOTE:** Complete only if Provider does not have an NPI.

Element	Name	ATTRIBUTES				Codes/ Values	Comments
		Use	Min/ Max	Data Type			
REF01	Reference Identification Qualifier	R	2/3	AN	G2	Commercial Provider ID or ODJFS Medicaid Reporting/ Provider ID	
REF02	Reference Identification	R	1/50	AN		Enter Reporting or Provider ID Assigned by ODJFS. Enter Provider ID assigned by MCP, if Provider does not have an ID assigned by ODJFS.	

## Loop 2310B: NM1 – Rendering Provider Name

**Loop Repeat:** 1

**Segment Repeat:** 1

**Usage:** Situational

**Notes:** Any Rendering Provider that has an NPI must submit it with this segment.

The provider information submitted in this loop should be for a Medicaid billing provider that provides services. It should not be Trading Partner information.

If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error.

An encounter that contains an NPI that does not pass check digit validation WILL REJECT.

Element	Name	ATTRIBUTES			Comments
		Use	Min/Max	Data Type	
NM109	Rendering Provider Identifier	S	2/80	ID	Provider NPI

## Loop 2310B: REF – Rendering Provider Secondary Information

**Loop Repeat:** 1

**Segment Repeat:** 2

**Usage:** Situational

**NOTE:** Complete only if Provider does not have an NPI.

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
REF01	Reference Identification Qualifier	R	2/3	AN	G2	Commercial Provider ID or ODJFS Medicaid Reporting/ Provider ID
REF02	Reference Identification	R	1/50	AN		Enter Reporting or Provider ID Assigned by ODJFS. Enter Provider ID assigned by MCP, if Provider does not have an ID assigned by ODJFS.

## Loop 2310C: NM1 – Service Facility Location Name

**Loop Repeat:** 1

**Segment Repeat:** 1

**Usage:** Situational

**NOTE:** Any organization health care provider that has an NPI must submit it with this segment.

The provider information submitted in this loop should be for an organization health care provider that provides services. It should not be Trading Partner information.

If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error.

An encounter that contains an NPI that does not pass check digit validation WILL REJECT.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/ Max	Data Type		
NM102	Entity Type Qualifier	R	1/1	ID	2	
NM109	Laboratory or Facility Primary Identifier	S	2/80	AN		Provider NPI

## Loop 2310C: REF – Service Facility Location Secondary Information

**Loop Repeat:** 1

**Segment Repeat:** 2

**Usage:** Situational

**NOTE:** Complete only if Provider does not have an NPI.

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
REF01	Reference Identification Qualifier	R	2/3	AN	G2	Commercial Provider ID or ODJFS Medicaid Reporting/ Provider ID
REF02	Reference Identification	R	1/50	AN		Enter Reporting or Provider ID Assigned by ODJFS. Enter Provider ID assigned by MCP, if Provider does not have an ID assigned by ODJFS.

## Loop 2310D: NM1 – Assistant Surgeon Name

**Loop Repeat:** 1

**Segment Repeat:** 1

**Usage:** Situational

**NOTE:** Any Provider that has an NPI must submit it with this segment.

The provider information submitted in this loop should be for a Medicaid billing provider that provides services. It should not be Trading Partner information.

If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error.

An encounter that contains an NPI that does not pass check digit validation WILL REJECT.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/Max	Data Type		
NM109	Assistant Surgeon Primary Identifier	R	2/80	ID		Provider NPI

## Loop 2310D: REF – Assistant Surgeon Secondary Information

**Loop Repeat:** 1

**Segment Repeat:** 4

**Usage:** Situational

**NOTE:** Complete only if Provider does not have an NPI.

Element	Name	ATTRIBUTES				Codes/ Values	Comments
		Use	Min/ Max	Data Type			
REF01	Reference Identification Qualifier	R	2/3	AN	G2	Commercial Provider ID or ODJFS Medicaid Reporting/ Provider ID	
REF02	Reference Identification	R	1/50	AN		Enter Reporting or Provider ID Assigned by ODJFS. Enter Provider ID assigned by MCP, if Provider does not have an ID assigned by ODJFS.	

### Loop 2320: SBR – Other Subscriber Information

**Loop Repeat:** 10

**Segment Repeat:** 1

**Usage:** Situational

**NOTE:** This is required for the first occurrence and subsequent occurrences when there is other payer information.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/ Max	Data Type		
SBR01	Payer Responsibility Sequence Number Code	R	1/1	ID	P  S T	<b>The first occurrence must contain information for the MCP as the primary/secondary payer.</b> If the primary payer is a third party, the second occurrence of this segment should contain a P and information related to the relevant third party payer.  Secondary Tertiary
SBR02	Individual Relationship Code	R	2/2	ID	18	Self – This is the only option for the first occurrence. Subsequent occurrences should be billed as appropriate.
SBR03	Reference Identification	O	1/30	AN		For the first occurrence this should be the 7 digit region/program specific Medicaid provider number of the MCP. Subsequent occurrences may contain COB payer information.

SBR09	Claim Filing Indicator Code	O	1/2	ID	HM	Health Maintenance Organization (HMO) – This is only for the first occurrence. On subsequent occurrences, fill out as appropriate.
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### Loop 2320: AMT – Coordination of Benefits (COB) Payer Paid Amount

**Loop Repeat:** 10

**Segment Repeat:** 1

**Usage:** Required

**NOTE:** This is required for the first occurrence of the 2320 loop and should contain the MCP paid amount at the claim level.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/ Max	Data Type		
AMT01	Amount Qualifier Code	M	1/3	ID	D	
AMT02	Payer Paid Amount	R	1/18	R		<p><b>Non-Capitated Encounters:</b> Zero “0” is an acceptable value.</p> <p>The first occurrence of this element will always contain the amount that the MCP Paid on the claim.</p> <p><b>Capitated Encounters:</b> Zero “0” is not an acceptable value.</p> <p>The MCP must shadow price by placing the Total Payment Amount at the claim level based on how the MCP’s system adjudicated</p>

		ATTRIBUTES				
Element	Name	Usage	Min/Max	Data Type	Codes/ Values	Comments
						<p>the claim from the Provider.</p> <p>Where applicable, in subsequent occurrences, this element will contain the Amount Paid by the Other Payer.</p>

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### Loop 2330B: NM1 – Other Payer Name

**Loop Repeat:** 1

**Segment Repeat:** 1

**Usage:** Required

**NOTE:** This is required for the first occurrence on all Encounter claims.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/ Max	Data Type		
NM109	Other Payer Primary Identifier	R	2/80	AN		<p>This information must match the information in SVD01.</p> <p>The first occurrence this should be the 7 digit region/program specific Medicaid provider number of the MCP.</p> <p>Subsequent occurrences may contain COB payer information (e.g. NAIC).</p>

## Loop 2330B: DTP – Claim Check or Remittance Date

**Loop Repeat:** 1

**Segment Repeat:** 1

**Usage:** Required

**NOTE:** This is required for the first occurrence on all Encounter claims.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/ Max	Data Type		
DTP01	Date/Time Qualifier	R	3/3	ID	573	Date claim was paid by the MCP.
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Adjudication or Payment Date	R	1/35	AN		This is required for the first occurrence on all Encounters.

## Loop 2400: CN1 – Contract Information

**Loop Repeat:** 999

**Segment Repeat:** 1

**Usage:** Situational

**NOTE:** MCP payment arrangement at the line level. On a Dental encounter, MCP payment arrangement information must come in at both the claim and the line level; exception: if there is only one line item, the information must come in at either the claim or line level, but not both. The information cannot be duplicate information,

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/Max	Data Type		
CN101	Contract Type code	R	2/2	ID	02 03 04 05 06 09	Per Diem Variable Per Diem Flat Capitated Percent Other
CN102	Monetary Amount	O	1/18	R		
CN103	Percent	O	1/6	R		Allowance or charge percent
CN104	Reference Identification	O	1/30	AN		

CN105	Terms Discount Percent	O	1/6	R		
CN106	Version Identifier	O	1/30	AN		

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## Loop 2420A: NM1 – Rendering Provider Name

**Loop Repeat:** 1

**Segment Repeat:** 1

**Usage:** Situational

**NOTE:** Any Rendering Provider that has an NPI must submit it with this segment.

The provider information submitted in this loop should be for a Medicaid billing provider that provides services. It should not be Trading Partner information.

If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error.

An encounter that contains an NPI that does not pass check digit validation WILL REJECT.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Use	Min/ Max	Data Type		
NM109	Rendering Provider Identifier	S	2/80	ID		Provider NPI

### Loop 2420A: REF – Rendering Provider Secondary Identification

**Loop Repeat:** 1

**Segment Repeat:** 20

**Usage:** Situational

**NOTE:** Complete only if Provider does not have an NPI.

Element	Name	ATTRIBUTES				Codes/ Values	Comments
		Use	Min/ Max	Data Type			
REF01	Reference Identification Qualifier	R	2/3	AN	G2	Commercial Provider ID or ODJFS Medicaid Reporting/ Provider ID	
REF02	Reference Identification	R	1/50	AN		Enter Reporting or Provider ID Assigned by ODJFS. Enter Provider ID assigned by MCP, if Provider does not have an ID assigned by ODJFS.	

## Loop 2420B: NM1 – Assistant Surgeon Name

**Loop Repeat:** 1

**Segment Repeat:** 1

**Usage:** Situational

**NOTE:** Any Provider that has an NPI must submit it with this segment.

The provider information submitted in this loop should be for a Medicaid billing provider that provides services. It should not be Trading Partner information.

If there is not a legacy Medicaid provider number associated with the NPI information submitted on the encounter, the MCP will receive an informational error.

An encounter that contains an NPI that does not pass check digit validation WILL REJECT.

Element	Name	ATTRIBUTES			Comments
		Use	Min/ Max	Data Type	
NM109	Rendering Provider Identifier	S	2/80	ID	Provider NPI

## Loop 2420B: REF – Assistant Surgeon Secondary Information

**Loop Repeat:** 1

**Segment Repeat:** 20

**Usage:** Situational

**NOTE:** Complete only if Provider does not have an NPI.

Element	Name	ATTRIBUTES				Codes/ Values	Comments
		Use	Min/ Max	Data Type			
REF01	Reference Identification Qualifier	R	2/3	AN	G2	Commercial Provider ID or ODJFS Medicaid Reporting/ Provider ID	
REF02	Reference Identification	R	1/50	AN		Enter Reporting or Provider ID Assigned by ODJFS. Enter Provider ID assigned by MCP, if Provider does not have an ID assigned by ODJFS.	

## Loop 2430: SVD – Line Adjudication Information

**Loop Repeat:** 15

**Segment Repeat:** 1

**Usage:** Situational

**NOTE:** This is required for the first occurrence of the 2320 loop and should contain the MCP amount of the line level. Subsequent occurrences may contain COB payment amounts.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/ Max	Data Type		
SVD01	Identification Code	R	2/80	AN		<p>This number should match NM109 in Loop ID-2330B identifying Other Payer.</p> <p>For the first occurrence this should be the 7 digit region/program specific Medicaid provider number of the MCP. Subsequent occurrences may contain COB payer information (e.g. NAIC).</p>
SVD02	Service Line Paid Amount	R	1/18	AN		<p>For the first occurrence this should be the MCP line level amount paid.</p> <p>Zero '0' is an acceptable value for this element.</p> <p>The MCP must shadow price Capitated Encounters by placing the allowed amount at</p>

		ATTRIBUTES				
Element	Name	Usage	Min/ Max	Data Type	Codes/ Values	Comments
						the line level.  Subsequent occurrences may contain COB payment amounts.

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## Loop 2430: DTP – Line Check or Remittance Date

**Loop Repeat:** 15

**Segment Repeat:** 1

**Usage:** Required

**NOTE:** This is required for the first occurrence on all Encounter claims and may be provided for subsequent items.

Element	Name	ATTRIBUTES			Codes/ Values	Comments
		Usage	Min/ Max	Data Type		
DTP01	Date/Time Qualifier	R	3/3	ID	573	Date claim was paid by the Managed Care Plan.
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		