



**Ohio Companion Guide  
837 Fee-For-Service Professional Claims**

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## Disclosure Statement

The information contained in this guide is meant to provide assistance to providers regarding the electronic submission of health information to the Ohio Department of Job and Family Services (ODJFS). The sole purpose of this document is to provide guidance to entities who wish to become a Trading Partner. Every effort has been made to assure the information in this guide conforms to current requirements of the law. Each Medicaid provider and Trading Partner has the ultimate responsibility to follow federal and state laws, including the [Ohio Administrative Code](#). All users of this guide are advised to review these legal requirements with their legal counsel.

## Preface

The Ohio Electronic Data Interchange (EDI) Companion Guides are developed and maintained by ODJFS. They are designed to be used in conjunction with the Accredited Standards Committee (ASC) X12 Health Insurance Portability and Accountability Act of 1996 (HIPAA) Implementation Guides dated May 2000, the Addenda adopted October 2002, and other ASC X12 acknowledgement transactions. The EDI Companion Guides are compliant with both the ASC X12 syntax and the HIPAA guides.

Each EDI Companion Guide is intended to convey information that is contained within the framework of the ASC X12 Implementation Guides adopted for use under HIPAA. The EDI Companion Guides are not intended to convey information that in any way exceeds the requirements or usages of data expressed in the ASC X12 Implementation Guides.

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

The segments and elements used in this document are necessary for the ODJFS adjudication system for Fee-For-Service Claims.

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## INTRODUCTION

When billing ODJFS in an EDI format, the following services must be submitted on the 837 Professional:

Physician services provided by individual physician practices, physician group practices, hospice organizations, and ambulatory surgery centers;

Hospice services;

Ambulatory surgery center facility services;

Clinic services provided by fee-for-service clinics (federally qualified health centers, rural health clinics and outpatient health facilities)

Home health services;

Waiver services;

Private duty nursing services;

Podiatry services;

Advanced practice nurse services;

Psychology services;

Physical therapy services;

Laboratory services;

Diagnostic facility services;

Ambulance services;

Ambulette services;

Chiropractor services;

Durable medical equipment services;

Medical supply services;

Vision, optometric, optician and eyewear services.

## GENERAL INFORMATION

This EDI Companion Guide supplements the 837 Professional Claim Implementation Guide, Version 004010X098A1.

The objectives of this document are:

- To identify the specific information needed by the ODJFS in those instances where the ASC X12 HIPAA Implementation Guide indicates that the choice is dependent on the Payer.
- To point out preferred selections for data elements where multiple alternatives exist.

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

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

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

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

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

### Data Formatting

All objects including \*.837, \*.997 files can either be wrapped or unwrapped, which means the files must contain carriage return/line feed control characters at the end of every line or the data in the files must be streamed to be processed. The method chosen must be consistent throughout the entire file.

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

The EDI objects must strictly adhere to the structure, syntax, and semantic requirements as specified in the ASC X12 National Standard, HIPAA legislation, and as provided in the ODJFS Companion Guides.

### American Standard Code for Information Exchange Formatting

ODJFS does not accept Extended Binary Coded Decimal Interchange Code (EBCDIC) files. All data transfers are expected to be in the American Standard Code for Information Exchange (ASCII) format.

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

## References

In addition to the resources available on the ODJFS Trading Partner website at <http://jfs.ohio.gov/OHP/tradingpartners/info.stm>, there are other websites that contain helpful information to assist in the implementation of the electronic data interchange process. The links to these websites are listed below and are separated by category for easy reference.

### EDI Basics

For information about EDI software and services, see 1EDI Source, Inc.

### Government / Associations

- Center for Medicare and Medicaid Services (CMS): <http://www.cms.hhs.gov>
- Answers to Frequently Asked Questions: [https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std\\_alp.php?p\\_sid=GiSFk8jj](https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=GiSFk8jj)
- Health and Human Services (HHS) Office for Civil Rights (Privacy) <http://www.hhs.gov/ocr/hipaa/>
- WEDI SNIP: Workgroup for EDI, Strategic National Implementation Process: <http://www.wedi.org/snip/>
- CMS website for National Provider identifier (NPI): <http://www.cms.hhs.gov/NationalProvIdentStand/>

### ASC X12 Standards

- Washington Publishing Company - <http://www.wpc-edi.com/>
- Data Interchange Standards Association - <http://disa.org/>
- American National Standards Institute - <http://ansi.org/>
- Accredited Standards Committee – <http://www.x12.org>

### Ohio Department of Job and Family Services

- ODJFS web site - <http://jfs.ohio.gov>
- Ohio Health Plans (OHP) website - <http://jfs.ohio.gov/ohp/>
- ODJFS Communication/Security Partner – <http://www.eds.com>

### EDI Support

- Email: [MMIS-EDI-Support@jfs.ohio.gov](mailto:MMIS-EDI-Support@jfs.ohio.gov) and Phone: (614) 387-1212

## ELEMENTS

### ISA - Interchange Control Header – Page B3 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 1

Loop Repeat: None

Example: ISA\*00\*.....\*00\*.....\*ZZ\*7.DIGIT.ID.....\*ZZ\*MMISODJFS.....\*010801\*1452\*U\*00401\*000000001\*0\*P\*::~~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
ISA01	Authorization Information Qualifier	R	2/2	ID	00	
ISA03	Security Information Qualifier	R	2/2	ID	00	
ISA05	Sender Interchange ID Qualifier	R	2/2	ID	ZZ	Mutually defined. This is the only code that ODJFS recognizes for this element.
ISA06	Interchange Sender ID	R	15/15	AN		This field should contain the 7-digit Trading Partner ID assigned to the Sender of this file. Since this is a fixed-length field, it should be filled with spaces to meet the minimum length requirement of 15.
ISA07	Interchange Receiver ID Qualifier	R	2/2	ID	ZZ	Mutually defined. This is the only code that ODJFS recognizes for this element.
ISA08	Interchange Receiver ID	R	15/15	AN	MMISODJFS	This field should contain the value MMISODJFS assigned to the Receiver of this file (Ohio Department of Job and Family Services). Since this is a fixed-length field, it should be filled with spaces to meet the minimum length requirement of 15.
ISA14	Acknowledgment Requested	R	1/1	ID	0 1	No Acknowledgment Requested Interchange Acknowledgment Requested
ISA15	Usage Indicator	R	1/1	ID	P T	Production Test

## GS – Functional Group Header – Page B8 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 1

Loop Repeat: None

Example: GS\*HC\*MEDICAID ID\*MMISODJFS\*20080708\*0802\*1\*X\*004010X098A1~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
GS02	Application Sender's Code	R	2/15	AN		This field should contain the 7-digit Trading Partner ID assigned to the Sender of this file.
GS03	Application Receiver's Code	R	2/15	AN	MMISODJFS	This field should contain the value MMISODJFS assigned to the Receiver of this file.

## ST – Transaction Set Header – Page 61 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 1

Loop Repeat: None

Example: ST\*837\*987654~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
ST01	Transaction Set Identifier Code	R	3/3	ID	837	The only valid value within this transaction set for ST01 is 837
ST02	Transaction Set Control Number	R	4/9	AN		The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.

## BHT – Beginning of Hierarchical Transaction – Page 62 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: None

Example: BHT\*0019\*00\*0123\*19970618\*0932\*CH~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
BHT02	Transaction Set Purpose Code	R	2/2	ID	00	Original
BHT06	Transaction Type Code	R	2/2	ID	CH	Chargeable

**NM1 – Submitter Name – Page 66 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 1000A

Example: NM1\*41\*2\*CRAMMER, DOLE, PALMER, AND JOHANSON\*\*\*\*\*46\*1234567~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	41	Submitter – Entity transmitting transaction set.
NM109	Identification Code	R	2/80	AN		This is the seven-digit number ODJFS assigned to the Medicaid Trading Partner. Medicaid numbers assigned to identify healthcare providers (e.g. Physicians) are not valid. Medicaid Trading Partners with a test status may only submit test EDI transactions. Medicaid Trading Partners with an active status may submit business transactions to ODJFS. A Medicaid Trading Partner is given an active status when they have passed the testing phase and have met all of the criteria specified by ODJFS.

## NM1 – Receiver Name – Page 72 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 1000B

Example: NM1\*40\*2\*OH DEPT OF JOB AND FAMILY SERVICES\*\*\*\*\*46\* MMISODJFS ~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	40	Receiver – Entity to accept transmission.
NM102	Entity Type Code	R	1/1	ID	2	Non-Person Entity
NM109	Identification Code	R	2/80	AN	MMISODJFS	Receiver ID for ODJFS = MMISODJFS

## PRV – Billing/Pay-to Provider Specialty Information – Page 76 HIPAA 837P Imp Guide

Usage: Optional

Segment Max Use within Transaction: 1

Loop ID: 2000A

Example: PRV\*BI\*ZZ\*193200000X~

**NOTE: When the billing or "Pay To" provider is a professional group practice the 2310B loop must be completed. For ODJFS, adjudication is not impacted by the taxonomy number.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
PRV01	Provider Code	R	1/3	ID	BI PT	Billing Pay-to  Enter "BI" if loop 2010AB or 2310B are not completed. Enter "PT" or "BI", (whichever is applicable) if both the 2010AA and 2010AB loops are submitted and the 2310B is not completed.
PRV02	Reference Identification Qualifier	R	2/3	ID	ZZ	Mutually defined. This is the only code that ODJFS recognizes for this element
PRV03	Reference Identification	R	1/30	AN		

## NM1 – Billing Provider Name – Page 81 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2010AA

Example: NM1\*85\*2\*CRAMMER, DOLE, PALMER, AND JOHNSON\*\*\*\*\*24\*111223333~

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

When the 2010AA loop is submitted without the 2010AB loop the information in the 2010AA loop is used. When the 2010AA loop is submitted with the 2010AB loop then the information in the 2010AB loop is used.

For most providers billing on an 837P, the billing provider, pay to provider, and rendering provider are the same provider. For group professional practices the rendering provider is always different from the billing and/or pay-to provider so the 2310B loop must also be submitted.

The NPI for the following providers must be included in this segment: FFS Clinics, Hospice, Home Health Agencies, and Waiver Providers, Ambulatory Surgery Centers, Federally Qualified Health Centers (FQHC's), Rural Health Clinics RHC's, Individual Practitioners in solo (non-group) practice, professional Group practices, ambulance, pharmacies, durable medical equipment, medical supply (DME) providers, laboratories, Diagnostic facilities and Vision and eyewear providers.

The National Provider Identifier (NPI) is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the billing loop on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the billing loop of the electronic claim until further notice. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

NPI is required on all crossover claims submitted to ODJFS.

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	85	Billing Provider

NM102	Entity Type Qualifier	R	1/1	ID	1	Person
					2	Non-Person Entity
						When the billing provider is a group professional practice the 2310B loop must be completed.
NM109	Identification Code	R	2/80	AN		For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.
						Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

## REF – Billing Provider Secondary Identification – Page 87 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 20

Loop ID: 2010AA

Example: REF\*1D\*1234567~

**NOTE: The NPI is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the billing loop on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the billing loop of the electronic claim until further notice. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.**

**For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.**

**Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
REF01	Reference Identification Qualifier	R	2/3	ID	1D EI SY	Medicaid Provider Number  Employer's Identification Number  Social Security Number
REF02	Reference Identification	R	1/30	AN		For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.  Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

## NM1 – Pay-to Provider Name – Page 95 HIPAA 837P Imp Guide

Usage: Optional

Segment Max Use within Transaction: 1

Loop ID: 2010AB

Example: NM1\*87\*1\*DOE\*JOHN\*\*\*\*XX\*4442222333~

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

When the 2010AA loop is submitted without the 2010AB loop the information in the 2010AA loop is used. Then the 2010AA loop is submitted with the 2010AB loop then the information in the 2010AB loop is used.

For most providers billing on an 837P, the billing provider, pay to provider, and rendering provider are the same provider. For group professional practices the rendering provider is always different from the billing and/or pay-to provider so the 2310B loop must also be submitted.

The NPI for the following providers must be included in this segment: FFS Clinics, Hospice, Home Health Agencies, and Waiver Providers, Ambulatory Surgery Centers, FQHC's, RHC's, Individual Practitioners in solo (non-group) practice, professional Group practices, ambulance, pharmacies, durable medical equipment, medical supply (DME) providers, laboratories, Diagnostic facilities and Vision and eyewear providers.

The NPI is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the billing loop on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the billing loop of the electronic claim until further notice. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

NPI is required on all crossover claims submitted to ODJFS.

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	87	Pay-to Provider

NM109	Identification Code	R	2/80	AN	<p>For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.</p> <p>Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.</p>
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## REF – Pay-to-Provider Secondary Identification – Page 101 HIPAA 837P Imp Guide

Usage: Optional

Segment Max Use within Transaction: 20

Loop ID: 2010AB

Example: REF\*1D\*1234567~

**NOTE: The NPI is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the billing loop on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the billing loop of the electronic claim until further notice. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.**

**For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.**

**Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
REF01	Reference Identification Qualifier	R	2/3	ID	1D	Medicaid Provider Number
					EI	Employer's Identification Number
					SY	Social Security Number
REF02	Reference Identification	R	1/30	AN		For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.  Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

## HL - Subscriber Hierarchical Level – Page 103 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2000B

Example: HL\*2\*1\*22\*0~

**NOTE: For Ohio Medicaid, the “insured”, “subscriber” and the ”patient” are always the same person.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
HL03	Hierarchical Level Code	R	1/2	ID	22	Subscriber - Identifies the employee or group member who is covered for insurance and to whom, or on behalf of whom, the insurer agrees to pay benefits
HL04	Hierarchical Child Code	R	1/1	ID	0	No Subordinate HL in This Hierarchical Structure

## SBR – Subscriber Information – Page 105 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2000B

Example: SBR\*S\*18\*GRP01020102\*\*\*\*\*MC~

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
SBR01	Payer Responsibility Sequence Number Code	R	1/1	ID	P S T	P Primary S Secondary T Tertiary  When there is other payer liability for this claim, ODJFS expects the SBR01 to be either "S or T". This condition includes an ODJFS supplemental payment to a FQHC or RHC.
SBR02	Individual Relationship Code	R	2/2	ID	18	Self  Required for Medicaid, the subscriber is always the same person as the patient.
SBR09	Claim Filing Indicator Code	S	1/2	ID	MC	Since Medicaid is the destination payer "MC" must be submitted.

## NM1 – Subscriber Name – Page 112 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2010BA

Example: NM1\*IL\*1\*DOE\*JOHN\*T\*\*JR\*MI\*123456789123~

**NOTE: No claim can be paid if the NM109 does not contain a valid 12-digit Medicaid recipient billing number or the Ohio Disability Assistance billing number.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	IL	Insured or Subscriber
NM108	Identification Code Qualifier	R	1/2	ID	MI	Member Identification Number
NM109	Identification Code	R	2/80	AN		12-digit Medicaid recipient billing number or the Ohio Disability Assistance Billing number.

## NM1 – Payer Name – Page 124 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2010BB

Example: NM1\*PR\*2\*OH DEPT OF JOB AND FAMILY SERV\*\*\*\*\*PI\*MMISODJFS~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	PR	Payer
NM109	Payer Identifier	R	2/80	AN	MMISODJFS	

## CLM – Claim Information – Page 160 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2300

Example: CLM\*A37YH556\*500\*\*\*11::1\*Y\*A\*Y\*Y\*C~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
CLM02	Total Claim Charge Amount	R	1/18	R		Total claim charges must be equal to the sum of all line item charges. For Third Party Liability (TPL) claims total charges must balance.

## DTP – Initial Treatment Date – Page 170 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 150

Loop ID: 2300

Example: DTP\*454\*D8\*19970607~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
DTP01	Date/Time Qualifier	R	3/3	ID	454	Initial Treatment – Date medical treatment first began
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		

**DTP – Date, Onset of Current Illness/Symptom – Page 174 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 150

Loop ID: 2300

Example: DTP\*431\*D8\*19970607~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
DTP01	Date/Time Qualifier	R	3/3	ID	431	Onset of Current Symptoms or Illness – Date first symptoms appeared
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		ODJFS does not accept date ranges.

## DTP – Date, Similar Illness/Symptom Onset – Page 178 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 150

Loop ID: 2300

Example: DTP\*438\*D8\*19970607~

Element	Name	Use	ATTRIBUTES			Comments
			Min/Max	Data Type	Codes/Values	
DTP01	Date/Time Qualifier	R	3/3	ID	438	Onset of Similar Symptoms or Illness – Date symptoms related to current illness first appeared.
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		ODJFS does not accept date ranges.

## DTP – Date, Accident – Page 180 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 150

Loop ID: 2300

Example: DTP\*439\*D8\*19970607~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
DTP01	Date/Time Qualifier	R	3/3	ID	439	Accident – Date mishap occurred
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		ODJFS does not accept date ranges

## DTP – Date, Last Menstrual Period – Page 182 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 150

Loop ID: 2300

Example: DTP\*484\*D8\*19970607~

Element	Name	Use	ATTRIBUTES			Comments
			Min/Max	Data Type	Codes/Values	
DTP01	Date/Time Qualifier	R	3/3	ID	484	Last Menstrual Period
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		ODJFS does not accept date ranges

## DTP – Date, Last X-ray – Page 183 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 150

Loop ID: 2300

Example: DTP\*455\*D8\*19970607~

Element	Name	Use	ATTRIBUTES			Comments
			Min/Max	Data Type	Codes/Values	
DTP01	Date/Time Qualifier	R	3/3	ID	455	Last X-ray – Date of the most recent x-ray.
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		ODJFS does not accept date ranges

## DTP – Date, Hearing and Vision Prescription Date – Page 185 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 150

Loop ID: 2300

Example: DTP\*471\*D8\*19970115~

**NOTE: Date the eyeglass vendor receives order. This segment is used exclusively by eyeglass vendors.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
DTP01	Date/Time Qualifier	R	3/3	ID	471	
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		

## DTP – Date Discharge – Page 195 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 150

Loop ID: 2300

Example: DTP\*096\*D8\*19970115~

**NOTE: Required for Home Health and Private Duty Nursing Providers when billing services provided as a result of a post-hospital stay.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
DTP01	Date/Time Qualifier	R	3/3	ID	096	Discharge
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		

## AMT – Patient Amount Paid – Page 205 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 40

Loop ID: 2300

Example: AMT\*F5\*0~

**NOTE: Patient Amount Paid should be zero.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
AMT01	Amount Qualifier Code	R	1/3	ID	F5	Patient Amount Paid

**REF – Prior Authorization or Referral Number – Page 214 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 30

Loop ID: 2300

Example: REF\*G1\*13579~

**NOTE: Only certain services require Prior Authorization. See Ohio Medicaid Handbooks for more information about services requiring Prior Authorization.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
REF01	Reference Identification Qualifier	R	2/3	ID	G1	Prior Authorization Number ODJFS only uses G1 in Claims Processing
REF02	Reference Identification	R	1/30	AN		Use the prior authorization number issued by ODJFS

**REF – Original Reference Number (ICN/DCN) – Page 216 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 30

Loop ID: 2300

Example: REF\*F8\*12345678912345678~

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

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
REF01	Reference Identification Qualifier	R	2/3	ID	F8	Original Reference Number
REF02	Reference Identification	R	1/30	AN		The value is the unique 13-digit interChange control number (ICN) assigned by Medicaid to the original claim. The format of this 13-digit ICN should not include any spaces or hyphens.

**REF – Clinical Laboratory Improvement Amendment (CLIA) Number – Page 218 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 30

Loop ID: 2300

Example: REF\*X4\*12D4567890~

**NOTE: Under Ohio Medicaid, only the provider performing the test can bill for the service.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
REF01	Reference Identification Qualifier	R	2/3	ID	X4	Clinical Laboratory Improvement Amendment Number
REF02	Reference Identification	R	1/30	AN		

## REF – Demonstration Project Identifier– Page 229 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 30

Loop ID: 2300

Example: REF\*P4\*THJ1222~

**NOTE: At this time ODJFS does not have programs with demonstration project identifiers.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
REF01	Reference Identification Qualifier	R	2/3	ID	P4	Project Code
REF02	Reference Identification	R	1/30	AN		

**NTE – Claim Note – Page 233 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 20

Loop ID: 2300

Example: NTE\*ADD\*COPAY PREG~

**NOTE: Use this segment to report Ohio Medicaid Co-payment exclusions. When a Medicaid Schools Program claim is submitted, the 10 character code (see Application Value List below) must be the first item listed in the NTE02. There must always be a single space between the word ATTEST and the three character exclusion code.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NTE01	Note Reference Code	R	3/3	ID	ADD	Additional Information
					CER	Certification narrative
NTE02	Description	R	1/80	AN		<p>When a Medicaid co-payment exclusion applies, the 10 character code (see Application Value List below) must be the first item listed in the NTE02. There must always be a single space between the word COPAY and the four character exclusion code.</p> <p>Application Value List:                      COPAY EMER (Emergency)                      COPAY HSPC (Hospice)                      COPAY PREG (Pregnancy)</p> <p>When a Medicaid Schools Program claim is submitted, the 10 character code (see Application Value List below) must be the first item listed in the NTE02. There must always be a single space between the word ATTEST and the three character exclusion code.</p> <p>Application Value List:                      ATTEST NAY                      ATTEST YES</p>

## HI – Health Care Diagnosis Code – Page 254 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 25

Loop ID: 2300

Example: HI\*BK:8901\*BF:87200\*BF:5559~

**NOTE: Used for claim processing except for laboratory, diagnostic facilities, portable x-ray, and waiver claims.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
HI01-2	Diagnosis Code	R	1/30	AN		Submit the Principle Diagnosis Code to the highest level of specificity for the date of service.  Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.

## NM1 – Referring Provider Name – Page 271 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2310A

Example: NM1\*DN\*1\*WELBY\*MARCUS\*W\*\*JR\*34\*444332222~

**NOTE: ODJFS requires a referring provider number for claims for individuals enrolled in the PACT program when the rendering provider is not the designated PACT provider. This segment must also be completed for all physician consultation codes and pathology and clinical laboratory consultation codes.**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. The referring provider loop is situational, depending on the claim type. If the loop is present in the 837, ODJFS will deny any claims that do not include the NPI in the loop. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the referring provider loop of the electronic claim until further notice. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

The 9111115 value is no longer an ODJFS acceptable value. Do not use 9111115 in this field.

If the referring entity or provider is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the referring entity or provider. If the attempt is not successful, the billing provider may use the NPI Registry (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) to obtain the referring entity or provider's NPI to enter it on the claim.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	DN	Referring Provider
					P3	Primary Care Provider
NM109	Identification Code	R	2/80	AN		If the referring entity or provider is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the referring entity or provider. If the attempt is not successful, the billing provider may use the NPI Registry ( <a href="https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do">https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do</a> ) to obtain the referring entity or provider's NPI to enter it on the claim.

					<p>The 9111115 value is no longer an ODJFS acceptable value. Do not use 9111115 in this field.</p> <p>For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.</p> <p>Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.</p>
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## REF – Referring Provider Secondary Identification – Page 276 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 20

Loop ID: 2310A

Example: REF\*1D\*1234567~

**NOTE: ODJFS requires a referring provider number for claims for individuals enrolled in the PACT program when the rendering provider is not the designated PACT provider. This segment must also be completed for all physician consultation codes and pathology and clinical laboratory consultation codes.**

The 9111115 value is no longer an acceptable value. Do not use 9111115 in this field.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
REF01	Reference Identification Qualifier	R	2/3	ID	1D EI SY	Medicaid Provider Number Employer's Identification Number Social Security Number
REF02	Reference Identification	R	1/30	AN		The 9111115 value is no longer an acceptable value. Do not use 9111115 in this field.  For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.  Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

## NM1 - Rendering Provider Name – Page 278 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2310B

Example: NM1\*82\*1\*BEATTY\*GARY\*C\*\*SR\*34\*123456789~

**NOTE: The 2310B Rendering Provider loop is always required when the NPI in the 2010AA and/or 2010AB loops is for a professional group practice. Professional group practices enrolled under the Ohio Medicaid program include provider types physician group, osteopath group, dentist group, Advanced Practice nurse (APN) group, optometrist group, podiatrist group, chiropractor group, mechanotherapist group, physical therapist group, psychologist group, chiromechanotherapist group.**

**This loop is also required when a hospice organization or an Ambulatory Surgery Center (ASC) is seeking payment for physician or APN professional services. No rendering provider loop should be submitted for hospice per diem payments or ASC facility payments.**

**No other 837P transactions (e.g., Clinics, FQHCs, RHCs, OHFs, Ambulatory Surgery Centers, Laboratories) require the rendering provider loop. If the REF02 of the 2310B is completed for other 837P transactions, the provider number must match the numbers submitted in the 2010AA and/or 2010AB loops to assure claims will pay correctly.**

**The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the rendering provider field, if required on a claim. Although the Medicaid legacy ID is not required, ODJFS will continue to accept claims that contain both NPI and the Medicaid legacy ID in the rendering provider field. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected**

**For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.**

**A claim that contains an NPI that does not pass check digit validation WILL DENY.**

**Atypical providers should send their EIN or SSN in the NM1 segment.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	82	Rendering Provider
NM109	Identification Code	R	2/80	AN		For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

						<p>A claim that contains an NPI that does not pass check digit validation WILL DENY.</p> <p>Atypical providers should send their EIN or SSN in the NM1 segment.</p>
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## **PRV – Rendering Provider Specialty Information – Page 281 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2310A

Example: PRV\*PE\*ZZ\*208D00000X~

**NOTE: ODJFS does not require provider taxonomy codes.**

## REF - Rendering Provider Secondary Identification – Page 283 HIPAA 837P Imp Guide

Usage: Optional

Segment Max Use within Transaction: 20

Loop ID: 2310B

Example: REF\*1D\*1234567~

**NOTE: The 2310B Rendering Provider loop is always required when the NPI in the 2010AA and/or 2010AB loops is for a professional group practice. Professional group practices**

**enrolled under the Ohio Medicaid program include provider types physician group (21), osteopath group (23), dentist group (31), Advanced Practice nurse (APN) group (57), optometrist group (61), podiatrist group (62), Chiropractor group (63), mechanotherapist group (64), physical therapist group (66), psychologist group (67), chiromechanotherapist group (68).**

**Also required for payment of physician or APN professional services submitted by hospices or ASCs. Do not submit a rendering provider number for hospice per diem payments or ASC facility payments.**

**No other 837P transactions require a rendering provider number. If the REF02 of the 2310B is completed for other 837P transactions, the provider number must match the numbers submitted in the 2010AA and/or 2010AB loops to assure claims will pay correctly.**

**The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the rendering provider field, if required on a claim. Although the Medicaid legacy ID is not required, ODJFS will continue to accept claims that contain both NPI and the Medicaid legacy ID in the rendering provider field. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.**

**For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.**

**A claim that contains an NPI that does not pass check digit validation WILL DENY.**

**Atypical providers should send their EIN or SSN in the NM1 segment.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
REF01	Reference Identification Qualifier	R	2/3	ID	1D	Medicaid Provider Number
					EI	Employer's Identification Number
					SY	Social Security Number
REF02	Reference Identification	R	1/30	AN		For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can

					<p>send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.</p> <p>A claim that contains an NPI that does not pass check digit validation WILL DENY.</p> <p>Atypical providers should send their EIN or SSN in the NM1 segment.</p>
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**SBR – Other Subscriber Information – Page 303 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2320

Example: SBR\*S\*01\*GR00786\*\*MC\*\*\*\*MB~

**NOTE: Required whenever an individual is also covered by Medicare part A, B, or C and/or is covered under another third party payer.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
SBR01	Payer Responsibility Sequence Number Code	R	1/1	ID	P	P Primary
					S	S Secondary
					T	T Tertiary
SBR09	Claim Filing Indicator Code	S	1/2	ID		Required on all Part B and Part C Crossover claims. Must submit MB for Part B and 16 for Part C.

**CAS – Claim Level Adjustments – Page 308 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 99

Loop ID: 2320

Example: CAS\*PR\*1\*7.93~

**NOTE: All Medicare Part A, Medicare Part B, Medicare Part C, and all TPL claims submitted to ODJFS must contain, at a minimum, the CAS codes and associated monetary amounts issued by the payer who adjudicated the claim immediately prior to submitting the claim to ODJFS. The sum of the CAS code monetary amounts (2320 and 2430 loops) and the payer paid amount must balance to equal the total billed charges. ODJFS requires the claim to be adjudicated by all other payers prior to submitting the claim.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
CAS01	Claim Adjustment Group Code	R	1/2	ID	CO	Contractual Obligations
					CR	Correction and Reversals
					OA	Other adjustments
					PI	Payer Initiated Reductions
					PR	Patient Responsibility

**AMT – Coordination of Benefits (COB) Payer Paid Amount – Page 317 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 15

Loop ID: 2320

Example: AMT\*D\*152~

**NOTE: Required on all COB claims.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
AMT01	Amount Qualifier Code	R	1/3	ID	D	Payer Amount Paid

**AMT – Coordination of Benefits (COB) Approved Amount – Page 318 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 15

Loop ID: 2320

Example: AMT\*AAE\*150.45~

**NOTE: All COB Claims (Medicare Part A, B, or C Crossover and TPL Claims) must have either an AMT01 or AAE or B6 and a coinciding monetary amount in AMT02. Crosswalk the AMT02 amount from the 835 CLP from the other payer(s). In cases when claims are not adjudicated by the other payer (e.g., when payment is under a capitation payment arrangement), the monetary amount may be zero.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
AMT01	Amount Qualifier Code	R	1/3	ID	AAE	Approved Amount

**AMT – Coordination of Benefits (COB) Allowed – Page 319 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 15

Loop ID: 2320

Example: AMT\*B6\*200.55~

**NOTE: All COB Claims (Medicare Part A, B, or C Crossover and TPL Claims) must have either an AMT01 or AAE or B6 and a coinciding monetary amount in AMT02. Crosswalk the AMT02 amount from the 835 CLP from the other payer(s). In cases when claims are not adjudicated by the other payer (e.g., when payment is under a capitation payment arrangement), the monetary amount may be zero.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
AMT01	Amount Qualifier Code	R	1/3	ID	B6	Allowed – Actual – Amount considered for payment under the provisions of the contract.

**AMT – Coordination of Benefits (COB) Patient Paid Amount – Page 324 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 15

Loop ID: 2320

Example: AMT\*F5\*0~

**NOTE: Patient Paid Amount should be zero.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
AMT01	Amount Qualifier Code	R	1/3	ID	F5	Patient Amount Paid – Monetary amount value already paid by one receiving medical care.

## NM1 – Other Payer Name – Page 343 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2330B

Example: NM1\*PR\*2\*UNION MUTUAL OF OREGON\*\*\*\*\*PI\*1122333~

**NOTE: Special Note for FQHC/RHC supplemental payments.**

**FQHC/RHC: PI (Payer information) must be submitted on all Federally Qualified Health Center/Rural Health Center (FQHC/RHC) transactions seeking supplemental payments from ODJFS for services rendered to Medicaid Managed Care enrollees. The Medicaid provider number assigned to the Medicaid Managed Care Organization for the subscriber/patient (i.e., Medicaid managed care enrollee) must be submitted in the NM109 of the 2330B loop.**

**Special Note for Medicare Part C (i.e. Medicare Managed Care plan) Crossover Claims.**

**The primary identifier for the Medicare Managed Care Organization (MCO) or a Medicare Health Maintenance Organization (HMO) for the subscriber/patient (i.e., Medicare Managed Care enrollee) must be submitted for a Medicaid cost sharing payment to be made.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	PR	Payer
NM108	Identification Code Qualifier	R	1/2	ID	PI XV	Payer Identification Health Care Financing Administration National Payer Identification Number (PAYERID)
NM109	Identification Code	R	2/80	AN		PI (Payer Identification) is used for Federally Qualified Health Center/Rural Health Center (FQHC/RHC) Medicaid Provider Number.  Special Note for FQHC/RHC supplemental payments.  FQHC/RHC: PI (Payer information) must be submitted on all Federally Qualified Health Center/Rural Health Center (FQHC/RHC) transactions seeking supplemental payments from ODJFS for services rendered to Medicaid Managed Care enrollees. The Medicaid provider number assigned to the Medicaid Managed Care Organization for the subscriber/patient (i.e., Medicaid managed care enrollee) must be submitted in the NM109 of the

					<p>2330B loop.</p> <p>Special Note for Medicare Part C (i.e. Medicare Managed Care plan) Crossover Claims.</p> <p>The primary identifier for the Medicare Managed Care Organization (MCO) or a Medicare Health Maintenance Organization (HMO) for the subscriber/patient (i.e., Medicare Managed Care enrollee) must be submitted for a Medicaid cost sharing payment to be made.</p>
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## DTP – Claim Adjudication Date – Page 349 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 2

Loop ID: 2330B

Example: DTP\*573\*D8\*19970607~

**NOTE: Required on all Coordination of Benefit (COB) claims when the COB exception applies or when the payer identified in this iteration of the 2330 loop has a capitation arrangement with the provider; the date may be no later that 180 days from the date of service.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
DTP01	Date/Time Qualifier	R	3/3	ID	573	Date claim paid
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		

## NM1 – Other Payer Patient Name – Page 357 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2330C

Example: NM1\*QC\*1\*\*\*\*\*MI\*123456789123~

**NOTE: Medicaid billing number for the patient is required in the NM109 when submitting a claim to Medicare or any other primary insurance carrier and the individual is also enrolled in the Medicaid program. In this situation Medicaid is the non-destination payer.**

**This loop is also required when Medicaid is the destination payer for claims for individuals who are also covered under Medicare (A,B,or C) or other third party plans. In this situation the HIC number for a Medicare covered individual or the patient's plan ID for the third party plan must be submitted.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
NM101	Entity Identifier Code	R	2/3	ID	QC	Patient – individual receiving medical care.
NM109	Identification Code	R	2/80	AN		<p>Medicaid billing number for the patient is required in the NM109 when submitting a claim to Medicare or any other primary insurance carrier and the individual is also enrolled in the Medicaid program. In this situation Medicaid is the non-destination payer.</p> <p>This loop is also required when Medicaid is the destination payer for claims for individuals who are also covered under Medicare (A,B,or C) or other third party plans. In this situation the HIC number for a Medicare covered individual or the patient's plan ID for the third party plan must be submitted.</p>

## SV1 – Professional Service – Page 383 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 1

Loop ID: 2400

Example: SV1\*HC:99211:25\*12.25\*UN\*1\*11\*\*1:2:3\*\*N~

**NOTE: For the Medicaid Schools Program (MSP), the service code for Targeted Case Management, T1017, cannot be billed on the same claim as any other MSP service code.**

**If T1017 is billed on the same claim as another MSP service code, the claim will be denied and the provider will have to resubmit the services on separate claims.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
SV101-01	Product/Service ID Qualifier	R	2/2	ID		For the Medicaid Schools Program (MSP), the service code for Targeted Case Management, T1017, cannot be billed on the same claim as any other MSP service code. If T1017 is billed on the same claim as another MSP service code, the claim will be denied and the provider will have to resubmit the services on separate claims.
SV101-03	Procedure Modifier	S	2/2	AN		There will be specific situations for which Medicaid requires the use of multiple modifiers or requires at least one modifier for reimbursement. Refer to the Medicaid Handbook for policies pertaining to modifiers.
SV104	Quantity	R	1/15	R		For many codes only a unit of "1" is allowed.  Anesthesia services, drug codes and codes defined as each nerve, each 15 minutes, each digit, etc, may come in as multiple units unless otherwise indicated in the Ohio Medicaid Handbook.  Special Note for Home Health, private duty nursing, nursing and daily living, personal care, or attendant care providers: Each unit entered in this element denotes fifteen minutes. The number of units submitted may not exceed the length of a visit. Each visit must be separated in a separate service line loop.
SV111	Yes/No Condition or Response Code	S	1/1	ID		Required if Medicaid services are the result of a screening referral. Must be completed for all referrals made under the EPSDT program.
SV112	Yes/No Condition or Response Code	S	1/1	ID		Must be completed on all family planning related procedures.

## **CRC – Hospice Employee Indicator – Page 411 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 3

Loop ID: 2400

Example: CRC\*70\*Y\*65~

**NOTE: Required by HIPAA for Hospice claims. This must be completed when the hospice is submitting claims for physician services. Under Medicaid the provider assigned to the Medicaid provider number submitted in the REF02 of the 2310B must be employed by the hospice for reimbursement to be made to the hospice.**

## DTP – Date – Service Date – Page 416 HIPAA 837P Imp Guide

Usage: Required

Segment Max Use within Transaction: 15

Loop ID: 2400

Example: DTP\*472\*D8\*19970607~

**NOTE: Medicaid does not allow date ranges even for drug services. The date of administration of the drug must be used. Drugs dispensed for administration at home may not be submitted on the 837 Professional.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
DTP01	Date/Time Qualifier	R	3/3	ID	472	Service – Begin and end dates of the service being rendered
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	D8 Date Expressed in Format CCYYMMDD  For Ohio Medicaid only D8 is valid. Medicaid does not allow date ranges. Billed procedures must be itemized separately for each date of service. This policy is applicable for home health and hospice claims even though other payers permit date span billing.
DTP03	Date Time Period	R	1/35	AN		

**DTP – Date – Shipped – Page 430 HIPAA 837P Imp Guide**

Usage: Required

Segment Max Use within Transaction: 15

Loop ID: 2400

Example: DTP\*011\*D8\*19970607~

**NOTE: Date that eyeglasses were shipped. Required on all vision eyewear claims to denote the date the eyeglasses were dispensed.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
DTP01	Date/Time Qualifier	R	3/3	ID	011	Shipped
DTP02	Date Time Period Format Qualifier	R	2/3	ID	D8	Date Expressed in Format CCYYMMDD
DTP03	Date Time Period	R	1/35	AN		

## DTP – Date – Acute Manifestation – Page 435 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2400

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
DTP01	Date/Time Qualifier	R	3/3	ID	453	Acute Manifestation of a Chronic Condition Date serious symptoms were exhibited for a long term illness

## REF - Prior Authorization or Referral Number – Page 448 HIPAA 837P Imp Guide

Usage: Optional

Segment Max Use within Transaction: 30

Loop ID: 2400

Example: REF\*G1\*1234567~

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
REF01	Reference Identification Qualifier	R	2/3	ID	G1	ODJFS only uses G1 in Claims Processing.
REF02	Reference Identification	R	1/30	AN		

## REF – Line Item Control Number – Page 450 HIPAA 837P Imp Guide

Usage: Optional

Segment Max Use within Transaction: 30

Loop ID: 2400

Example: REF\*6R\*1234567~

**NOTE: Returned on 835**

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
REF01	Reference Identification Qualifier	R	2/3	ID	6R	Provider Control Number – Number assigned by information provider company for tracking and billing purposes
REF02	Reference Identification	R	1/30	AN		

**REF- Clinical Laboratory Improvement Amendment (CLIA) Identification – Page 454 HIPAA 837P Imp Guide**

Usage: Optional

Segment Max Use within Transaction: 30

Loop ID: 2400

Example: REF\*X4\*12D4567890~

**NOTE: Required for all non-CLIA exempt clinical laboratory procedures and for a few radiology procedures covered under CLIA.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
REF01	Reference Identification Qualifier	R	2/3	ID	X4	Clinical Laboratory Improvement Amendment Number
REF02	Reference Identification	R	1/30	AN		

**REF – Referring CLIA Facility Identification – Page 456 HIPAA 837P Imp Guide**

Usage: Optional

Segment Max Use within Transaction: 30

Loop ID: 2400

Example: REF\*F4\*34D1234567~

**NOTE: Required for Medicaid claims when laboratory services are referred to another laboratory covered by the CLIA Act. With the exception of hospitals, Medicaid providers should not be billing for referred laboratory services.**

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
REF01	Reference Identification Qualifier	R	2/3	ID	F4	Facility Certification Number – A unique number assigned to qualifying facilities to perform services
REF02	Reference Identification	R	1/30	AN		

## AMT – Approved Amount – Page 464 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 15

Loop ID: 2400

Example: AMT\*AAE\*250~

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
AMT01	Amount Qualifier Code	R	1/3	ID	AAE	Approved Amount

## LIN – Drug Identification – Page 480 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2410

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
LIN01	Assigned Identification	N/U	1/20	AN		
LIN02	Product/Service ID Qualifier	R	2/2	ID	N4	National Drug Code in 5-4-2 Format 5-digit manufacturer ID, 4-digit product ID, 2-digit trade package Size
LIN03	Product/Service ID	R	1/48	AN		

## NM1 - Rendering Provider Name – Page 488 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2420A

Example: NM1\*82\*1\*BEATTY\*GARY\*C\*\*SR\*XX\*4443332222~

**NOTE:** If a rendering provider number is required by ODJFS and the NM109 of the 2310B and the 2420A loops are also not present, the service line will be denied.

If a rendering provider number is required by ODJFS and the REF02 of the 2310B loop contains the NPI assigned to the individual practitioner, all the service lines billed in the 2400 loop will be attributed to this rendering provider, even if a different rendering provider number is given in the NM109 of the 2420A loop.

If a rendering provider is required by ODJFS and the NM109 of the 2310B loop is blank but the NM109 of the 2420A loop contains the NPI of the individual practitioner(s) (i.e., the rendering provider within a group practice), all the service lines billed will be attributed to the rendering provider NPI listed for the first service line in the 2400 loop, even if a different rendering provider number is given in the NM109 of the 2420A loop for any subsequent service line (i.e., service lines 2, 3, 4.....,etc.) contained in the 2400 loop.

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the rendering provider field, if it is required on a claim. Although the Medicaid legacy ID is not required, ODJFS will continue to accept claims that contain both NPI and the Medicaid legacy ID in the rendering provider field. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment.

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	82	Rendering Provider
NM109	Identification Code	R	2/80	AN		For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.  A claim that contains an NPI that does not pass check digit validation WILL DENY.

						Atypical providers should send their EIN or SSN in the NM1 segment.
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## **PRV – Rendering Provider Specialty Information – Page 491 HIPAA 837P Imp Guide**

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2420A

Example: PRV\*PE\*ZZ\*208D00000X~

**NOTE: For ODJFS, adjudication is not impacted by the taxonomy code. ODJFS does require the use of certain modifiers to denote the type of healthcare provider who rendered the services incident to the rendering provider. (E.G. APN Services, physician assistants, psychologists, social workers, clinical counselors, etc..)**

## REF - Rendering Provider Secondary Identification - Page 493 HIPAA 837P Imp Guide

Usage: Optional

Segment Max Use within Transaction: 20

Loop ID: 2420A

Example: REF\*1D\*1234567~

**NOTE:** If a rendering provider number is required by ODJFS and the NM109 of the 2310B and the 2420A loop is also blank, the service line will be denied.

If a rendering provider number is required by ODJFS and the REF02 of the 2310B loop contains the NPI assigned to the individual practitioner, all the service lines billed in the 2400 loop will be attributed to this rendering provider, even if a different rendering provider number is given in the NM109 of the 2420A loop.

If a rendering provider is required by ODJFS and the NM109 of the 2310B loop is blank but the NM109 of the 2420A loop contains the NPI of the individual practitioner(s) (i.e., the rendering provider within a group practice), all the service lines billed will be attributed to the rendering provider NPI listed for the first service line in the 2400 loop, even if a different rendering provider number is given in the NM109 of the 2420A loop for any subsequent service line (i.e., service lines 2, 3, 4.....,etc.) contained in the 2400 loop.

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the rendering provider field, if required on a claim. Although the Medicaid legacy ID is not required, ODJFS will continue to accept claims that contain both NPI and the Medicaid legacy ID in the rendering provider field. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the

NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.

Atypical providers should send their EIN or SSN in the NM1 segment.

Element	Name	Use	ATTRIBUTES			Comments
			Min/Max	Data Type	Codes/Values	
REF01	Reference Identification Qualifier	R	2/3	ID	1D	Medicaid Provider Number
					EI	Employer's Identification Number
					SY	Social Security Number

REF02	Reference Identification	R	1/30	AN		<p>For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.</p> <p>Atypical providers should send their EIN or SSN in the NM1 segment.</p>
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## NM1 – Referring Provider Name – Page 524 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 1

Loop ID: 2420F

Example: NM1\*DN\*1\*WELBY\*MARCUS\*W\*\*JR\*34\*444332222~

**NOTE: ODJFS will not use this field in the adjudication of the claim unless the Ohio Medicaid program requires a referring provider number for the provider and category of service type, and the NM109 of the 2310A loop is blank. Note, completion of this loop is only required by ODJFS for claims coming in from professional group practices and only when the referring provider number was not submitted in the NM109 of the 2310A loop. See special note in the NM109 element of the 2310A loop for the list of professional group practices.**

If a referring provider number is required by ODJFS and the NM109 of the 2310A and the 2420F loop is also blank, the service line will be denied.

If a referring provider number is required by ODJFS and the REF02 of the 2310A loop contains an NPI assigned to the individual practitioner, all the service lines billed in the 2400 loop will be attributed to this referring provider, even if a different referring provider number is given in the NM109 of the 2420F loop.

If a referring provider is required by ODJFS and the NM109 of the 2310A loop is blank but the NM109 of the 2420F loop contains the NPI of the individual practitioner(s) (i.e., the referring provider within a group practice), all the service lines billed will be attributed to the referring provider number listed for the first service line in the 2400 loop, even if a different referring provider number is given in the NM109 of the 2420F loop for any subsequent service line (i.e., service lines 2, 3, 4.....,etc.) contained in the 2400 loop.

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. The referring provider loop is situational, depending on the claim type. If the loop is present in the 837, ODJFS will deny any claims that do not include the NPI in the loop. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the referring provider loop of the electronic claim until further notice. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

If the referring entity or provider is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the referring entity or provider. If the attempt is not successful, the billing provider may use the NPI Registry (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) to obtain the referring entity or provider's NPI to enter it on the claim.

The 9111115 value is no longer an ODJFS acceptable value. Do not use 9111115 in this field.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
NM101	Entity Identifier Code	R	2/3	ID	DN P3	Referring Provider Primary Care Provider
NM109	Identification Code	R	2/80	AN		<p>The 9111115 value is no longer an ODJFS acceptable value. Do not use 9111115 in this field.</p> <p>For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.</p> <p>Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.</p>

## REF – Referring Provider Secondary Identification – Page 529 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 20

Loop ID: 2420F

Example: REF\*1D\*1234567~

**NOTE: ODJFS will not use this field in the adjudication of the claim unless the Ohio Medicaid program requires a referring provider number for the provider and category of service type, and the NM109 of the 2310A loop is blank. Note, completion of this loop is only required by ODJFS for claims coming in from professional group practices and only when the referring provider number was not submitted in the NM109 of the 2310A loop. See special note in the NM109 element of the 2310A loop for the list of professional group practices.**

If a referring provider number is required by ODJFS and the NM109 of the 2310A and the 2420F loop is also blank, the service line will be denied.

If a referring provider number is required by ODJFS and the REF02 of the 2310A loop contains an NPI assigned to the individual practitioner, all the service lines billed in the 2400 loop will be attributed to this referring provider, even if a different referring provider number is given in the NM109 of the 2420F loop.

If a referring provider is required by ODJFS and the NM109 of the 2310A loop is blank but the NM109 of the 2420F loop contains the NPI of the individual practitioner(s) (i.e., the referring provider within a group practice), all the service lines billed will be attributed to the referring provider number listed for the first service line in the 2400 loop, even if a different referring provider number is given in the NM109 of the 2420F loop for any subsequent service line (i.e., service lines 2, 3, 4.....,etc.) contained in the 2400 loop.

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. The referring provider loop is situational, depending on the claim type. If the loop is present in the 837, ODJFS will deny any claims that do not include the NPI in the loop. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the referring provider loop of the electronic claim until further notice. If it is included, a legacy ID will be validated. An invalid legacy ID will be rejected.

If the referring entity or provider is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the referring entity or provider. If the attempt is not successful, the billing provider may use the NPI Registry (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) to obtain the referring entity or provider's NPI to enter it on the claim.

The 9111115 value is no longer an ODJFS acceptable value. Do not use 9111115 in this field.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

Element	Name	ATTRIBUTES				Comments
		Use	Min/Max	Data Type	Codes/Values	
REF02	Reference Identification	R	1/30	AN		<p>The 9111115 value is no longer an acceptable value. Do not use 9111115 in this field.</p> <p>For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop with the EI or SY qualifier code.</p> <p>Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.</p>

## CAS – Level Adjustments – Page 540 HIPAA 837P Imp Guide

Usage: Situational

Segment Max Use within Transaction: 99

Loop ID: 2430

Example: CAS\*PR\*1\*7.93~

**NOTE: All Medicare Part A, Medicare Part B, Medicare Part C, and all TPL claims submitted to ODJFS must contain, at a minimum, the CAS codes and associated monetary amounts issued by the payer who adjudicated the claim immediately prior to submitting the claim to ODJFS. The sum of the CAS code monetary amounts (2320 and 2430 loops) and the payer paid amount must balance to equal the total billed charges.**

Generally, ODJFS requires the claim to be adjudicated by all other payers prior to submitting the claim to ODJFS. ODJFS makes a few exceptions to this policy. These exceptions are set forth in the 837P Addendum entitled, "Special Instructions for Electronic Data Interchange (EDI) Coordination of Benefits (COB) 837P Claims."

Element	Name	ATTRIBUTES				Comments
		Use	Min/ Max	Data Type	Codes/ Values	
CAS01	Claim Adjustment Group Code	R	1/2	ID	CO	Contractual Obligations
					CR	Correction and Reversals
					OA	Other adjustments
					PI	Payer Initiated Reductions
					PR	Patient Responsibility