IOWA MEDICAID ENTERPRISE

Standard Companion Guide Transaction Information

Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010A1/A2

Companion Guide Version Number: 1.2

June 30, 2012

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

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Transaction Instruction (TI)

1 TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X222	Health Care Claim: Professional (837)
005010X222A1	Health Care Claim: Professional (837) - Addenda
005010X223	Health Care Claim: Institutional (837)
005010X223A1	Health Care Claim: Institutional (837) - Addenda
005010X223A2	Health Care Claim: Institutional (837) - Addenda
005010X224	Health Care Claim: Dental (837)
005010X224A1	Health Care Claim: Dental (837) - Addenda
005010X224A2	Health Care Claim: Dental (837) - Addenda

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

3.1 005010X222A1 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
Header	**BHT**	**BEGINNING OF HIERARCHICAL TRANSACTION**		
Header	BHT02	Transaction Set Purpose Code	‘00’	BHT02 must equal ORIGINAL.
Header	BHT06	Transaction Type Code	‘CH’	BHT06 must equal CHARGEABLE.
1000B	**NM1**	**RECEIVER NAME**		
1000B	NM109	Receiver Primary Identifier		The receiver primary identifier is **'18049'**.
2000A	**PRV**	**BILLING PROVIDER SPECIALTY INFORMATION**		**NPI billing requires the taxonomy code to be sent with the claim in the 2000A/PRV.**
2010AA	**N4**	**BILLING PROVIDER CITY/STATE/ZIP CODE**		
2010AA	N403	Billing Provider Postal Zone or ZIP Code		The nine digit zip code that is billed should match the nine digit zip code that was verified with IME. When Zip+4 verified with IME is 0000, use 9998 for claims submission.
2000B	**SBR**	**SUBSCRIBER INFORMATION**		
2000B	SBR02	Individual Relationship Code	‘18’	For Medicaid, the subscriber is always the same as the patient.

Loop ID	Reference	Name	Codes	Notes/Comments
2000B	SBR09	Claim Filing Indicator Code	'MC'	
2010BA	**NM1**	**SUBSCRIBER NAME**		
2010BA	NM108	Identification Code Qualifier	'MI'	Qualifier for Medicaid must be submitted.
2010BA	NM109	Subscriber Primary Identifier		The 8 digit Iowa Medicaid recipient ID must be submitted.
2010BB	**REF**	**BILLING PROVIDER SECONDARY IDENTIFICATION**		
2010BB	REF02	Billing Provider Additional Identifier	'G2'	Atypical providers must send their atypical provider number (starting with X00…) in the REF segment with a G2 qualifier.
2010BB	**NM1**	**PAYER NAME**		
2010BB	NM109	Payer Identifier		The payer primary identifier is **'18049'**.
2000C	**HL**	**PATIENT DETAIL**		**The Patient Hierarchical Level is not used in Medicaid.**
2300	**CLM**	**CLAIM INFORMATION**		**EDISS may reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.**
2300	CLM20	Delay Reason Code		Data submitted as a delay reason code in CLM20 may not be used for processing.
2300	**PWK**	**CLAIM SUPPLEMENTAL INFORMATION**		
2300	PWK02	Report of Transmission Code	'BM', 'FX'	The attachment code of 'BM' or 'FX' must be submitted if a paper attachment is submitted for the electronic claim in order to be matched with the claim. If sending by mail, mail to P.O. Box 150001, Des Moines, IA 50315. If sending by fax, the fax number is 515-256-4626.

Loop ID	Reference	Name	Codes	Notes/Comments
2300	PWK06	Attachment Control Number		Only the first 20 bytes will be used. This number should be indicated on the paper attachment.
2300	**REF**	**PRIOR AUTHORIZATION**		
2300	REF02	Prior Authorization Number		Only the first 10 bytes will be used.
2300	**REF**	CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) NUMBER		
2300	REF02	Clinical Laboratory Improvement Amendment (CLIA) Number		Only the first 10 bytes will be used.
2300	**HI**	**HEALTH CARE DIAGNOSIS CODE**		**Only the first 4 diagnosis codes will be used.**
2310A	**NM1**	**REFERRING PROVIDER NAME**		**If both a Referring Provider and a Primary Care Provider are sent, then the MediPASS provider NPI must be sent with the 'P3' qualifier. Otherwise, send the MediPASS provider NPI with the 'DN' qualifier.**
2310A	**REF**	**REFERRING PROVIDER SECONDARY IDENTIFICATION**		
2310A	REF02	Referring Provider Additional Identifier	'G2'	Atypical providers must send their atypical provider number (starting with X00…) in the REF segment with a G2 qualifier.
2310B	**REF**	**RENDERING PROVIDER SECONDARY IDENTIFICATION**		
2310B	REF02	Rendering Provider Additional Identifier	'G2'	Atypical providers must send their atypical provider number (starting with X00…) in the REF segment with a G2 qualifier.
2310C	**N4**	**SERVICE FACILITY LOCATION CITY/STATE/ZIP**		

Loop ID	Reference	Name	Codes	Notes/Comments
2310C	N403	Laboratory or Facility Postal Zone ZIP Code		The nine digit zip code that is billed should match the nine digit zip code that was verified with IME.
2400	**SV1**	**PROFESSIONAL SERVICE**		
2400	SV101 - 1	Product or Service ID Qualifier	'HC'	Only Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes will be processed by Medicaid
2400	SV101 – 5	Procedure Modifier		Medicaid will not process a third modifier.
2400	SV101 – 6	Procedure Modifier		Medicaid will not process a forth modifier.
2400	SV104	Service Unit Count		Service unit counts (units or minutes) cannot exceed 9999999.999.
2410	**CTP**	**DRUG IDENTIFICATION**		
2410	CTP04	National Drug Unit Count		National Drug Unit Count cannot exceed 9999999.999.
2420A	**REF**	**RENDERING PROVIDER SECONDARY IDENTIFICATION**		
2420A	REF02	Rendering Provider Additional Identifier	'G2'	Atypical providers must send their atypical provider number (starting with X00…) in the REF segment with a G2 qualifier.

3.2 005010X223A2 Health Care Claim: Institutional

Loop ID	Reference	Name	Codes	Notes/Comments
Header	**BHT**	**BEGINNING OF HIERARCHICAL TRANSACTION**		
Header	BHT02	Transaction Set Purpose Code	'00'	BHT02 must equal ORIGINAL.
Header	BHT06	Transaction Type Code	'CH'	BHT06 must equal CHARGEABLE.
1000B	**NM1**	**RECEIVER NAME**		

Loop ID	Reference	Name	Codes	Notes/Comments
1000B	NM109	Receiver Primary Identifier		The receiver primary identifier is **'18049'**.
2000A	**PRV**	**BILLING PROVIDER SPECIALTY INFORMATION**		**NPI billing requires the taxonomy code to be sent with the claim in the 2000A/PRV.**
2010AA	**N4**	**BILLING PROVIDER CITY/STATE/ZIP CODE**		
2010AA	N403	Billing Provider Postal Zone or ZIP Code		The nine digit zip code that is billed should match the nine digit zip code that was verified with IME. When Zip+4 verified with IME is 0000, use 9998 for claims submission.
2000B	**SBR**	**SUBSCRIBER INFORMATION**		
2000B	SBR02	Individual Relationship Code	'18'	For Medicaid, the subscriber is always the same as the patient.
2000B	SBR09	Claim Filing Indicator Code	'MC'	
2010BA	**NM1**	**SUBSCRIBER NAME**		
2010BA	NM108	Identification Code Qualifier	'MI'	Qualifier for Medicaid must be submitted.
2010BA	NM109	Subscriber Primary Identifier		The 8 digit Iowa Medicaid recipient ID must be submitted.
2010BB	**REF**	**BILLING PROVIDER SECONDARY IDENTIFICATION**		
2010BB	REF02	Billing Provider Additional Identifier	'G2'	Atypical providers must send their atypical provider number (starting with X00…) in the REF segment with a G2 qualifier.
2010BB	**NM1**	**PAYER NAME**		
2010BB	NM109	Payer Identifier		The payer primary identifier is **'18049'**.
2000C	**HL**	**PATIENT DETAIL**		**The Patient Hierarchical Level is not used in Medicaid.**

Loop ID	Reference	Name	Codes	Notes/Comments
2300	**CLM**	**CLAIM INFORMATION**		**EDISS may reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.**
2300	CLM20	Delay Reason Code		Data submitted as a delay reason code in CLM20 may not be used for processing.
2300	**PWK**	**CLAIM SUPPLEMENTAL INFORMATION**		
2300	PWK02	Report of Transmission Code	'BM', 'FX'	The attachment code of 'BM' or 'FX' must be submitted if a paper attachment is submitted for the electronic claim in order to be matched with the claim. If sending by mail, mail to P.O. Box 150001, Des Moines, IA 50315. If sending by fax, the fax number is 515-256-4626.
2300	PWK06	Attachment Control Number		Only the first 20 bytes will be used. This number should be indicated on the paper attachment.
2300	**REF**	**PRIOR AUTHORIZATION**		
2300	REF02	Prior Authorization Number		Only the first 10 bytes will be used.
2300	**HI**	**OCCURRENCE SPAN INFORMATION**		**Only the first 1 occurrence code will be used.**
2310F	**NM1**	**REFERRING PROVIDER NAME**		**Only 1 iteration of this loop will be used. Send the Medipass provider in this loop**
2400	**SV1**	**PROFESSIONAL SERVICE**		**MMIS will only price on 99 service lines. Any service lines greater than 99 services lines will be accepted but will not be priced.**
2400	SV202 - 1	Product or Service ID Qualifier	'HC'	Only Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes will be processed by Medicaid

3.3 005010X224A2 Health Care Claim: Dental

Loop ID	Reference	Name	Codes	Notes/Comments
1000B	**NM1**	**RECEIVER NAME**		
1000B	NM109	Receiver Primary Identifier		The receiver primary identifier is **'18049'**.
2000A	**PRV**	**BILLING PROVIDER SPECIALTY INFORMATION**		**NPI billing requires the taxonomy code to be sent with the claim in the 2000A/PRV.**
2010AA	**N4**	**BILLING PROVIDER CITY/STATE/ZIP CODE**		
2010AA	N403	Billing Provider Postal Zone or ZIP Code		The nine digit zip code that is billed should match the nine digit zip code that was verified with IME. When Zip+4 verified with IME is 0000, use 9998 for claims submission.
2000B	**SBR**	**SUBSCRIBER INFORMATION**		
2000B	SBR02	Individual Relationship Code	'18'	For Medicaid, the subscriber is always the same as the patient.
2000B	SBR09	Claim Filing Indicator Code	'MC'	
2010BA	**NM1**	**SUBSCRIBER NAME**		
2010BA	NM108	Identification Code Qualifier	'MI'	Qualifier for Medicaid must be submitted.
2010BA	NM109	Subscriber Primary Identifier		The 8 digit Iowa Medicaid recipient ID must be submitted.
2010BB	**REF**	**BILLING PROVIDER SECONDARY IDENTIFICATION**		
2010BB	REF02	Billing Provider Additional Identifier	'G2'	Atypical providers must send their atypical provider number (starting with X00…) in the REF segment with a G2 qualifier.
2010BB	**NM1**	**PAYER NAME**		
2010BB	NM109	Payer Identifier		The payer primary identifier is **'18049'**.

Loop ID	Reference	Name	Codes	Notes/Comments
2000C	**HL**	**PATIENT DETAIL**		**The Patient Hierarchical Level is not used in Medicaid.**
2300	**CLM**	**CLAIM INFORMATION**		**EDISS may reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.**
2300	CLM20	Delay Reason Code		Data submitted as a delay reason code in CLM20 may not be used for processing.
2300	**PWK**	**CLAIM SUPPLEMENTAL INFORMATION**		
2300	PWK02	Report of Transmission Code	'BM', 'FX'	The attachment code of 'BM' or 'FX' must be submitted if a paper attachment is submitted for the electronic claim in order to be matched with the claim. If sending by mail, mail to P.O. Box 150001, Des Moines, IA 50315. If sending by fax, the fax number is 515-256-4626.
2300	PWK06	Attachment Control Number		Only the first 20 bytes will be used. This number should be indicated on the paper attachment.
2310A	**NM1**	**REFERRING PROVIDER NAME**		**If both a Referring Provider and a Primary Care Provider are sent, then the MediPASS provider NPI must be sent with the 'P3' qualifier. Otherwise, send the MediPASS provider NPI with the 'DN' qualifier.**
2310A	**REF**	**REFERRING PROVIDER SECONDARY IDENTIFICATION**		**Only the first iteration of this loop will be used.**
2310A	REF02	Referring Provider Additional Identifier	'G2'	Atypical providers must send their atypical provider number (starting with X00…) in the REF segment with a G2 qualifier.

Loop ID	Reference	Name	Codes	Notes/Comments
2400	**SV3**	**PROFESSIONAL SERVICE**		
2400	SV302	Line Item Charge Amount		Claims greater than $100,000.00 will be returned.
2400	**TOO**	**Tooth Identification**		**Only the first occurrence of the segment will be used.**
2420A	**REF**	**RENDERING PROVIDER SECONDARY IDENTIFICATION**		**Only the first occurrence of the segment will be used.**

4 TI Additional Information

This section must contain one or more of the following situational sections, if applicable.

4.1 Business Scenarios

This section contains all typical business scenarios with transmission examples. The scenarios and examples are intended to be explicit examples of situations that are not described in detail within in the implementation guide.

- EDI Support Services (EDISS) collects transactions from two different connectivity portals for the Iowa Medicaid Line of Business.
    - Iowa Mediciad Web Portal – Provides a means for Iowa Medicaid Trading Partners to conduct electronic transactions with EDISS via the internet.
    - Bulletin Board System (Smart Transfer) – Provides direct connection to EDISS and is obtained through dialing into the EDISS Bulletin Board System (BBS) through a phone modem.
- The EDISS Trading Partner community is comprised of Vendors and Direct Submitters.
    - **Vendor** - A vendor is an entity that provides hardware, software and/or ongoing technical support for covered entities. In EDI, a vendor can be classified as a software vendor, billing service or clearinghouse.

- **Direct Submitter** - A facility which sends electronic health care transactions to EDISS without the aid of a third party vendor. Facilities that use a software vendor but handle submitting their claims internally are still considered direct.

- EDISS issues claim reports after each received transaction. The reports are generated by EDISS' front-end collection system and are a vital part in following the claims as they process through the EDISS front-end collection system. EDISS reports are listed in the order they would be received from EDISS after the electronic file has been submitted.
  - 999 Functional Acknowledgement
  - 277CA Claims Acknowledgement

4.2 Payer Specific Business Rules and Limitations

This section contains payer-specific information that is not necessarily tied to specific data elements or segments (which are more appropriately described in section 3). It includes descriptions of business rules, processes, or limitations that impact how the payer uses the content of inbound transactions or creates the content of outbound transactions. This information is intended to help the trading partner understand the business context of the EDI transactions.

- All inbound claim data is edited against HIPAA x12 standards.
  - EDISS has edits built into claim processing that check for structural and syntactical correctness. Claim data that does not pass these edit levels is returned to the Trading Partner on HIPAA based acknowledgement reports (999 Functional Acknowledgement and 277CA Claims Acknowledgement).
- All claim data that has correct structure and syntax is forwarded to Medicaid Management Information System (MMIS) for adjudication and payment.
- 837I – The Other Operating Physician Name segment 2310C NM1 'ZZ' in 5010 is considered as a replacement of Other Provider Name segment 2310C NM1 '73' in 4010

Category 1

TR3 front matter, notes, or other specifications that identify two or more optional business alternatives for the payer or other sending entity.

Example

005010X221 (835)

4.2.1 Claim Overpayment Recovery

ACME Health Plan recoups all overpayments immediately using reversals and corrections as described in option 1 of implementation guide §1.10.2.17.

Category 2

To identify processing schedules or constraints that are important to trading partner expectations.

Example

4.2.2 Scheduled Maintenance

EDI Support Services (EDISS) schedules regular maintenance every Thursday 12:00 AM – 2:00 AM and Sunday from 6:00 AM to 12:00 PM Central time. Real-time processing is not available during this period.

4.3 Frequently Asked Questions

For a surplus of information regarding billing electronic transactions and assistance with understanding the EDI process, please visit www.edissweb.com.

4.4 Other Resources

For more information regarding electronic claims submission, HIPAA Standards and general EDI-industry questions visit the following links:

- http://www.edissweb.com/med/news/hipaa5010.html
- http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp
- http://www.wpc-edi.com/

5 TI Change Summary

At a minimum, this section details the changes between this version and the previous version

Version 1.1 - Added notes to the Zip+4 content of the 2010AA N4 loops for Professional, Institutional and Dental claim submissions.

Version 1.3 – Deleted CLM05-3 specific requirements.