EDI COMPANION GUIDES

X12N VERSION 5010 COMPANION GUIDE V 1.3

DISCLOSURE STATEMENT

The information in this document is intended for billing providers and technical staff who wish to exchange electronic transactions with MO HealthNet. This document is to be used in conjunction with the ASC X12N Implementation Guides to define transaction requirements. It does not define MO HealthNet policy billing issues. These types of issues can be found in the MO HealthNet Provider Manuals through the MO HealthNet Division's website at https://www.emomed.com.

PREFACE

This Companion Guide to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content being requested when data is transmitted electronically to the MO HealthNet fiscal agent. Transmissions based on this companion document, used in tandem with the ASC X12N Implementation Guides, are compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

INTRODUCTION

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 (DHHS) 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 translations 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.

PURPOSE OF THE COMPANION GUIDE

The X12 Version 5010 Companion Guide explains the procedures necessary for trading partners to successfully exchange transactions electronically with MO HealthNet in standard HIPAA compliant forms. These transactions include the following.

Health Care Eligibility Benefit Inquiry and Response (270/271)	ASC X12N/ 005010X279A1

Health Care Claim Status Request and Response (276/277)	ASC X12N/ 005010X212
Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	ASC X12N/ 005010X218
Benefit Enrollment and Maintenance (834)	ASC X12N/ 005010X220A1
Health Care Claim Payment Advice (835)	ASC X12N/ 005010X221A1
Health Care Claim: Dental (837)	ASC X12N/ 005010X224A2
Health Care Claim: Institutional (837)	ASC X12N/ 005010X223A2
Health Care Claim: Professional (837)	ASC X12N/ 005010X222A1
Implementation Acknowledgment(999)	ASC X12N/ 005010X231

This Companion Guide is not intended to replace the ASC X12N Implementation Guides; rather it is intended to be used in conjunction with them. Additionally, the Companion Guide is intended to convey information that is within the framework and structure of the ASC X12N Implementation Guides and not to contradict or exceed them.

SCOPE

This Companion Guide provides information for populating data elements that are defined as payer or trading partner specific. In addition, it provides explanation of how claims are processed within the Missouri Medicaid Management Information System (MMIS) when specific data elements are populated with each of the valid choices (e.g., claim frequency type).

OVERVIEW

A summary of the sections in this Companion Guide follows:

Section 1—Getting Started: This section provides information for the completion of the necessary paperwork to begin testing with MO HealthNet.

Section 2—Testing With The Payer: This section provides a detailed description of the testing phase.

Section 3—Connectivity With The Payer: This section provides connectivity information.

Section 4—Contact Information: This section provides the contact information for technical assistance and billing issues.

Section 5—Control Segments/Envelopes: This section describes use of the interchange control and functional group control segments.

Section 6—Payer Specific Business Rules and Limitations: This section describes how to send transactions that have business rules specific to MO HealthNet.

REFERENCES

The ASC X12N Implementation Guides adopted under HIPAA that this document supplements can be found at http://store.x12.org. The MO HealthNet Provider Manuals can be accessed through the MO HealthNet Division's website at https://www.emomed.com.

ADDITIONAL INFORMATION

Users of this Companion Guide must understand general EDI (Electronic Data Interchange) terminology. In addition, an understanding of the loop and segment structure within the ASC X12N Implementation Guides is helpful.

SECTION 1 - GETTING STARTED

WORKING WITH MO HEALTHNET

To begin exchanging EDI transactions with MO HealthNet, a biller must select one of three options for the exchange of electronic transactions. The first option is via an Internet connection through an ISP (Internet Service Provider) of the billers' choice. The second option utilizes Sterling Commerce's Connect:Direct software to link directly to Infocrossing Healthcare Services (IHS) Data Center. The third option utilizes secure File Transfer Protocol (FTP).

Billers opting to use the Internet connection (Direct Data Entry or Batch files through eMomed) option are responsible for any costs involved in obtaining and use of the ISP to connect to the Internet. No additional cost is charged by MO HealthNet or its fiscal agent to use the Internet connection solution. A biller choosing this option must complete the Application for MO HealthNet Internet Access Account, which can be obtained at https://www.emomed.com. For assistance with this form, call the IHS Technical Help Desk at (573) 635-3559. Batch submission of X12 file(s) through eMomed has a size limit of 2MB. Anything over 2 MB should be zipped.

Billers opting to use the Connect:Direct software solution should be aware that they are responsible for all setup and on-going cost involved in the purchasing and maintaining of the software, as well as for paying a monthly port charge to IHS as long as the connection is available for use. Billers should complete, sign, and mail the Application for MO HealthNet Connect:Direct Access Account and be contacted by technical support before purchasing the software. This application is available by emailing the IHS Technical Help Desk at internethelpdesk@momed.com. Upon receipt of the signed application, an IHS technical support person will make contact asking for information needed to ensure the correct software is purchased.

Billers opting to use the SFTP connection are responsible for any costs involved with obtaining a SFTP server. For new SFTP billers, be aware that they are responsible for all setup and on-going cost involved in the purchasing and maintaining of the software, as well as for paying a monthly charge to IHS as long as the connection is available for use. A biller choosing to use SFTP should contact the IHS Technical Help Desk at internethelpdesk@momed.com.

TRADING PARTNER REGISTRATION

In addition to selecting a connection method, a biller must complete a Trading Partner Agreement form. The Trading Partner Agreement form is used to communicate trading partner identifiers and to indicate which transactions the biller wishes to exchange. The form is available at https://www.emomed.com/. For assistance with this form call the IHS Help Desk at (573) 635-3559.

An EDI Trading Partner is defined as any MO HealthNet customer (provider, billing service, software vendor, etc.) that transmits to, or receives electronic data from MO HealthNet.

NOTE: If you already have a trading partner agreement on file with MO Health Net for your desired transaction(s), do not fill out a new trading partner agreement. The current trading partner agreement is being amended to include the 5010 version of X12.

CERTIFICATION AND TESTING OVERVIEW

Certification from a third party is not required to exchange EDI with MO HealthNet, however, doing so can help to speed the process of approval of the billers' transactions. Each type of transaction a biller wishes to send to MO HealthNet must pass test requirements before the biller is set up to send production transactions. Successful completion of test requirements requires, at a minimum, that the transactions are HIPAA compliant.

SECTION 2 - TESTING WITH THE PAYER

To test with MO HealthNet the appropriate access account application and Trading Partner Agreement form must be complete and on file with Infocrossing Healthcare Services.

Following completion of these forms, the Infocrossing Healthcare Services Help Desk notifies the biller that they are approved to send test transactions for those transactions they indicated on the Trading Partner Agreement form. In addition, the billers User ID and password is given to them at this time.

Until HIPAA is implemented into the production Missouri MMIS, billers may be required to send an additional test file for each transaction before being moved to production.

INTERNET OPTION

If the biller has chosen to exchange data through the Internet option:

- The biller logons to https://www.emomed.com.
- The biller selects "File Management" link.
- The biller selects “Manage Test Files.”
- The biller selects “Upload HIPAA test file.”
- The biller populates the window with the test file name.
- The biller submits the information.
- A window appears either showing the file in process or of non-receipt of the test file.
- If receipt was successful, the biller should check for appropriate responses in the "Upload HIPAA test file" link first to make sure the status says “Processing Finished.“ The biller should go to “Test File

Management" and look at the "Implementation Acknowledgment(999)." If the 999 shows the file was not accepted and the biller is unable to determine the reason for the non-receipt, contact the IHS Technical Help Desk at (573) 635-3559. If the biller has an accepted 999, they should look for the appropriate response file (claim confirmation for 837 file, 271 for eligibility verification or 277 for claim status).

- If no claim confirmation, 271 or 277 file is available after 2 complete business days, contact the IHS Technical Help Desk at (573) 635-3559.
- When the biller is satisfied with the results of the test (i.e., test claims are not rejected) and wants a specific transaction to be moved to production, the biller sends an e-mail to the IHS Technical Help Desk at internethelpdesk@momed.com. The biller must state in the e-mail what transaction they want to be moved to production and their user ID. When IHS verifies that the biller has successfully submitted test claims, IHS moves the biller to production. IHS then returns the e-mail letting the biller know that they can send claims to production.

CONNECT:DIRECT OPTION

For information on Connect:Direct, please email the IHS Technical Help Desk at internethelpdesk@momed.com.

SECTION 3 - CONNECTIVITY WITH THE PAYER

TRANSMISSION ADMINISTRATIVE PROCEDURES

MO HealthNet processes batch transactions and Internet direct data entry (DDE) submissions every week night. Any expected response transactions can be accessed the following business day. Billers experiencing problems with sending or receiving files may contact the IHS Technical Help Desk at (573) 635-3559.

COMMUNICATION PROTOCOL SPECIFICATIONS

The MO HealthNet Billing website, www.emomed.com, uses https (secured http) to send and receive transactions. Billers using Connect:Direct have a direct link to the fiscal agent, resulting in a secure connection.

PASSWORDS

In order to submit a batch transmission, a biller needs either their Internet User ID and password or their NDM ID and password. Passwords are not required within a transaction.

SCHEDULED MAINTENANCE

MO HealthNet schedules regular maintenance. Real-time processing is not available during this period. MO HealthNet will inform billers of such maintenance via https://www.emomed.com/ or email.

SECTION 4 - CONTACT INFORMATION

EDI CUSTOMER SERVICE

For questions pertaining to EDI processes, billers should first reference the appropriate Implementation Guides at http://store.x12.org or the Companion Guides at https://www.emomed.com/. If answers are not available within these guides, billers may contact the IHS Technical Help Desk at (573) 635-3559.

PROVIDER SERVICE NUMBER

Billers with questions pertaining to MO HealthNet policies should first access the MO HealthNet Provider Manuals and MO HealthNet Electronic Billing Layout Manuals found through the MO HealthNet Division's website at https://www.emomed.com/. If answers are not available from these manuals, billers may contact the MO HealthNet Provider Relations hotline at (573) 751-2896.

APPLICABLE WEBSITES E-MAIL

- ANSI X12N HIPAA Implementation Guides are accessed at http://store.x12.org.
- This HIPAA Companion Guide is accessed at https://www.emomed.com/.
- MO HealthNet transaction and DDE submission and receipts are accessed https://www.emomed.com.
- MO HealthNet Provider Manuals and MO HealthNet Electronic Billing Layout Manuals are accessed at https://www.emomed.com/.

SECTION 5 - CONTROL SEGMENTS/ENVELOPES

Legend
SHADED rows represent “segments” that have been added or changed from version 4010.

ISA-IEA

Batch

This section describes MO HealthNet's use of the interchange control segments specifically for batch transactions. It includes a description of expected sender and receiver codes and delimiters. NOTE: Uppercase lettering must be used in this segment.

Incoming Transactions to MO HealthNet

Loop	Segment	Data Element	Comments
NA	ISA	NA	Billers may use the data element separator and segment terminator of their choice, from the Basic Character Set or Extended Character Set, which are both defined in Appendix A of the ASC X12N Implementation Guide.
NA	ISA	ISA05	Use ‘ZZ’
NA	ISA	ISA06	Use the billers User ID provided upon successful completion of the Trading Partner Agreement.
NA	ISA	ISA07	Use ‘30’
NA	ISA	ISA08	Use ‘431754897’
NA	ISA	ISA13	This Unique Number must be identical to the Interchange Control Number in IEA02. Right justify, left pad with zeros to nine (9) bytes. Each submitter must start with a value of their choice and increment by at least one (1) each time a file is sent.
NA	ISA	ISA15	During the testing phase, billers must use "T." Once approved for production, use "P."
NA	ISA	ISA16	Billers may use the component element separator of their choice, from the Basic Character Set or Extended Character Set, which are both defined in Appendix A of the ASC X12N Implementation Guide.

Outgoing Transactions From MO HealthNet

Loop	Segment	Data Element	Comments
NA	ISA	NA	MO HealthNet uses ‘|’ as a data element separator and ‘~’ as a segment terminator.
NA	ISA	ISA05	MO HealthNet uses ‘30’
NA	ISA	ISA06	MO HealthNet uses ‘431754897’
NA	ISA	ISA07	MO HealthNet uses ‘ZZ’
NA	ISA	ISA08	MO HealthNet uses the 9-digit MO HealthNet provider ID.
NA	ISA	ISA11	MO HealthNet uses ‘^’
NA	ISA	ISA16	MO HealthNet uses ‘!’ as a component element separator.

On-Line

This section describes MO HealthNet's use of the interchange control segments specifically for on-line transactions. It includes a description of expected sender and receiver codes and delimiters. NOTE: Uppercase lettering must be used in this segment. On-line transactions must be proceeded by a 4-byte CICS transaction ID, followed immediately by 'ISA'. A unique CICS transaction ID is assigned to each POS vendor for each on-line transaction. Contact Infocrossing Healthcare Services if you're unsure of the CICS transaction ID(s) for your company.

Incoming Transactions to MO HealthNet

Loop	Segment	Data Element	Comments
NA	ISA	NA	Billers may use the data element separator and segment terminator of their choice, from the Basic Character Set or Extended Character Set, which are both defined in Appendix A of the ASC X12N Implementation Guide.
NA	ISA	ISA05	Use ‘ZZ’
NA	ISA	ISA06	Use the CICS Tran ID of the transaction that you are sending.
NA	ISA	ISA07	Use ‘30’
NA	ISA	ISA08	Use ‘431754897’
NA	ISA	ISA15	During the testing phase, billers must use "T." Once approved for production, use "P."
NA	ISA	ISA16	Billers may use the component element separator of their choice, from the Basic Character Set or Extended Character Set, which are both defined in Appendix A of the ASC X12N Implementation Guide.

Outgoing Transactions From MO HealthNet

Loop	Segment	Data Element	Comments
NA	ISA	NA	MO HealthNet uses ‘|’ as a data element separator and ‘~’ as a segment terminator.
NA	ISA	ISA05	MO HealthNet uses ‘30’
NA	ISA	ISA06	MO HealthNet uses ‘431754897’
NA	ISA	ISA07	MO HealthNet returns value sent in ISA05 of incoming transaction.
NA	ISA	ISA08	MO HealthNet returns value sent in ISA06 of incoming transaction.
NA	ISA	ISA16	MO HealthNet uses ‘!’ as a component element separator.

GS-GE

Batch

This section describes MO HealthNet's use of the functional group control segments specifically for batch transactions. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how MO HealthNet expects functional groups to be sent and how MO HealthNet sends functional groups. These discussions describe how similar transaction sets are packaged and MO HealthNet's use of functional group control numbers. NOTE: Uppercase lettering must be used in this segment.

Incoming Transactions to MO HealthNet

Loop	**Segment**	**Data Element**	**Comments**
NA	GS	GS02	Use the billers user ID provided upon successful completion of the Trading Partner Agreement.
NA	GS	GS03	Use '431754897'
NA	GS	GS06	*This Unique Number must be identical to the Group Control Number in GE02. Each submitter should start with a value of their choice and increment by at least one (1) each time a file is sent.*

Outgoing Transactions From MO HealthNet

Loop	Segment	Data Element	Comments
NA	GS	GS02	MO HealthNet uses '431754897'
NA	GS	GS03	MO HealthNet uses the 9-digit MO HealthNet provider ID.

On-Line

This section describes MO HealthNet's use of the functional group control segments specifically for on-line transactions. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how MO HealthNet expects functional groups to be sent and how MO HealthNet sends functional groups. These discussions describe how similar transaction sets are packaged and MO HealthNet's use of functional group control numbers. NOTE: Uppercase lettering must be used in this segment.

Incoming Transactions to MO HealthNet

Loop	Segment	Data Element	Comments
NA	GS	GS02	Billers can use the code of their choice.
NA	GS	GS03	Use '431754897'

Outgoing Transactions From MO HealthNet

Loop	Segment	Data Element	Comments
NA	GS	GS02	MO HealthNet uses '431754897'
NA	GS	GS03	MO HealthNet returns the value sent in ISA06 of incoming transaction.

SECTION 6 - PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

INTRODUCTION

Through the use of tables, this section describes how to bill or interpret MO HealthNet specific business rules (e.g., how to send/interpret diopters information or fluoride justification). It also describes how to populate or interpret trading partner or payer specific data elements. The tables contain a row for each segment or data element where MO HealthNet has something additional to convey. The intent is to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

Legend
SHADED rows represent "segments" that have been added or changed from version 4010.
Any that has been deleted will have a strike through showing it has been deleted.

6.1 ASC X12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)

The MO HealthNet system supports the required primary search options for 'patient is subscriber' for this transaction. If the four data elements identified are not all submitted, two rules apply. First, the participant's (subscriber) number may be submitted as the only search criteria. Second, the participant's name and date of birth are combined to attempt to uniquely identify a participant, so these elements should both be submitted. The MO HealthNet system also supports the required alternate search options for 'patient is subscriber' and the name/date of birth search option.

Additional alternate search options supported:

- Social Security Number (SSN)/Date of Birth (DOB):
- Case
    - The SSN is sent in the 2100C/REF segment.
- Casehead ID/ Date of Birth (DOB)
    - This method can be used when the MO HealthNet number of someone with the same casehead ID as the subscriber is known. In this event, the

casehead ID is sent in the 2100C/REF segment and the DOB of the subscriber is sent in the DMG segment.

The MO HealthNet system only supports Service Type Code '30' in EQ01. Subsequently, it does not support requests for multiple Service Type Codes.

The MO HealthNet system does not support the use of the 2100D dependent loop for any searches.

MO HealthNet follows the submission limitations noted in Section 1.3.2 of the Implementation Guide: ninety-nine requests in batch and one request in real time. Any requests exceeding these limitations are ignored.

270 Health Care Eligibility Benefit Inquiry and Response

Loop	Segment	Data Element	Comments
NA	BHT	BHT02	'13'
2100A	NM1	NM101	PR
2100A	NM1	NM102	'2'
2100A	NM1	NM103	MO HEALTHNET
2100A	NM1	NM108	PI
2100A	NM1	NM109	'431754897'
2100B	NM1	NM108	This value should be XX. For MO HealthNet Managed Care Health Plans only, if the MO HealthNet provider number is sent, then the value should be SV.
2100B	NM1	NM109	This value is the Centers for Medicare and Medicaid Services National Provider Identifier (NPI). For MO HealthNet Managed Care Health Plans only, if NM108 = SV, then the MO HealthNet provider number should be sent.
2100B	PRV	PRV03	MO HealthNet requires the taxonomy code if the information receiver is using one NPI for multiple MO HealthNet legacy provider numbers.
2100C	NM1	NM108	MI
2100C	NM1	NM109	MO HealthNet participant number of the subscriber. This information provides the greatest chance of finding a match in the MO HealthNet system.
2100C	REF	REF02	Use EJ, NQ or SY

2100C	REF	REF03	For EJ, use the patient account number For NQ, use the casehead ID if doing a casehead ID/date of birth search. (See the information at the beginning of this section for more details.) For SY, use the SSN if doing a SSN search. The SSN is only returned in the 271 if it used to find eligibility.
2100C	DMG	DMG02	This field is required for searches using the SSN, casehead or name. Use the DOB of the subscriber if using the name or SSN and the DOB of the dependent in the casehead search.
2100C	DTP	DTP01-DTP03	If this segment is not used, the MO HealthNet system assumes the current date at the time the transaction is being processed.The first date of service cannot be more than one year old, nor can it be in a future calendar month. The last date of service cannot be in a future calendar month. Future dates through the end of the current calendar month are verified.
2110C	DTP		MO HealthNet only supports Service Type Code ‘30’, therefore the eligibility request date is collected at the 2100C level, not from this segment

271 Health Care Eligibility Benefit Inquiry and Response

Loop	Segment	Data Element	Comments
2100B	NM1	NM101-NM109	This data is populated with information contained in the MO HealthNet database.
2100B	REF	REF01	This data is populated with information received on the 270.
2100B	REF	REF02	This data is populated with information received on the 270.
2000C	TRN	TRN02	When TRN01=1, this field contains the authorization number.
2000C	TRN	TRN03	When TRN01=1, this field contains '9431754897'
2000C	TRN	TRN04	When TRN01=1, this field contains 'MO HealthNet'
2100C	NM1	NM103-NM109	This data is populated with information contained in the MO HealthNet database.
2100C	REF	REF01	If the SSN is used on the 270 and was used to find eligibility, SY is in this field. If the Patient-account number was used on the 270, EJ is in this field. If neither were used, this segment is not used.

2100C	REF	REF02	If the SSN is sent in on the 270 and was used to find eligibility, this field contains the SSN. If the patient account number was used on the 270, this field contains the patient account number. If neither were sent, this segment is not used.
2100C	N3	N301-N302	This data is populated with information contained in the MO HealthNet database.
2100C	N4	N401-N403	This data is populated with information contained in the MO HealthNet database.
~~2100C~~	~~N4~~	~~N406~~	~~This field contains the 3-digit county code along with a description of the county.~~
2110C	EB	EB	One EB segment is used for any change in eligibility. For both online and batch, the limit of EB segments is 20.
2110C	EB	EB05	This data is populated with two different types of numbers that identify the coverage of the EB segment. When EB01=1, B, or F, and EB04 = MC, this field contains the MO HealthNet Eligibility Code (ME Code). When EB01=R and EB04=OT, this field contains up to 5 TPL coverage codes delimited by commas. If there are more than 5 applicable coverage codes, another complete EB segment follows with another 5 codes, and again until all coverage codes are listed.
2110C	REF	REF02	When REF01=M7, this field contains the MO HealthNet Eligibility Code (ME Code).
~~2120C~~	~~NM1~~	~~NM108~~	~~If MO HealthNet has the National Provider Identifier (NPI) available in the system, this value is XX. If not (applies to Health Plans only), it remains as is.~~
~~2120C~~	~~NM1~~	~~NM109~~	~~This number is the NPI. For Health Plans only, if NM108 is not XX, this is the MO HealthNet Provider number.~~
~~2120C~~	~~N3~~	~~N301-N302~~	~~This data is populated the street address.~~
~~2120C~~	~~N4~~	~~N401-N403~~	~~This data is populated the city name, state, and zip code.~~
2120C	PER	PER04	This field is populated with the MO HealthNet Managed Care Health Plan hotline number or the provider's office number.

6.2 ASC X12N/ 005010X212A1 HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE (276/277)

The MO HealthNet system utilizes certain fields in the 276 transaction in order to find a valid claim match. At a minimum, the National Provider Identifier (NPI), participant (subscriber)

number, and claim first date of service are required to find a claim. The 276 transaction requires a subsequent date to fill in the date range in the 2200D loop, segment DTP. The subsequent date is handled as if it is the last date of service. If there is no last date of service, then the first date of service is used to fill in the date range. Including the claim ICN (loop 2200D, segment REF) offers an even-greater chance of finding a match in the system. If more than one of the search criteria fields is sent, a hierarchy is used to attempt to match. The first attempt is by the claim ICN, if it was sent. If the claim ICN was not sent, then all claims are selected for the provider/participant/first date of service – last date of service combination.
It is stated in the 276 transaction that a claim status request may be requested at the claim detail level (loop 2210D). The MO HealthNet system does not handle a request that is detail line specific at this time.
On the 277, the data found in loops 2100C and 2100D is from the MO HealthNet database files. For online submissions of the 276 transaction, only one occurrence of the 2100C and 2100D loops is processed. If an ICN is not used for selection, there is no limit on the actual date range of the 2200D loop, segment DTP; although, it should be noted that the larger the date range is, the greater the response time.

276 Health Care Claim Status Request and Response

Loop	Segment	Data Element	Comments
2100A	NM1	NM101	PR – Payer
2100A	NM1	NM102	2 – Non-person Entity
2100A	NM1	NM103	MO HEALTHNET
2100C	NM1	NM108	This value should be XX. For MO HealthNet Managed Care Health Plans only, this value may be SV - SV Provider Number.
2100C	NM1	NM109	This value should be the NPI. For Health Plans only, if the value in NM108 is SV, the MO HealthNet provider number needs to be sent.
2100D	NM1	NM108	MI – Member ID
2100D	NM1	NM109	MO HealthNet participant number
2200D	REF	REF01	1K
2200D	REF	REF02	Payer Claim Control # (this data element corresponds to the 837 CLM01)
2200D	DTP	DTP03	Claim Service Period - First date of service and Last date of service. There are no limits on the range at this time, but range may impact online response time if search is too large

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Loop	Segment	Data Element	Reference Designator	Comments
2100C	NM1	Entity Type Qualifier	NM102	2 – Non-Person Entity
2100C	NM1	Identification Code Qualifier	NM108	XX-NPI or for Health Plans only, SV – Service Provider Number.
2100C	NM1	Identification Code	NM109	MO HealthNet uses the National Provider Identifier (NPI). For Health Plans only, if NM108 = SV, the MO HealthNet provider number needs to be sent.

6.3 ASC X12N/ 005010X218A1 Payroll Deducted and Other Group Premium Payment for Insurance (820)

Loop	Segment	Data Element	Comments
	TRN	TRN02	The RA number is used for the Reassociation Key.
2300B	RMR	RMR02	The ICN is used here for Capitation Claims and the Financial Control Number and ICN are used here for Financial transactions.

6.4 ASC X12N/ 005010X220A1 BENEFIT ENROLLMENT AND MAINTENANCE (834)

~~Loop~~	~~Segment~~	~~Data Elements~~	~~Comments~~
~~2000~~	~~INS~~	~~INS03~~	~~Proprietary layout :PFX: RECORD-TYPE, position 1 length 1. ***Conversion*** to X12 qualifiers~~
~~Header~~	~~ISA/GS~~	~~ISA08, GS03~~	~~Proprietary layout :PFX: PROV-ID, position 2 length 10~~
~~2000~~	~~REF~~	~~REF02,REF02~~	~~Proprietary layout :PFX: BASE-ID, position 11 length 8~~

2100A	NM1	NM103	Proprietary layout :PFX: RECIP-LAST-NAME, position 19 length 19
2100A	NM1	NM104	Proprietary layout :PFX: RECIP-FIRST-NAME, position 38 length 12
2100A	NM1	NM105	Proprietary layout :PFX: RECIP-MI, position 50 length 1
2300	HD	HD04 (position 1, length 2)	Proprietary layout :PFX: ME-CODE, position 51 length 2. Note: If field is spaces, defaults to 'XX'.
2100A	N4	N406	Proprietary layout :PFX: PAY-CTY, position 53 length 3
2300	DTP	DTP03	Proprietary layout :PFX: START-DATE, position 56 length 8. Note: Enrollments first loop, Me Code Change first loop, Weekly Recon first loop
2300	DTP	DTP03	Proprietary layout :PFX: STOP-DATE, position 64 length 8. Note: Disenrollments first loop, Weekly Recon second loop (when applicable)
2300	HD	HD04 (position 3, length 1)	Proprietary layout :PFX: AUTOASSGN-IND, position 72 length 1. Note: If field is spaces, defaults to 'X'.
2000	DTP	DTP03	Proprietary layout :PFX: DATE-LAST-CHANGED, position 73 length 8. Note: For disenrollments: first loop For Me Code Change: first loop For Weekly Recon: first loop
2310	NM1	NM109	Proprietary layout :PFX: LOCK-PCP-ID, position 81 length 10. Note: populated only when applicable. This field is National Provider Identifier (NPI).
2310	PLA	PLA03	Proprietary layout :PFX: LOCK-PCP-EFF-DATE, position 90 length 8 Note: populated only when PCP-ID exists
2000	REF	REF02	Proprietary layout :PFX: CASEHEAD-ID, position 98 length 10

~~2100G~~	~~NM1~~	~~NM103~~	~~Proprietary layout :PFX: CASEHEAD-LNAME, position 108 length 19. Note: If :PFX: RECIP-LAST-NAME not equal :PFX: CASEHEAD-LNAME and :PFX: RECIP-FIRST-NAME not equal :PFX: CASEHEAD-FNAME then populate element~~
~~2100G~~	~~NM1~~	~~NM104~~	~~Proprietary layout :PFX: CASEHEAD-FNAME, position 127 length 12. Note: If :PFX: RECIP-LAST-NAME not equal :PFX: CASEHEAD-LNAME and :PFX: RECIP-FIRST-NAME not equal :PFX: CASEHEAD-FNAME then populate element~~
~~2100G~~	~~N3~~	~~N301~~	~~Proprietary layout :PFX: RECIP-ADDRESS, position 139 length 25. Note: If :PFX: RECIP-ADDRESS > spaces or low values then element is populated else defaults :PFX: RECIP-STREET. Also, if address is incorrect defaults to PO BOX 6500~~
~~2100G~~	~~N3~~	~~N302~~	~~Proprietary layout :PFX: RECIP-STREET, position 164 length 25. If :PFX: RECIP-STREET > spaces or low values then element is populated.~~
~~2100G~~	~~N4~~	~~N401~~	~~Proprietary layout :PFX: RECIP-CITY, position 189 length 22. If city incorrect, defaults to Jefferson City.~~
~~2100G~~	~~N4~~	~~N402~~	~~Proprietary layout :PFX: RECIP-STATE, position 211 length 2. If state incorrect, defaults to MO~~
~~2100G~~	~~N4~~	~~N403~~	~~Proprietary layout :PFX: RECIP-ZIP-CODE, position 213 length 5. ZIP +4 has been added to the 834 layout. If zip code is incorrect, defaults to 65102-6500~~
~~2100A~~	~~DMG~~	~~DMG02~~	~~Proprietary layout :PFX: DATE-OF-BIRTH, position 218 length 8~~

~~2100A~~	~~DMG~~	~~DMG03~~	~~Proprietary layout :PFX: SEX-CODE, position 226 length 1. ***Conversion***~~
~~2100A~~	~~NM1~~	~~NM109~~	~~Proprietary layout :PFX: SSN, position 227 length 9~~
~~2300~~	~~HD~~	~~HD04 (position 5, length 2)~~	~~Proprietary layout :PFX: DISENROLL-IND, position 236 length 2. Note: Only when applicable for Disenrollment and defaults to 'XX' when field is spaces.~~
~~2000~~	~~DTP~~	~~Loop 2000: DTP03 second repeat~~	~~Proprietary layout :PFX: ME-EFFECTIVE-DATE, position 238 length 8.~~
~~2100A~~	~~PER~~	~~PER04~~	~~Proprietary layout :PFX: RECIP-PHONE-NUM, position 246 length 10~~
~~2100A~~	~~PER~~	~~PER03~~	~~Proprietary layout :PFX: RECIP-PHONE-TYPE, position 256 length 1~~
~~2100A~~	~~LUI~~	~~LUI02 OR LUI03~~	~~Proprietary layout :PFX: PRIM-LANG-IND, position 257 length 1. ***Conversion*** if no code found, the description is populated (LUI03/352) that is currently used by DFS~~
~~2300~~	~~HD~~	~~HD04 (position 4, length 1)~~	~~Proprietary layout :PFX: DAY-SPEC-ELIG, position 258 length 1. Note: If field is spaces, defaults to 'X'.~~

~~2100A~~	~~DMG~~	~~DMG05~~	~~Proprietary layout :PFX: RACE-CODE, position 259 length 1, ***Conversion***~~

Loop	Segment	Data Element	Notes/Comments
2000	INS	INS03	MO HealthNet treats add and reinstate records in the same manner.
2300	HD	HD04	The plan coverage description consists of ME code, Auto assign indicator, Disenrollment indicator, and Day specific eligibility. If no Plan Coverage Description is available MO HealthNet sends an XX.
2310	PLA	PLA03	Populated only when PCP-ID exists.
2100G	N3	N301	If address is incorrect defaults to PO BOX 6500.
2100G	N4	N402	If state incorrect, defaults to MO.
2100G	N4	N403	If zip code is incorrect, defaults to 65102-6500.

6.5 ASC X12N/ 005010X221A1 HEALTH CARE CLAIM PAYMENT ADVICE (835)

Loop	Segment	Data Element	Comments
1000B	N1	N103	If N104 is populated with NPI , it will be XX or 'FI' (Federal Tax payer's Identification number)
1000B	N1	N104	If N103 is XX, N104 will be National Provider Identifier. If N103 is FI, N104 will be Federal Tax payer's Identification number.
2100	NM1	NM108	The value should be XX –National Provider Identifier. For Managed Care Health Plans only the value in NM108 Can be MC or PC,
2100	NM1	NM109	This value should be the NPI. For Managed Care Health Plans only, if the value in NM108 is MC or PC, the managed care health plan provider number will be sent.
2100	CLP	CLP01	If not sent on the incoming claim, this defaults to spaces, except for drug claims. Drug claims have the prescription number plugged here. If no prescription number is available it defaults to '999999999'.
2100	CLP	CLP06	If not sent on the incoming claim, this defaults to spaces, except for drug claims. Drug claims received through POS have '13' plugged. All other drug claims have 'MC' plugged.
2100	CLP	CLP08	If not sent on the incoming claim, this defaults to space, except for drug claims. Drug claims always have spaces.
2100	CLP	CLP09	If not sent on the incoming claim, this defaults to space, except for drug claims. Drug claims always have spaces.
~~2110~~	~~REF~~	~~NA~~	~~Service Identification Segment:~~ ~~If the line item control number is not sent on the incoming claim, this segment is not produced.~~
2110	SVC	SVC06	Will be sent when the adjudicated procedure code provided in SVC01 is different from the submitted procedure code from the original claim
	PLB	PLB03-2	Financial control number prefixed with 'FCN:' or AR number prefixed with 'AR:'

6.6 837 GENERAL INFORMATION

- Claims submitted with more than 28 detail lines are split into multiple claims.
- Dollar amounts at the detail level in excess of 99,999.99 and at the header level in excess of 9,999,999.99 are truncated from the left.
- It is recommended to transmit only a maximum of 1,000 claims within an ST/SE transaction set envelope, due to the possibility that the entire envelope could be rejected if just one claim segment were found invalid by our translator.
- It is also recommended to limit the number of ST/SE transaction set envelopes to a maximum of 20 per GS/GE function group envelopes and a maximum of 1 GS/GE function group envelope per ISA/IEA interchange control envelope, due to WTX performance processing.
- Multiple ISA/IEA interchange control envelopes per transaction are acceptable.
- All providers except Managed Care Health Plans are required to use XX as the NM108 qualifier and their NPI as the NM109 value in all provider identification loops, where applicable to include, but not limited to:
    - Professional – 2010AA, 2310A, 2310B, 2310C, 2310D, 2420A, 2420C, 2420D, 2420F
    - Dental – 2010AA, 2310A, 2310B, 2310D, 2310E, 2420A, 2420B, 2420C
    - Institutional – 2010AA, 2310A, 2310B, 2310C, 2310D, 2310E, 2310F, 2420A, 2420B, 2420C, 2420D.
- Managed Care Health Plans only: Managed Care Health Plans may continue to submit managed care health plan provider numbers for all provider identification loops except 2010AA which must contain the managed care health plans atypical NPI (Mxxxxxxxxx).

Loop	Segment	Data Element	Comments
NA	BHT	BHT02	Both values ‘00’ and ‘18’ are processed the same. If the file is a reissue, claims fail duplicate editing within the MMIS if they were previously processed.
NA	BHT	BHT06	When ‘CH’ is used claims are processed as fee for service claims. When ‘RP’ is used claims are processed as encounter claims.
1000B	NM1	NM109	Use ‘431754897’.

2000A	PRV	PRV03	Billing/Pay to provider: Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers
2010AA	NM1	NM108	Must use 'XX'.
2010AA	NM1	NM109	Fee for Service providers must use NPI. Managed Care Health Plans must use the atypical NPI you have been assigned (Mxxxxxxxxx).
2010BA	NM1	NM103	Uppercase letters must be used.
2010BA	NM1	NM104	Uppercase letters must be used.
2010BA	NM1	NM105	Uppercase letters must be used.
~~2010BA~~	~~NM1~~	~~NM107~~	~~Uppercase letters must be used.~~
2300	CLM5	CLM05-3	When any value other than '7' or '8' is used, the claim processes as an original claim. When '7' is used, a credit is generated using the number found in 2300 REF02 when REF01 is F8. The new claim is processed as an original claim. If an incorrect original reference number is given, the new claim fails duplicate editing in the MMIS. When '8' is used, a credit only is generated using the number found in 2300 REF02 when REF01 is F8. Managed Care Health Plans should send the CLM05-3 as 1, 7, or 8 just the same as the fee for service claims. A MCVOID record is created from the 837 received when the frequency is either '7' or '8'.

6.7 ASC X12N/ 005010X222A1 PROFESSIONAL SPECIFIC INFORMATION(837)

- If loop 2400 service dates are not populated, loop 2300 admit and discharge dates are used for the detail line dates of service. If loop 2400 service dates and loop 2300 admit and discharge dates are not populated, zeroes are used for the detail line service dates.

Loop	Segment	Data Element	Comments
~~NA~~	~~REF~~	~~REF02~~	~~During the testing phase, billers must use "004010X098DA1." Once approved for production, use "004010X098A1."~~
~~2000A~~	~~PRV~~	~~PRV03~~	~~Billing Provider Secondary Identifier segment:~~

			~~Provider's 10 digit taxonomy code (Code designating the provider type, classification and specialization)~~ ~~This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers.~~
~~2300~~	~~CLM~~	~~CLM05-3~~	~~When '1' is used, the claim processes as an original claim.~~ ~~When '7' is used, a credit is generated using the number found in 2300 REF02 when REF01 is F8. The new claim is processed as an original claim. If an incorrect original reference number is given, the new claim fails duplicate editing in the MMIS.~~ ~~When '8' is used, a credit only is generated using the number found in 2300 REF02 when REF01 is F8.~~ ~~MO HealthNet Managed Care health plans should send the CLM05-3 as 1, 7, or 8 just the same as the fee-for-service claims. A MCVOID record is created from the 837 received.~~
2300	NTE	NTE01	For fee-for-service (FFS) dental claims, where topical fluoride treatment for adults is done, enter 'ADD' here and provide the conditions or criteria for the treatment in NTE02. Up to 5 occurrences of the NTE segment are used. Reference the MO HealthNet Provider Manual: Section 15: Billing Instructions - Dental for additional information. For dental encounters containing capitated services, enter 'ADD' in NTE01 and 'CAPITATED SERVICES' in NTE02.
2300	NTE	NTE02	For fee-for-service (FFS) dental claims, where topical fluoride treatment for adults is done, enter 'ADD' in NTE01 and provide the conditions or criteria for the treatment here. Up to 5 occurrences of the NTE segment are used. Reference the MO HealthNet Provider Manual: Section 15: Billing Instructions - Dental for additional information. For dental encounters containing capitated services, enter 'CAPITATED SERVICES' in NTE02 and 'ADD' in NTE01.
~~2300~~	~~NTE~~	~~NTE01~~	~~This field is needed for Fee for Service claims only.~~ ~~For Optical claims with dates of service prior to June 15, 2009, where MO HealthNet policy requires submission of prescription information to process the claim, this segment can be used. If used, this element should be populated with 'ADD'. Refer to the Optical Manual for specific requirements.~~
~~2300~~	~~NTE~~	~~NTE02~~	~~This field is needed for Fee for Service claims only.~~ ~~For Optical claims with dates of service prior to June 15, 2009, if~~

			~~NTE01 is populated with 'ADD.' This element should be populated according to the layout shown in Appendix A. For optical prescriptions, refer to the Optical Manual for specific requirements.~~
2300	REF	REF01	Value 'F8' is required when CLM-05-3 is '7' or '8.' Value 'F8' should also be used if the biller wishes to send a previous ICN to show timely filing conditions were met.
2300	REF	NA	The Service Authorization Exception Code Segment does not apply to MO HealthNet claims.
~~2310A~~	~~PRV~~	~~PRV03~~	~~Referring provider~~ ~~Provider's 10 digit taxonomy code (Code designating the provider type, classification and specialization)~~ ~~This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers~~
2310A	REF	REF01	Only the Managed Care Health Plans should be using this segment Qualifier 'G2' will be used for the Managed Care Health Plans to send their managed care health plan provider number.
2310A	REF	REF02	Only the Managed Care Health Plans should be using this segment. The managed care health plan provider number should be sent in this field.
2310B	PRV	PRV03	Rendering provider Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers
2310B	REF	REF01	Only the Managed Care Health Plans should be using this segment Qualifier 'G2' will be used for the health plans to send their managed care health plan provider number.
2310B	REF	REF02	Only the Managed Care Health Plans should be using this segment. The managed care health plan provider number should be sent in this field.
2300	HCP	NA	The Claim Pricing/Repricing Information segment is not used by MO HealthNet
2400	SV1	SV101-1	Use Qualifier Code 'HC' for HCPCS Codes. Qualifier Code 'HC' should be used for J-Code procedure codes with a date of service of 2/1/08 or after.

			Retail pharmacies billing NDC codes for drugs should use the HIPAA compliant NCPDP VD.0 submission form
2400	SV1	SV101-2	Physicians billing for drugs should use the appropriate 'J' HCPCS procedure codes, but will also be required to use the NDC, Decimal Quantity, and Prescription Number if the date of service is on or after 2/1/08.
2400	SV1	SV101-3 SV101-4 SV101-5 SV101-6	Reference the appropriate MO HealthNet Provider Manual to determine when these are required
2400	SV1	SV104	Units and minutes containing decimals are truncated.
2400	LQ	LQ01	Use the 'UT' qualifier code for Health Care Financing Administration (HCFA) Durable Medical Equipment Regional Carrier (DMERC) Certificate of Medical Necessity (CMN) forms.
2400	LQ	LQ02	Use the '4842' form identifier for HCFA DMERC CMN oxygen forms.
~~2400~~	~~FRM~~	~~FRM01~~	~~For HCFA DMERC CMN oxygen data, use '5' on question 5.~~
~~2400~~	~~FRM~~	~~FRM02~~	~~For HCFA DMERC CMN oxygen data, answer with a 'Y' for yes, 'N' for no, or 'W' for not applicable~~
2420A	PRV	PRV03	Rendering at service level Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers.
2420F	PRV	PRV03	Referring at service level Providers 10 digit taxonomy code. (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers
2420F	REF	REF01	Only the Managed Care Health Plans should be using this segment Qualifier 'G2' will be used for the health plans to send their managed care health plan provider number.
2420F	REF	REF02	Only the Managed Care Health Plans should be using this segment. The managed care health plan provider number should be sent in this field.

6.8 837 ASC X12N/ 005010X224A1 DENTAL SPECIFIC INFORMATION(837)

Loop	Segment	Data Element	Comments
~~NA~~	~~REF~~	~~REF02~~	~~During the testing phase, billers must use "004010X097DA1." Once approved for production, use "004010X097A1."~~
~~2000A~~	~~PRV~~	~~PRV03~~	~~Billing/Pay to Identifier segment:~~ ~~Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization)~~ ~~This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers~~
2300	REF	NA	The Service Authorization Exception Code segment is not used for MO HealthNet.
2300	NTE	NTE01	For fee-for-service (FFS) dental claims, where topical fluoride treatment for adults is done, enter 'ADD' here and provide the conditions or criteria for the treatment in NTE02. Up to 5 occurrences of the NTE segment are used. Reference the MO HealthNet Provider Manual: Section 15: Billing Instructions - Dental for additional information. For dental encounters containing capitated services, enter 'ADD' in NTE01 and 'CAPITATED SERVICES' in NTE02.
2300	NTE	NTE02	For fee-for-service (FFS) dental claims, where topical fluoride treatment for adults is done, enter 'ADD' in NTE01 and provide the conditions or criteria for the treatment here. Up to 5 occurrences of the NTE segment are used. Reference the MO HealthNet Provider Manual: Section 15: Billing Instructions - Dental for additional information. For dental encounters containing capitated services, enter 'CAPITATED SERVICES' in NTE02 and 'ADD' in NTE01.
2300	SV3	SV301-3 SV301-4 SV301-5 SV301-6	Procedure code modifiers are not used for claims billed on the dental 837.
2310A	PRV	PRV03	Referring provider Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization)

			This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers
2310A	REF	REF01	Only the Managed Care Health Plans should be using this segment. Qualifier 'G2' will be used for the health plans to send their managed care health plan provider number in the REF02 field of this segment.
2310A	REF	REF02	Only the Managed Care Health Plans should be using this segment. The managed care health plan provider number should be sent in this field.
~~2310B~~	~~PRV~~	~~PRV03~~	~~Rendering provider~~ ~~Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization)~~ ~~This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers~~
2310B	REF	REF01	Only the Managed Care Health Plans should be using this segment. Qualifier 'G2' will be used for the health plans to send their managed care health plan provider number in the REF02 field of this segment.
2310B	REF	REF02	Only the Managed Care Health Plans should be using this segment. The managed care health plan provider number should be sent in this field.
~~2300~~	~~SV3~~	~~SV306~~	~~Quantities with decimals are truncated.~~
2400	SV3	SV301-3 SV301-4 SV301-5 SV301-6	Procedure code modifiers are not used for claims billed on the dental 837
2400	SV3	SV306	Quantities with decimals are truncated.

2400	TOO	NA	Only one tooth number per detail line is processed by MO HealthNet. Additional tooth numbers are ignored.
~~2420A~~	~~PRV~~	~~PRV03~~	~~Rendering Provider~~ ~~Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization)~~ ~~This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers~~
2420A	REF	REF01	Only the Managed Care Health Plans should be using this segment.
2420A	REF	REF02	Qualifier 'G2' will be used for the Managed Care Health Plans to send their managed care health plan provider number in the REF02 field of this segment.

6.9 837 ASC X12N/ 005010X223A1 INSTITUIOTNAL SPECIFIC INFORMATION (837)

For nursing home claims, each SV2 segment generates a separate claim.

Loop	Segment	Data Element	Comments
~~NA~~	~~REF~~	~~REF02~~	~~During the testing phase, billers must use "004010X096DA1". Once approved for production, use "004010X096A1".~~
~~2000A~~	~~PRV~~	~~PRV03~~	~~Billing/Pay to provider:~~ ~~Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization)~~ ~~This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers~~
~~2300~~	~~CLM~~	~~CLM05-3~~	~~When any value other than '7' or '8' is used, the claim processes as an original claim.~~ ~~When '7' is used, a credit is generated using the number found in 2300 REF02 when REF01 is F8. The new claim is processed as an original claim. If an incorrect original reference number is given,~~

			~~the new claim fails duplicate editing in the MMIS.~~ ~~When '8' is used, a credit only is generated using the number found in 2300 REF02 when REF01 is F8.~~ ~~MO HealthNet Managed Care health plans should send the CLM05-3 as 1, 7, or 8 just the same as the fee for service claims. A MCVOID record is created from the 837 received.~~
~~2300~~	~~CLM~~	~~CLM18~~	~~This data element is not used to determine whether a paper remittance advice is generated for this claim. Providers indicate in their Trading Partner Agreement whether remittance advices are to be generated on paper or electronically.~~
2300	CL1	CL101	Required for all inpatient claims. Also required for outpatient emergency room claims.
2300	REF	NA	The Service Authorization Exception Code segment is not used for MO HealthNet.
2300	REF Payer Claim Control Number	REF02	Value 'F8' is required in REF01 of this segment when CLM-05-3 is '7' or '8.' Value 'F8' should also be used if the biller wishes to send a previous ICN to show timely filing conditions were met. The previous ICN is what should be sent in this field.
2300	REF Peer Review Org Approval Nbr	REF01	This field is needed for fee-for-service claims only. Peer Review Organization (PRO) Approval Number Segment: For inpatient claims requiring certification, enter the identification qualifier of G4. For these claims, the REF02 segment must be completed with the Affiliated Computer Services (ACS) certification number. For all other claims, this segment is not used by MO HealthNet.
2300	REF	REF02	This field is needed for fee-for-service claims only. Peer Review Organization (PRO) Approval Number Segment: For inpatient claims requiring certification, enter the identification qualifier of G4. For these claims, the REF02 segment must be completed with the Affiliated Computer Services (ACS) certification number. For all other claims, this segment is not used by MO HealthNet.
2300	NTE	NTE01	For fee-for-service (FFS) dental claims, where topical fluoride treatment for adults is done, enter 'ADD' here and provide the conditions or criteria for the treatment in NTE02. Up to 5 occurrences of the NTE segment are used. Reference the MO

			HealthNet Provider Manual: Section 15: Billing Instructions - Dental for additional information. For dental encounters containing capitated services, enter 'ADD' in NTE01 and 'CAPITATED SERVICES' in NTE02.
2300	NTE	NTE02	For fee-for-service (FFS) dental claims, where topical fluoride treatment for adults is done, enter 'ADD' in NTE01 and provide the conditions or criteria for the treatment here. Up to 5 occurrences of the NTE segment are used. Reference the MO HealthNet Provider Manual: Section 15: Billing Instructions - Dental for additional information. For dental encounters containing capitated services, enter 'CAPITATED SERVICES' in NTE02 and 'ADD' in NTE01.
~~2300~~	~~NTE~~	~~NTE01~~	~~This field is needed for fee-for-service claims only.~~ ~~For home health claims, if submitting the "Home Health Certification and Plan of Treatment"~~ ~~**to prove medical necessity for two visits provided on the same date of service**~~~~, enter the applicable Note Reference Code identifying the functional area or purpose reported in NTE02.~~
~~2300~~	~~NTE~~	~~NTE02~~	~~This field is needed for fee-for-service claims only.~~ ~~For home health claims, if submitting the "Home Health Certification and Plan of Treatment"~~ ~~**to prove medical necessity for two visits provided on the same date of service**~~~~, enter the narrative information from the "Home Health Certification and Plan of Treatment" and the "Medical Update and Patient Information" forms clarifying the data elements reported in NTE01. Patient information to be reported, based on the Note Reference Code, may include:~~ ~~ALG - may report patient's allergies that are relevant to the care being given~~ ~~DCP - goals, rehab potential or discharge plans must be reported~~ ~~DGN - may report additional information concerning diagnosis~~ ~~DME - may report equipment and supplies that are relevant to the care being provided~~ ~~MED - may report patient's medications that are relevant to the care being provided~~ ~~NTR - may report patient's nutritional requirements that are relevant to the care being provided~~ ~~ODT - must report interim order by physician for applicable time frame, by discipline; first three (3) bytes of note must begin with~~

			~~SN , AI , PT , OT , or ST , indicating the discipline the interim orders address~~ ~~RHB - reason homebound must be reported~~ ~~RLH - reasons patient leaves home-not applicable to MO HealthNet~~ ~~RLH - times and reasons patient not at home-not applicable to MO HealthNet~~ ~~SET - may report unusual home or social environment, or both, that are relevant to the care being provided~~ ~~SFM - may report safety measures taken that are relevant to the care being provided~~ ~~SPT - may report supplemental information in the plan of care~~ ~~UPI - must report information required by Home Health program policy, such as: date and time of birth and date and time of discharge if billing Y9505 or 99501; weight, height, and age of low birthweight child; documentation of deficient weight relative to the child's height for a failure-to-thrive child; patient's status on dates of service being billed; or other information home health agency deems important for adjudication decisions.~~
~~2300~~	~~CR6~~	~~CR601 - CR621~~	~~This field is needed for fee-for-service claims only.~~ ~~For home health claims, if submitting the "Home Health Certification and Plan of Treatment"~~ **~~to prove medical necessity for two visits provided on the same date of service~~**~~, this segment is required to report information related to the certification of a home health care patient.~~
~~2300~~	~~CR6~~	~~CR610~~	~~This field is needed for fee-for-service claims only.~~ ~~For home health claims, if submitting the "Home Health Certification and Plan of Treatment"~~ **~~to prove medical necessity for two visits provided on the same date of service~~**~~, the Product/Service ID Qualifier must always be 'HC" - HCPCS Codes.~~
~~2300~~	~~CR6~~	~~CR611~~	~~This field is needed for fee-for-service claims only.~~ ~~For home health claims, if submitting the "Home Health Certification and Plan of Treatment"~~ **~~to prove medical necessity for two visits provided on the same date of service~~**~~, the surgical procedure code must always be reported using HCPCS Codes.~~
~~2300~~	~~CRC~~	~~CRC01 - CRC07~~	~~This field is needed for fee-for-service claims only.~~ ~~For home health claims, if submitting the "Home Health Certification and Plan of Treatment"~~ **~~to prove medical necessity~~**

			for two visits provided on the same date of service, this segment is required to report 'Home Health Plan of Treatment' information on the home health care patient's conditions.
2300	CRC	CRC01	This field is needed for fee-for-service claims only. For home health claims, if submitting the "Home Health Certification and Plan of Treatment" **to prove medical necessity for two visits provided on the same date of service**, information must be reported for both Code Category '75' - Functional Limitations and '76' Activities Permitted.
2300	HI	HI01-1	Principal Procedure Information Segment: For inpatient claims, the surgical procedure code must always be represented using ICD-9-CM procedures. Therefore, this value should always be 'BR' for inpatient claims. For all other claims, use 'BP'.
2300	HI	HI01-2	Principal Procedure Information Segment: For inpatient claims, the surgical procedure code must always be represented using ICD-9-CM procedures. For all other claims, use CPT or HCPCS procedure codes.
2300	HI	HI01-1 through HI12-1	Other Procedure Information segment: For inpatient claims, the surgical procedure code must always be represented using ICD-9-CM procedures. Therefore, this value should always be 'BO' for inpatient claims. For all other claims, use 'BQ'.
2300	HI	HI01-2 through HI12-2	Other Procedure Information Segment: For inpatient claims, the surgical procedure code must always be represented using ICD-9-CM procedures. For all other claims, use CPT or HCPCS procedure codes.
2300	QTY	QTY02	Quantities containing decimals are truncated.
2300	HCP	NA	The Claim Pricing/Repricing Information segment is not used by MO HealthNet.

~~2305~~	~~CR7~~	~~CR01 - CR703~~	~~This field is needed for fee-for-service claims only.~~ ~~For home health claims, if submitting the "Home Health Certification and Plan of Treatment"~~ **~~to prove medical necessity for two visits provided on the same date of service~~**~~, this segment is required to report information identifying the disciplines ordered by the physician.~~
~~2305~~	~~HSD~~	~~HSD01 - HSD08~~	~~This field is needed for fee-for-service claims only.~~ ~~For home health claims, if submitting the "Home Health Certification and Plan of Treatment"~~ **~~to prove medical necessity for two visits provided on the same date of service~~**~~, this segment is required to report the amount, duration, and frequency of skilled services provided to the home health care patient.~~
2310A	NM1	NM101 - NM109	~~For fee-for-service home health claims, if submitting the "Home Health Certification and Plan of Treatment"~~ **~~to prove medical necessity for two visits provided on the same date of service~~**~~, this segment is required to report the Primary Physician responsible on a Home Health Agency Plan of Treatment.~~ This segment is required for home health and inpatient encounters.
2310A	PRV	PRV03	Attending Physician Specialty Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers
~~2310C~~	~~NM1~~	~~NM101~~	~~Other Provider Name~~ ~~This field is required for outpatient encounter claims. The~~ **~~Entity Identifier Code~~** ~~should be set to~~ **~~73.~~**
~~2310C~~	~~NM1~~	~~NM102~~	~~Other Provider Name~~ ~~This field is required for outpatient and home health encounter claims. The~~ **~~Entity Type Qualifier~~** ~~should be set to~~ **~~1 - for a person or 2 - for a non-person entity.~~**
~~2310C~~	~~NM1~~	~~NM103~~	~~Other Provider Name~~ ~~This field is required for outpatient and home health encounter claims. The~~ **~~Individual last name or organizational name~~** ~~should be populated here.~~

~~2310C~~	~~NM1~~	~~NM104~~	~~Other Provider Name~~ ~~This field is required for outpatient and home health encounter claims. The **Individual first name** should be populated here if NM102 was populated with a **1 – person**.~~
~~2310C~~	~~NM1~~	~~NM108~~	~~Other Provider Name~~ ~~This field is required for outpatient and home health encounter claims. The **Identification Code Qualifier** should be set to **XX – NPI, 24 – Employer's Identification number, or 34 – Social Security number**.~~
~~2310C~~	~~NM1~~	~~NM109~~	~~Other Provider Name~~ ~~This field is required for outpatient and home health encounter claims. The **Other Physician Primary ID** should be populated in this field.~~
~~2310C~~	~~REF~~	~~REF01~~	~~Other Provider Secondary Identification:~~ ~~For hospice claims, enter '1D' here and the NPI for the nursing home in REF02.~~ ~~For encounter claims, where the service was performed at an FQHC or RHC, enter '1D' here and the NPI in REF02.~~
~~2310C~~	~~REF~~	~~REF02~~	~~Other Provider Secondary Identification:~~ ~~For hospice claims, enter '1D' in REF01 and the NPI for the nursing home here.~~ ~~For encounter claims, where the service was performed at an FQHC or RHC, enter '1D' in REF01 and the NPI here.~~
2310E	NM1	NM101	Service Facility Name - This field is required for inpatient encounter claims.
2310E	NM1	NM102	Service Facility Name - This field is required for inpatient encounter claims. The Entity Type Qualifier should be set to 2 – for a non-person entity.

2310E	NM1	NM103	Service Facility Name - This field is required for inpatient encounter claims. Any name can be populated here.
~~2310E~~	~~NM1~~	~~NM108~~	~~Service Facility Name~~ ~~This field is required for inpatient encounter claims. The **Identification Code Qualifier** should be set to **24 - Employer's Identification number.**~~
~~2310E~~	~~NM1~~	~~NM109~~	~~Service Facility Name~~ ~~This field is required for inpatient encounter claims. The **Employer's Identification Number** should be populated in this field. This number must match a managed care provider number on the managed care provider demographic file or an exception will be posted to the claim.~~
2310E	REF	REF01	Service Facility Name - This field is required for inpatient encounter claims. The Identification Code Qualifier should be set to EI.
2310E	REF	REF02	Service Facility Name- This field is required for inpatient encounter claims. The Employer's Identification Number should be populated in this field. This number must match a managed care provider number on the managed care provider demographic file or an exception will be posted to the claim.
2400	SV2	SV201	For outpatient and hospice claims, refer to the MO HealthNet Policy manuals for specific requirements. For nursing home claims, select revenue code from one of the following categories: 1. Select revenue code to indicate reserve time periods: • 0180 equals non-covered leave of absence • 0182 equals home leave for patient convenience • 0183 equals home leave for therapeutic leave • 0184 equals hospital leave to an ICF/MR • 0185 equals hospital leave for non-ICF/MR facility • 0189 equals Medicare qualifying stay days 2. Select revenue code to indicate skilled nursing services: • 0190 equals subacute care general classification

			• 0191 equals subacute care - level I • 0192 equals subacute care - level II • 0193 equals subacute care - level III • 0194 equals subacute care - level IV • 0199 equals subacute care other Indicating any of the above revenue codes does not alter the amount of your per diem payment. Use these codes when you previously would have indicated a skilled nursing indicator of 'Y'. 3. Select revenue code to indicate non-skilled nursing time periods: • 0110 equals room-board/private • 0119 equals other/private • 0120 equals room-board/semi • 0129 equals other/2-bed Indicating any of these does not alter the amount of your per diem payment. Use these codes when you previously would have indicated a skilled nursing indicator of 'N' or blank.
2400	SV2	SV202-3 SV202-4 SV202-5 SV202-6	Reference the MO HealthNet Electronic Billing Layout Manuals for appropriate instructions on populating the procedure code modifiers.
2400	SV2	SV205	Quantities with decimals are truncated.
~~2420A~~	~~PRV~~	~~PRV03~~	~~Attending Physician Specialty~~ ~~Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization)~~ ~~This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers~~
~~2420B~~	~~PRV~~	~~PRV03~~	~~Operating Physician Specialty~~ ~~Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization)~~ ~~This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers~~

2420C	PRV	PRV03	Other Provider Name Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers

7.0 ASC X12C/005010X231 Implementation Acknowledgment (999)

The 999 is generated when a biller sends a transaction to MO HealthNet. The 999 indicates if the functional group has been received by MO HealthNet.

APPENDICES

APPENDIX A OPTICAL

Optical NTE segment NTE02 Data element specifications:

NOTE: This NTE segment should be coded at the 2300 claim level loop, as specified in Section 6 of this companion guide.

START POSITION	LENGTH	FIELD DESCRIPTION	COMMENTS
1	2	Prescription indicator	Always enter 'RX'.
3	1	Filler	Always enter space.
4	2	Right eye indicator	Always enter 'OD'.
6	1	Filler	Always enter space.
7	1	Right eye first diopter sign	If right eye first diopter information is needed for this claim, value is '+' or '-'. Default is '+'.
8	5	Right eye first diopter	If right eye first diopter information is needed for this claim the format is 00.00. Default is '00.00'.
13	1	Filler	Always enter space.
14	1	Right eye second diopter sign	If right eye second diopter information is needed for this claim, value is '+' or '-'. Default is '+'.
15	5	Right eye second diopter	If right eye second diopter information is needed for this claim the format is 00.00. Default is '00.00'.
20	1	Filler	Always enter space.

~~21~~	~~1~~	~~Times indicator~~	~~Always enter 'X'.~~
~~22~~	~~3~~	~~Times field~~	~~If right eye times information is needed for this claim, enter times value. Default is '000'. This must be numeric, with three digits.~~
~~25~~	~~1~~	~~Filler~~	~~Always enter space.~~
~~26~~	~~3~~	~~Right eye ADD indicator~~	~~Always enter 'ADD'.~~
~~29~~	~~1~~	~~Right eye ADD Sign~~	~~If right eye ADD information is needed for this claim, value is '+' or ' '. Default is '+'.~~
~~30~~	~~5~~	~~Right eye ADD field~~	~~If right eye ADD information is needed for this claim the format is 00.00. Default is '00.00'.~~
~~35~~	~~1~~	~~Filler~~	~~Always enter space.~~
~~36~~	~~2~~	~~Left eye indicator~~	~~Always enter 'OS'.~~
~~38~~	~~1~~	~~Filler~~	~~Always enter space.~~
~~39~~	~~1~~	~~Left eye first diopter sign~~	~~If left eye first diopter information is needed for this claim, value is '+' or '-'. Default is '+'.~~
~~40~~	~~5~~	~~Left eye first diopter~~	~~If left eye first diopter information is needed for this claim, the format is 00.00. Default is '00.00'.~~
~~45~~	~~1~~	~~Filler~~	~~Always enter space.~~
~~46~~	~~1~~	~~Left eye second diopter sign~~	~~If left eye second diopter information is needed for this claim, value is '+' or ' '. Default is '+'.~~
~~47~~	~~5~~	~~Left eye second diopter~~	~~If left eye second diopter information is needed for this claim, the format is 00.00. Default is '00.00'.~~
~~52~~	~~1~~	~~Filler~~	~~Always enter space.~~
~~53~~	~~1~~	~~Left eye Times indicator~~	~~Always enter 'X'. Otherwise, value is spaces.~~
~~54~~	~~3~~	~~Left eye Times field~~	~~If left eye times information is needed for this claim, enter times value. Default is '000'. This must be numeric, with three digits.~~
~~57~~	~~1~~	~~Filler~~	~~Always enter space.~~
~~58~~	~~3~~	~~Left eye ADD indicator~~	~~Always enter 'ADD'.~~
~~61~~	~~1~~	~~Left eye ADD sign~~	~~If left eye ADD information is needed for this claim, value is '+' or ' '. Default is '+'.~~
~~62~~	~~5~~	~~Left eye ADD field~~	~~If left eye ADD information is needed for this claim, the format is 00.00. Default is '00.00'.~~

~~**APPENDIX B - IMPLEMENTATION CHECKLIST**~~

~~The following is a list of the steps required to begin sending production HIPAA-compliant ASC X12N transactions to MO HealthNet:~~

1. ~~Biller completes either the Application for MO HealthNet Internet Access Account or the Application for MO HealthNet Connect:Direct Access Account.~~
2. ~~Biller completes the Trading Partner Agreement.~~
3. ~~Infocrossing Healthcare Services (IHS) Help Desk approves documents in steps 1 and 2 and notifies the biller of User ID and password.~~
4. ~~Biller sends test file(s).~~
5. ~~Biller reviews results from test file(s). Results are available within 1-2 business days.~~
6. ~~When the biller is satisfied with the results of the test (e.g., test claims aren't rejected), the biller contacts the IHS Help Desk to be moved to production for each specific transaction.~~

~~**APPENDIX C - CHANGE SUMMARY**~~

~~Updates to this guide can be accessed by clicking on the folder that says "Updated Manual List" in the table of contents. Then click on the "UPDATED MANUAL LIST" text underneath the folder to see a list of the Electronic Billing Layout Manuals in the document window. A link exists on a manual name if a revision has been made to that manual in approximately the last 6 months. After clicking on the manual name link, the sections with revisions show up in a "hit list" in the document window. Click on the section title in the hit list to jump to the revision. The revision is shown in green text. Click on the browser's back button to go back to the hit list. If there is just one section in the manual with a change in the last 6 months, then the link on the manual name in the Updated Manual List goes directly to the section with the revision (rather than showing the hit list first.)~~

SECTION 7 - RESOURCE FOR PROVIDERS.

7.1 Frequently Asked Questions

- What transactions will be available with the upgrade to the 5010 version?
  - Claims (professional, institutional and dental) – 837P, 837I and 837D
  - Claims status requests and responses – 276/277
  - Remittance Advices– 835
  - Eligibility requests and responses – 270/271
  - Enrollment and disenrollment in a health plan – 834
  - Premium payments – 820
  - Implementation Acknowledgement for Health Care Insurance - 999 (*Replaces the 4010A 997 acknowledgement for mandated transactions.)*

- What transactions will be available with the upgrade to NCPDP version D.0?
  - NCPDP D.0 Prescription Drug Programs
  - NCPDP D.0 Eligibility and Response
  - NCPDP D.0 Supplies and Professional Services

- Will you be supplying a Companion Guide?
  - Yes, we plan to have a combined Companion Guide published with each transaction requirement specified.
- Will you be providing a file level acknowledgment for claim files? If yes, what format?
  - Yes, we will have the 999 available as the file level acknowledgement.

- Will the upgrade to 5010 include the 277CA Acknowledgement Transaction?
  - No, the upgrade will not include the 277CA acknowledgement transaction.

- Will you require an acknowledgement for the 835 files?
  - No, we will not require an acknowledgement for the 835 files.

- When will your organization begin testing for 5010 by transaction type?
  - We do not have a specific date at this time. Our expectation is September 2011. The time line will be posted on https://www.emomed.com/ when available.

- Will the submitted ID we use to send batch files for version 4010A1 change?
  - No. Your current user ID will still remain the same.

- Can your test system support multiple claim files throughout the day?
  - Yes, you can submit a test file throughout the day. They are usually processed at 8 am and 12 pm.

- Will you be supporting dual formats, 4010 and 5010? If so, for how long?
  - Yes, MO HealthNet will be supporting dual formats of 4010 and 5010. The time frame is yet to be decided. Any update will be posted on https://www.emomed.com/.

- What is a dual format?
  - Dual format is accepting 4010 and 5010 versions at the same time.

- Are the changes from Errata versions implemented into testing?
  - Any Errata that has been mandated will be included in the upgrade to 5010 and included in the Companion Guide as required changes when applicable.

- Will the 5010 and NCPDP D.0 version upgrade include the ICD-10 changes?
  - Both the 5010 and NCPDP version D.0 will accommodate the expanded field length required for the International Classification of Diseases 10th Revision (ICD_10) but will not be implemented until 2013.

- When will MO HealthNet stop accepting ICD-9-CM codes?
  - ICD-9-CM codes will no longer be accepted for services provided on or after October 1, 2013. If you have further questions regarding the federal mandated date, please go to: https://questions.cms.hhs.gov/app/answers/detail/a_id/10019/%22 .

- When will MO HealthNet start accepting ICD-10-CM codes?
  - Providers can send in the ICD-10-CM codes for services provided on or after October 1, 2013. If you have further questions regarding the federal mandated date, please go to: https://questions.cms.hhs.gov/app/answers/detail/a_id/10019/%22
  - Will this affect online eMOMED billing?
  - 5010 required changes for eMOMED will be implemented on January 1, 2012. Providers may be required to provide additional information or may have information they no longer need to provide.

7.2 Additional Information:

Following are various websites and articles to help providers understand the 5010 and NCPDP D.0 changes. MO HealthNet is not responsible for the contents of these sites.

- Implementation timelines are available on the Centers for Medicare and Medicaid Services (CMS) Website at www.cms.hhs.gov/version5010andD.0
- The CMS has published side-by-side comparisons of version 5010 with version 4010A1 and NCPDP version D.0 with NCPDP version 501,

available at the CMS Website www.cms.hhs.gov/ElectronicBillingEDITrans/18-5010D0.asp

- Implementation guides for 5010 can be purchased from the ASC website at: http://store.x12.org/
- Implementation guides for D.0 are available from the NCPDP Website at: www.ncpdp.org.

7.3 Other Resources

The ASC X12N Implementation Guides adopted under HIPAA that this document supplements can be found at http://store.x12.org. The MO HealthNet Provider Manuals can be accessed through the MO HealthNet Division's website at https://www.emomed.com.

Users of this Companion Guide must understand general EDI (Electronic Data Interchange) terminology. In addition, an understanding of the loop and segment structure within the ASC X12N Implementation Guides is helpful.