



MMIS Replacement Project (MRP)

Health Care Claim Institutional (837) Transaction Standard Companion Guide

Companion to Health Care Claim ASC X12N 837 005010X223 Implementation Guide

Month 202X

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Disclosure Statement

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Preface

This Companion Guide to the Health Care Claims (837s) adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with the State of Mississippi, Division of Medicaid (DOM). Transmissions based on this Companion Guide, used in tandem with the **ASC X12N 837 005010X223 and the associated addendums 005010X223A1 and 005010X223A2; Implementation Guides**, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N 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.

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1. 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 transaction standards enabling the electronic exchange of health information and to adopt specifications for implementing each standard. HIPAA intends to:

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

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

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

1.1. Scope

The Companion Guide is to be used with and supplement the requirements in the HIPAA Accredited Standards Committee (ASC) X12 Implementation Guides. Implementation Guides define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of the Companion Guide is to provide trading partners with a guide to communicate Mississippi Division of Medicaid (MS DOM) specific information required to successfully exchange transactions.

The Companion Guide is intended for the business and technical users, within or on behalf of trading partners, responsible for the testing and setup of electronic claim status request and response transactions to MS DOM.

1.2. Overview

The Companion Guide provides guidance for establishing a relationship with MS DOM for the business purpose of doing Health Care Claims (837s).

1.3. References

This section specifies additional on-line sources of helpful information related to electronic data interchange (EDI) and X12 transactions.

- Workgroup for Electronic Data Interchange (WEDI) – <http://www.wedi.org>
- United States Department of Health and Human Services (DHHS) – <http://aspe.hhs.gov/>
- Centers for Medicare and Medicaid Services (CMS) – <http://www.cms.gov/>
- Designated Standard Maintenance Organizations (DSMO) – <http://www.hipaa-dsmo.org/>
- National Council of Prescription Drug Programs (NCPDP) – <http://www.ncdp.org/>
- National Uniform Billing Committee (NUBC) – <http://www.nubc.org/>

- Washington Publishing Company (WPC) at <http://wpc-edi.com/>
- Accredited Standards Committee (ASC X12) – <http://www.x12.org/>
- Affordable Care Act (ACA) Section 1104 information is at the CMS website. For information on ACA Administrative Simplification information follow this link: <https://www.cms.gov/regulations-and-guidance/HIPAA-Administrative-Simplification/affordable-care-act/operatingrulesforHIPAATransactions.html>

1.4. Additional Information

It is assumed that the trading partner has purchased and is familiar with the ASC X12 Type 3 Technical Report (TR3) being referenced in this Companion Guide. TR3s can be purchased from the ASC X12 store at <http://store.x12.org/store/>.

2. Getting Started

2.1. Working with Mississippi DOM

The Electronic Data Interchange (EDI) Department is available to assist trading partners when questions arise. See [Section 5](#) for details.

2.2. Trading Partner Registration

Trading Partner registration is completed through the secure provider portal. All required fields must be completed, and an electronic signature must be included.

2.3. Certification and Testing Overview

All covered entities who submit electronic transactions are required to certify. This includes Clearing houses, Software Vendors, Provider Groups, and Coordinated Care Organizations (CCOs). Such agencies certify users who submit transactions through them on their behalf. Users who submit transactions directly must be certified. Users who submit transactions through CCOs should receive certification requirement information from the CCO.

3. Testing with the Payer

This section contains a detailed description of the testing phase. Testing is required for the Health Care Claims (837). Before exchanging production transactions with MS DOM, each trading partner must complete production authorization testing. Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

To obtain approval for Production from Mississippi DOM, trading partners are recommended to submit five unique requests, but not to exceed 25 successful and unique submissions and receive the associated 999 (accepted) acknowledgement in response and validate adjudication by downloading and reviewing 835 Electronic Remittance Advice (ERA) in order to obtain approval from Mississippi DOM to promote to Production.

Trading Partner Authorization Testing is detailed in the Trading Partner Profile Testing Packet for ASC X12 transactions available on the MS DOM Training Portal ([https://medicaid.ms.gov/TBD Link "Coming soon"](https://medicaid.ms.gov/TBD Link 'Coming soon')) — click on the MOVEit Portal at [https://fts-npr.msxix.net/TBD Link "Coming soon"](https://fts-npr.msxix.net/TBD Link 'Coming soon') page.

Questions may be directed to the EDI Helpdesk at *1 TBD Toll free number "Coming soon"* or via the "Contact Us" link at the top of the Portal home page at: [https://portal-mod.msxix.net/ms/provider/Home/TBD Link "Coming soon"](https://portal-mod.msxix.net/ms/provider/Home/TBD Link 'Coming soon').

4. Connectivity with the Payer/Communications

Users must register and access the provider portal in order to upload EDI files.

To register/logon to the provider portal, visit:

Mississippi Division of Medicaid Portal for Providers > Home (TBD Link “Coming soon”).

4.1. Passwords

Passwords are provided during initial enrollment and can be reset by contacting Provider Relations – Electronic Claims Submission (ECS) Department at *1 TBD Toll free number “Coming soon”*. These passwords may not be shared.

<https://medicaid.ms.gov/EDI-Support/TBD> Link “Coming soon”.

5. Contact Information

In an effort to assist the community with their electronic data exchange needs, MS DOM has the following options available for either contacting a help desk or referencing a website for further assistance:

- For general information to go Mississippi DOM Website: *<https://medicaid.ms.gov/TBD> Link “Coming soon”*
- For EDI Services (technical, enrollment, or setup questions):
 - E-mail: *Mississippi.TBD@gainwelltechnologies.com*
 - Telephone: *1 TBD Toll free number “Coming soon”*
 - Hours are Monday through Friday from 08:00 AM to 05:00 PM CST.

6. Payer Specific Business Rules and Limitations

Payer specific business rule information regarding MS DOM can be found at the “For Our Providers” webpage on the MS DOM website, *Mississippi Division of Medicaid Portal for Providers > Home (TBD Link “Coming soon”).*

7. Acknowledgements and/or Reports

The acknowledgement process will create the TA1 and 999 acknowledgement responses for the inbound transactions.

8. Trading Partner Agreements

An Electronic Data Interchange (EDI) Trading Partner is defined as any MS DOM customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to or receives electronic data from MS DOM.

Payers have EDI Trading Partner Agreements (TPAs) that accompany the standard Implementation Guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

9. Transaction-Specific Information

This section describes how ASC X12N Implementation Guides (IGs) adopted under HIPAA are detailed in a table. The tables contain a row for each segment that has additional information MS DOM provides that can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite, and simple data elements
5. Any other information tied directly to a loop, segment, composite, or simple data element pertinent to trading electronically with MS DOM

In addition to the row for each segment, one or more additional rows are used to describe MS DOM usage for composite and simple data elements, and any other necessary information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

All MS DOM members are considered “subscribers”, so they all have individual loops. See the Implementation Guide for additional information. Dependent loops for eligibility transactions will not be processed.

9.1. Naming Your Files

When uploading batch files, the submitter must name their files using the following format for processing and tracking purposes:

1. FFS – Use “FFS” tag to identify the batch file as Fee-for-Service.
2. <SubmitterId> – Use the trading partner ID (submitter ID) assigned. This is to be used by all providers, vendors, and clearinghouses submitting batch transactions.
3. <filename> – Assign a file name - preferably something meaningful to receiver such as “270 fee for service”.
4. <datetime>. – Use the date/time value format of yyyyymmddhhmm to uniquely identified the file and avoid duplicate files.
5. <filetypeext> – Use the file type extension to identify the file type (e.g. .txt)

Coordinated Care Organization (CCO) is assigned preferably meaningful to a receiver such as ‘encounter’ followed by unique ID. This is to be used by CCOs submitting encounter claims.

Example:

```
CCO_<SubmitterId>_<filename>_<transaction type>_<datetime>.<ext>
CCO_XXXXXXXXX_ENCOUNTER_x_201611101308.837
<transaction type>
    1 – P – Professional
    2 – I – Institutional
    3 – D - Dental
<datetime>
<ext>
    837
```

10. Conventions

Most of the companion guide is in table format (see example below). Only loops, elements, or segments with clarifications or comments are listed. For further information, please see the TR3 for each transaction.

Table 1. Conventions Sample

Loop ID	Segment/ Element Reference	Loop Name	Codes	Notes/Comments
	837I	Health Care Claim Institutional		
	BHT	Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose Code	00, 18	00 – Original 18 - Reissue For CCO's, use 00 - Original
	BHT06	Transaction Type Code	CH, RP	CH – Chargeable (Fee for Service) RP - Reporting (Encounters)
2100A	NM1	Submitter Name		
	NM101	Entity Identifier Code	41	41 – Submitter
	NM103	Submitter Last Name or Organization Name		Submitter name should be "ADVANTAGE/MEDICARE-PART-C" for Medicare Advantage/ Part-C Claims
	NM109	Submitter Identifier		Value is Trading Partner ID that was provided during the EDI enrollment process.
	NM101	Entity Identifier Code	41	41 – Submitter

Table 2. Conventions Fields

Column Name	Description
Loop ID	Loop, header, or trailer.
Segment/Element Reference	Segment or Element ID.
Loop Name	Name of Loop, header, or trailer.
Codes	Code values.
Note/Comments	Comments or clarifications for Mississippi DOM. Values, data length, and repeats are also listed here. Clarifications in field length only indicate what Mississippi DOM uses or returns to process the transaction. MS DOM still accepts the minimum and maximum field lengths required by the Technical Report Type 3 (TR3) for each element.

10.1. Transaction 837, Health Claim: Institutional

Table 3. Health Care Claim Institutional (837I)

Loop ID	Reference	Name	Codes	Notes/Comments
	837I	Health Care Claim Institutional		
	ISA	Interchange Control Header		
ISA01		Authorization Information Qualifier	00	00 - No Authorization Information Present
ISA03		Security Information Qualifier	00	00 - No Authorization Information Present
ISA05		Interchange ID Qualifier	ZZ	ZZ – Mutually Defined
ISA06		Interchange Sender ID	Trading Partner ID	The Gainwell Technologies Electronic Transaction Identification Number (ETIN) assigned to the submitter is expected in this data element. This is the same as your Mississippi DOM Trading Partner ID
ISA07		Interchange ID Qualifier	ZZ	ZZ – Mutually Defined
ISA08		Interchange Receiver ID	77032	
ISA11		Repetition Separator	^	Caret
ISA12		Interchange Control Version Number	00501	
ISA15		Interchange Usage Indicator		Refer to TR3
ISA16		Component Element Separator	:	Colon
	GS	Functional Group Header		
GS01		Functional Identifier Code		Refer to TR3
GS02		Application Sender's Code	Trading Partner ID	Value should equal ISA06
GS03		Application Receiver's Code	77032	Value should equal ISA08
GS07		Responsible Agency Code	X	
GS08		Version / Release / Industry / Identifier Code	005010X223A2	
	ST	Transaction Set Header		Transactions (ST-SE envelopes) are limited to a maximum of 5000 CLM segments.
ST01		Transaction Set Identifier Code	837	837 – Health Care Claim
ST03		Implementation Convention Reference	005010X223A2	

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Loop ID	Reference	Name	Codes	Notes/Comments
	BHT	Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose Code	00, 18	00 – Original 18 - Reissue For CCO's, use 00 - Original
	BHT06	Transaction Type Code	CH, RP	CH – Chargeable (Fee for Service) RP - Reporting (Encounters)
1000A	NM1	Submitter Name		
	NM101	Entity Identifier Code	41	41 – Submitter
	NM103	Submitter Last Name or Organization Name		Submitter name should be "ADVANTAGE/MEDICARE-PART-C" for Medicare Advantage/ Part-C Claims For Managed Care, value is CCO Organizational Name
	NM109	Submitter Identifier		Value is Trading Partner ID that was provided during the EDI enrollment process
	PER	Submitter EDI Contact Information		
	PER01	Contact Function Code	IC	IC – Information Contact
	PER02	Submitter Contact Name		Refer to TR3
	PER03	Communication Number Qualifier	EM, FX, TE	EM – Electronic Mail FX – Facsimile TE – Telephone
	PER04	Communication Number		Refer to TR3
	PER05	Communication Number Qualifier	EM, EX, FX, TE	EM – Electronic Mail EX – Telephone Extension FX – Facsimile TE – Telephone For CCOs, use the "EM" qualifier to indicate Certification Statement
	PER06	Communication Number		For CCOs, submit the Certification Statement: "TO MY KNOWLEDGE INFORMATION AND BELIEF THE DATA IN THIS FILE IS ACCURATE COMPLETE AND TRUE" NOTE: if Cert not submitted the Encounter would be rejected
1000B	NM1	Receiver Name		
	NM101	Entity Identifier Code	40	40 – Receiver

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Loop ID	Reference	Name	Codes	Notes/Comments
	NM103	Receiver Name	MISSISSIPPI DIVISION OF MEDICAID	
	NM108	Identification Qualifier	46	46 – Electronic Transmitter Identification Number (ETIN)
	NM109	Receiver Primary Identifier	77032	Mississippi Division of Medicaid Health Plan ID.
2000A	HL	Billing Provider Hierarchical Level		
	HL03	Hierarchical Level Code	20	20 – Information
	PRV	Billing Provider Specialty Information		The PRV segment is required by Mississippi Medicaid when the Billing/Pay-to Provider has multiple entities or sub-parts that are represented by a single National Provider Identifier (NPI).
	PRV01	Provider Code	BI	BI – Billing
	PRV02	Reference Identification Qualifier	PXC	PXC - Health Care Provider Taxonomy Code
	PRV03	Provider Taxonomy Code		Value is the 10-byte taxonomy code Note: (Use the taxonomy code that is on file with Mississippi Medicaid for the Billing Provider. This value will be used as a tie breaker when more than 1 Medicaid provider is found on state provider file and to ensure that the claim processes correctly when NPI is used.)
2010AA	NM1	Billing Provider Name		
	NM101	Entity Identifier Code	85	85 – Billing Provider
	NM102	Entity Type Qualifier	2	2 – Non-Person Entity
	NM103	Billing Provider Last or Organization Name		Refer to TR3
	NM104	Billing Provider First Name		Refer to TR3
	NM105	Billing Provider Middle Name or Initial		Refer to TR3
	NM107	Billing Provider Name Suffix		Refer to TR3
	NM108	Identification Code Qualifier	XX	XX - NPI
	NM109	Billing Provider Identifier		Value is 10-digit NPI of Billing Provider
	N3	Billing Provider Address		Required; Billing Provider Address details

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Loop ID	Reference	Name	Codes	Notes/Comments
	N4	Billing Provider City, State, Zip Code		Required; Billing Provider City, State, Zip code
	REF	Billing Provider Tax Identification		
	REF01	Reference Identification Qualifier	EI	EI - Employer's Identification Number
	REF02	Billing Provider Tax Identification Number		Refer to TR3
2000B	HL	Subscriber Hierarchical Level		
	HL03	Hierarchical Level Code	22	22 – Subscriber
	SBR	Subscriber Information		
	SBR01	Payer Responsibility Sequence Number Code	A, B, C, D, E, F, G, H, P, S, T, U	A – Payer Four B – Payer Five C – Payer Six D – Payer Seven E – Payer Eight F – Payer Nine G – Payer Ten H – Payer Eleven P – Primary S – Secondary T – Tertiary U – Unknown
				For CCOs, use T - Tertiary

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Loop ID	Reference	Name	Codes	Notes/Comments
	SBR09	Claim Filing Indicator Code	11, 12, 13, 14, 15, 16, 17, AM, BL, CH, CI, DS, FI, HM, LM, MA, MB, MC, OF, TV, VA, WC, ZZ	11 - Other Non-Federal Programs 12 - Preferred Provider Organization (PPO) 13 - Point of Service (POS) 14 - Exclusive Provider Organization (EPO) 15 - Indemnity Insurance 16 - Health Maintenance Organization (HMO) Medicare Risk 17- Dental Maintenance Organization AM - Automobile Medical BL - Blue Cross/Blue Shield CH - Champus CI - Commercial Insurance Co. DS - Disability FI - Federal Employees Program HM - Health Maintenance Organization LM - Liability Medical MA - Medicare Part A MB - Medicare Part B MC - Medicaid OF - Other Federal Program TV - Title V VA - Veterans Affairs Plan WC - Workers' Compensation Health Claim ZZ - Mutually Defined For CCOs, use ZZ - Mutually Defined

2010BA	NM1	Subscriber Name	
	NM101	Entity Identifier Code	IL
	NM109	Subscriber Primary Identifier	IL - Insured or Subscriber
		Subscriber Primary Identifier	Value is 9-digit Mississippi Division of Medicaid Recipient/Beneficiary ID This field can be ten characters long if you are including your co-pay indicator
	N3	Subscriber Address	
		Required; Recipient Address details	
	N4	Subscriber City, State, Zip Code	
		Required; Recipient City, State, Zip code	
	DMG	Subscriber Demographic Information	
		Required; Recipient Demographic details	

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Loop ID	Reference	Name	Codes	Notes/Comments
	REF	Subscriber Secondary Supplemental Identifier		REF
2010BB	NM1	Payer Name		
	NM101	Entity Identifier Code	PR	PR – Payer
	NM102	Entity Type Qualifier	2	2 – Non-Person Entity
	NM103	Payer Name	MISSISSIPPI DIVISION OF MEDICAID	
	NM108	Identification Code Qualifier	PI, XV	PI - Payor Identification XV - Centers for Medicare and Medicaid Services Plan ID
	NM109	Payer Identifier	MS_TXIX	MS_TXIX - Mississippi Title 19
	REF	Billing Provider Secondary Identification		Required for atypicals or Non-Par providers.
	REF01	Reference Identification Qualifier	G2	G2 - Provider Commercial Number
	REF02	Billing Provider Secondary Identifier		Indicate the Mississippi Division of Medicaid provider number For atypicals and Non-Par provider is required MSCAN/MSCHIP Provider is required For Crossover claims, REF02 will contain the Billing Provider's Medicaid ID number
2000C		PATIENT HEIRARCHICAL LEVEL		Mississippi DOM does not use information in the Patient Loop since the subscriber is always the patient Any Claims received with a patient loop (2000C) will be returned
2300	CLM	Claim Information		
	CLM01	Patient Control Number		Refer to TR3
	CLM02	Total Claim Charge Amount		Refer to TR3
	CLM05-1	Facility Type Code		Refer to TR3
	CLM05-2	Facility Code Qualifier	A	A - Uniform Billing Claim Form Bill Type

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Loop ID	Reference	Name	Codes	Notes/Comments
	CLM05-3	Claim Frequency Code		This is a required data element. Please submit a valid code from the National Uniform Billing Data Element Specifications for Type of Bill, position 3 Submit "7" for Replacement of prior Claim OR Submit "8" for Void/Cancel of Prior Claim OR '1' - Original Claim See also 2300/REF02
	CLM07	Assignment or Plan Participation Code	A, C	A – Assigned C - Not Assigned
	CLM08	Benefits Assignment Certification Indicator	N, W, Y	N – No W - Not Applicable Y – Yes
	CLM09	Release of Information Code	I, Y	I - Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes Y - Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim
	DTP	Discharge Hour		
	DTP01	Date Time Qualifier	096	096 – Discharge Hour
	DTP02	Date Time Period Format Qualifier	TM	TM - Time Expressed in Format HHMM
	DTP03	Discharge Hour		Refer to TR3
	DTP	Statement Dates		
	DTP01	Date Time Qualifier	434	434 Statement
	DTP02	Date Time Period Format Qualifier	D8 RD8	D8 – CCYYMMDD RD8 - CCYYMMDD- CCYYMMDD
	DTP03	Statement From and To Date		CCYYMMDD
	DTP	Admission Date/Hour		
	DTP01	Date Time Qualifier	435	435 – Admission
	DTP02	Date Time Period Format Qualifier	D8 DT	D8 – CCYYMMDD DT - CCYYMMDDHHMM
	DTP03	Admission Date and Hour		Refer to TR3
	DTP	Date – Repricer Received		
	DTP01	Date Time Qualifier	050	050 - Received

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Loop ID	Reference	Name	Codes	Notes/Comments
	DTP02	Date Time Period Format Qualifier	D8	D8 - CCYYMMDD
	DTP03	Repricer Received Date		CCYYMMDD
	CL1	Institutional Claim Code		
	CL101	Admission Type Code		<i>Refer to TR3</i>
	CL102	Admission Source Code		<i>Refer to TR3</i>
	CL103	Patient Status Code		<i>Refer to TR3</i>
	PWK	Claim Supplemental Information		This segment is required for FFS Sterilization claims.
	PWK06	Attachment Control Number		Attachment Control Number To facilitate the matching of the attachment to the claim, the pay-to-provider id., recipient id, and date service should be used as the attachment control number in the paperwork segment of the 837 transaction.
	REF	Payer Claim Control Number		Required, when submitting Voids or adjustments or in correcting a previously denied encounter
	REF01	Reference Identification Qualifier	F8	F8 - Original Reference Number
	REF02	Reference Identification		Please submit the 17-digit transaction control number (TCN), or MES 13-digit Identification Control Number (ICN) , assigned by the MS MMIS adjudication system Note: that the previously submitted MSCAN/MSCHIP encounter TCN can be obtained from either the electronic 835 (RA) or 277 CA Claim status response files PAYER CLAIM CONTROL NUMBER To cancel or adjust a previously submitted claim, please submit the 17-digit TCN, assigned by the MS MMIS adjudication system and printed on the remittance advice for the previously submitted claim that is being replaced or voided by this claim
	NTE	Claim Note		Required for CCO Encounters Submissions

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Loop ID	Reference	Name	Codes	Notes/Comments
	NTE01	Note Reference Code	ADD	Please use the qualifier 'ADD' to indicate additional information
	NTE02	Description		Please submit a VALUE of 'Y/N' for PAR / NON-PAR value followed by a value for 'CLAIM RECEIVED DATE' IN CCYYMMDD format The sample value would look something similar: 'Y20110101'
	HI	Claim Health Care Diagnosis Code		Mississippi process/uses twelve diagnosis codes.
	HI01-1	Code List Qualifier Code	ABK, BK	ABK- International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis BK - International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Diagnosis
	HI01-2	Principal Diagnosis Code		Refer to TR3
	HI01-9	Present on Admission Indicator	N, U, W, Y	Required for Hospital Inpatient Claims N - No U - Unknown W - Not Applicable Y - Yes
	HI	Admitting Diagnosis		Required for Hospital Inpatient Claims
	HI	Diagnosis Related Group (DRG) Information		Required for Hospital Inpatient Claims
	HI01-1	Code List Qualifier Code	DR	DR - Diagnosis Related Group (DRG)
	HI01-2	Diagnosis Related Group (DRG) Code		Value is CCO assigned DRG Code
	HI	Other Diagnosis Information		Required on all Hospital Inpatient Claims; please report all Other Diagnosis Code Info MS MMIS process/uses all twenty four diagnosis codes

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Loop ID	Reference	Name	Codes	Notes/Comments
	HI01-9	Present on Admission Indicator	N, U, W, Y	Required for Hospital Inpatient Claims N - No U - Unknown W - Not Applicable Y - Yes
	HI	Principal Procedure Information		Required on Hospital Inpatient Claims
	HI	Other Procedure Information		Report any 'Other Procedure Codes' if Exist
	HI	Occurrence Information		Report if any 'Occurrence Code' Exist
	HI	Value Information		Report If any 'Value Code' info Exists
	HI	Condition Information		Report If any 'Condition Code' info Exists
2310A	NM1	Attending Provider Name		Report Attending Provider Info on Hospital Inpatient claims, if exists
	NM101	Entity Identifier Code	71	71 – Attending Physician
	NM102	Entity Type Qualifier	1	1 – Person
	NM103	Attending Provider Last Name		Refer to TR3
	NM104	Attending Provider First Name		Refer to TR3
	NM105	Attending Provider Middle Name or Initial		Refer to TR3
	NM107	Attending Provider Name Suffix		Refer to TR3
	NM108	Identification Code Qualifier	XX	XX - NPI
	NM109	Attending Provider Primary Identifier		Note: When the Attending Physician is a healthcare provider populate this field with the NPI number The Attending Physician NPI is necessary to adjudicate the claim if the loop is applicable If missing from the 2310A loop, all claims in the 837 will be returned to submitter
	PRV	Attending Provider Specialty Information		PRV segment is required by Mississippi Medicaid when the Attending NPI represents multiple entities or sub-parts.
	PRV01	Provider Code	AT	AT - Attending
	PRV02	Reference Identification Qualifier	PXC	PXC - Health Care Provider Taxonomy Code

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Loop ID	Reference	Name	Codes	Notes/Comments
	PRV03	Provider Taxonomy Code		Use 10-byte taxonomy code that is on file with Mississippi Medicaid for the attending provider
	REF	Attending Provider Secondary Identification		Indicate the Mississippi Division of Medicaid provider number
	REF01	Reference Identification Qualifier	0B, 1G, G2, LU	0B - State License Number 1G - Provider UPIN Number G2 - Provider Commercial Number LU - Location Number
	REF02	Attending Provider Secondary Identification		Refer to TR3
2310B	REF02	Operating Physician Secondary Identification		Indicate the Mississippi Division of Medicaid provider number
2310C	REF02	Other Operating Physician Secondary Identification		Indicate the Mississippi Division of Medicaid provider number
2310D	REF02	Rendering Provider Secondary Information		For atypicals and Non-Par provider is required Indicate the Mississippi Division of Medicaid provider number
2310E	NM1	Service Facility Location Name		
	NM101	Entity Identifier Code	77	77 - Service Location
	NM102	Entity Type Qualifier	2	2 - Non-Person Entity
	NM103	Laboratory or Facility Name		Refer to TR3
	NM108	Identification Code Qualifier	XX	XX- NPI
	NM109	Laboratory or Facility Primary Identifier		Value is 10-digit NPI of Laboratory or Facility
	N3	Service Facility Location Address		Required; Service Facility Location Address details
	N4	Service Facility Location City, State, Zip Code		Required; Service Facility Location City, State, Zip code
	REF	Service Facility Location Secondary Information		Indicate the Mississippi Division of Medicaid provider number.
	REF01	Reference Identification Qualifier	0B, G2, LU	0B - State License Number G2 - Provider Commercial Number LU - Location Number
	REF02	Laboratory or Facility Secondary Identifier		Refer to TR3

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Loop ID	Reference	Name	Codes	Notes/Comments
2320	SBR	Other Subscriber Information		Required.
	SBR01	Payer Responsibility Sequence Number Code	A, B, C, D, E, F, G, H, P, S, T, U	A - Payer Four B - Payer Five C - Payer Six D - Payer Seven E - Payer Eight F - Payer Nine G - Payer Ten H - Payer Eleven P - Primary S - Secondary T - Tertiary U - Unknown Use a value of 'T' (Tertiary) for Encounter submissions.
	SBR02	Individual Relationship Code	01, 18, 19, 20, 21, 39, 40, 53, G8	01 – Spouse 18 – Self 19 – Child 20 – Employee 21 – Unknown 39 - Organ Donor 40 - Cadaver Donor 53 - Life Partner G8 - Other Relationship
	SBR03	Insured Group or Policy Number		CCOs should report their Medicaid Provider ID
	SBR04	Other Insured Group Name		
	SBR09	Claim Filing Indicator Code	11, 12, 13, 14, 15, 16, 17, AM, BL, CH, CI, DS, FI, HM, LM, MA, MB, MC, OF, TV, VA, WC, ZZ	Required for CCO and Medicare Advantage Part C/ Medicare Part-A and Part-B claims. 11 - Other Non-Federal Programs 12 - Preferred Provider Organization (PPO) 13 - Point of Service (POS) 14 - Exclusive Provider Organization (EPO) 15 - Indemnity Insurance 16 - Health Maintenance Organization (HMO) Medicare Risk 17- Dental Maintenance Organization AM - Automobile Medical BL - Blue Cross/Blue Shield CH - Champus CI - Commercial Insurance Co.

Loop ID	Reference	Name	Codes	Notes/Comments
				DS - Disability FI - Federal Employees Program HM - Health Maintenance Organization LM - Liability Medical MA - Medicare Part A MB - Medicare Part B MC - Medicaid OF - Other Federal Program TV - Title V VA - Veterans Affairs Plan WC - Workers' Compensation Health Claim ZZ - Mutually Defined Use a value of 'ZZ' to identify the Other payers (CCO) Use a value of 'MA', 'MB' to identify Medicare Payers or '16' to identify Medicare C Advantage Plan. Otherwise, use a value of 'ZZ' to identify CCO payers 1st occurrence - Use a value of 'ZZ' to identify CCO payer, 2nd occurrence -if any TPL payer exists then use a value of 'CI' to identify TPL Payer.
	CAS	Claim Level Adjustments		Report any CAS info at the Line Level Required for Medicare Advantage/Part-C Claims
	CAS01	Claim Adjustment Group Code	CO, CR, OA, PI, PR	CO - Contractual Obligations CR - Correction and Reversals OA - Other adjustments PI - Payor Initiated Reductions PR - Patient Responsibility Claim Adjustment Group Code: Used to report the general category of a claim level payment adjustment if a Medicare Advantage Payer is identified in Loop 2320 (SBR09 = 'MA')
	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	Adjustment Reason Code		Adjustment Reason Code: Used to report the detailed reason the adjustment was made if a Medicare Advantage Payer is identified in Loop 2320 (SBR09 = 'MA').

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Loop ID	Reference	Name	Codes	Notes/Comments
	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	Adjustment Amount		Adjustment Amount: Used to report the amount of adjustment if a Medicare Advantage Payer is identified in Loop 2320 (SBR09 = 'MA').
	CAS04 CAS07 CAS10 CAS13 CAS16 CAS19	Adjustment Quantity		Refer to TR3
	AMT	Coordination of Benefits (COB) Payer Paid Amount		Required for CCO and Medicare Advantage/Part-C Claims
	AMT01	Amount Qualifier Code	D	D - Payor Amount Paid
	AMT02	Payer Paid Amount		COB PAYER PAID AMT "This is a required element and is used to report the CCO and Medicare Advantage/Part C Claims Paid amount for the Claim. Individual Line item. Payments may also be reported in Loop 2430 SVD02. (Payer Paid Amount)."
2330A	NM1	Other Subscriber Name		
	NM109	Other Insured Identifier		Value is 9-digit Mississippi Division of Medicaid Recipient/Beneficiary ID This field can be ten characters long if you are including your co-pay indicator
2330B	NM1	Other Payer Name		
	NM101	Entity Identifier Code	PR	PR – Payer
	NM108	Identification Code Qualifier	PI	PI - Payor Identification
	NM109	Other Payer Primary Identifier		Value is 'CCO Provider number OR Other Payer (if any)' This number must be identical to SVD01 (Loop ID-2430) for COB
	DTP	Other Payer Claim Check or Remittance Date		Encounters: Required by Mississippi Medicaid when CCOs adjudicated or paid the claim in their system
	DTP01	Date Time Qualifier	573	573 – Date Claim Paid
	DTP02	Date Time Period Format Qualifier	D8	D8 - CCYYMMDD

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Loop ID	Reference	Name	Codes	Notes/Comments
	DPT03	Date Time Period		Value is CCO Claim paid date
	REF	Other Payer Secondary Identifier		Value is CCO Claim Number
	REF	Other Payer Prior Authorization Number		Required for Inpatient Hospital
	REF	Other Payer Claim Control Number		Required for CCO
	REF01	Reference Identification Qualifier	F8	F8 - Original Reference Number
	REF02	Other Payer's Claim Control Number		Submit CCO's claim reference number
2330C	REF02	Other Payer Attending Provider Secondary Identification		Indicate the Mississippi Division of Medicaid provider number
2330E	REF02	Other Payer Operating Physician Secondary Information		Indicate the Mississippi Division of Medicaid provider number
2330F	REF02	Other Payer Service Facility Location Secondary Information		Indicate the Mississippi Division of Medicaid provider number
2400	LX	Service Line Number		
	LX01	Assigned Number		<i>Refer to TR3</i>
	SV2	Institutional Service Line		
	SV201	Service Line Revenue Code	ER, HC, HP, IV, WK	ER – Jurisdiction Specific Procedure and Supply Codes HC – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes IV – Home Infusion EDI Coalition (HIEC) Product/Service Code WK – Advanced Billing Concepts (ABC) Codes For CCOs, use HC - Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
	SV202-1	Product or Service ID Qualifier		<i>Refer to TR3</i>
	SV202-2	Procedure Code		<i>Refer to TR3</i>
	SV203	Lien Item Charge Amount		<i>Refer to TR3</i>
	SV204	Unit or Basis for Measurement Code	DA, UN	DA – Days UN – Units For CCOs, use UN - Units
	SV205	Service Unit Count		<i>Refer to TR3</i>

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Loop ID	Reference	Name	Codes	Notes/Comments
	PWK	Line Supplemental Information		Required on claims with attachments
	DTP	Date – Service		Required
	REF	Line Item Control Number		Required
	REF	Repriced Line Item Reference Number		Required
	REF	Adjusted Repriced Line Item Reference Number		Required
	AMT	Service Tax Amount		Required
	AMT	Facility Tax Amount		Required
	NTE	Claim Note		Required for CCO
	NTE01	Note Reference Code	ADD	Please use the qualifier ADD' to indicate additional information
	NTE02	Description		Please submit a VALUE of 'Y/N' for PAR / NON-PAR value followed by a value for 'CLAIM RECEIVED DATE' IN CCYYMMDD format The sample value would look something similar: 'Y20110101'
2400	HCP	Line Pricing/RePricing Information		
	HCP01	Pricing Methodology	00, 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14	00 – Zero Pricing (Not Covered Under Contract) 01 – Priced as Billed at 100% 02 – Priced at the Standard Fee Schedule 03 – Priced at a Contractual Percentage 04 – Bundled Pricing 05 – Peer Review Pricing 06 – Per Diem Pricing 07 – Flat Rate Pricing 08 – Combination Pricing 09 – Maternity Pricing 10 – Other Pricing 11 – Lower of Cost 12 – Ratio of Cost 13 – Cost Reimbursed 14 – Adjustment Pricing
	HCP02	Monetary Amount		Allowed Amount: Use to report the CCO allowed amount

Loop ID	Reference	Name	Codes	Notes/Comments
2410	LIN	Drug Identification	<i>(Note: Required when Loop 2400 procedure code is a drug-related HCPCS code.)</i>	
	LIN03	National Drug Code		NDC code Please use to specify billing/reporting of drugs provided that may be a part of the service described in SV1
2420A	REF	Operating Physician Secondary Identifier		Indicate the Mississippi Division of Medicaid provider number
2420C	REF	Rendering Provider Secondary Identification		Only Required for atypicals or non-par Providers
	REF02	Rendering Provider Secondary Identifier		Indicate the Mississippi Division of Medicaid provider number, if reported
2430	SVD	Line Adjudication Information		Required for Medicare Advantage/ Part-C Claims
	SVD01	Identification Code		Value is CCO assigned Provider Number OR this number should match NM109 in Loop ID-2330B identifying Other Payer
	SVD02	Service Line Paid Amount		Service Line Paid Amount: Report any CCO Paid Line Amounts OR TPL payments at the Line Service Line Paid Amount Used to report paid amount if a Medicare 'B' or Medicare Advantage C Payer is identified in Loop 2320 (SBR09 = 'MB' or '16')
	CAS	Claim Level Adjustments		Required, when CCO reports denied encounters OR TPL coverage OR Prior payer adjustments. For MSCAN/MSCHIP, please ensure to report any 'Copay dollars' using Group Code 'PR' and Reason Code '3' (Co-payment)

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Loop ID	Reference	Name	Codes	Notes/Comments
	CAS01	Claim Adjustment Group Code	CO, CR, OA, PI, PR	CO - Contractual Obligations CR - Correction and Reversals OA - Other adjustments PI - Payor Initiated Reductions PR - Patient Responsibility Claim Adjustment Group Code: Used to report the general category of a claim level payment adjustment if a Medicare Advantage Payer is identified in Loop 2320 (SBR09 = 'MA').
	CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	Adjustment Reason Code		Adjustment Reason Code: Used to report the detailed reason the adjustment was made if a Medicare Advantage Payer is identified in Loop 2320 (SBR09 = 'MA')
	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	Adjustment Amount		Adjustment Amount: Used to report the amount of adjustment if a Medicare Advantage Payer is identified in Loop 2320 (SBR09 = 'MA')
	CAS04 CAS07 CAS10 CAS13 CAS16 CAS19	Adjustment Quantity		Adjustment Amount: Used to report the quantity of adjustment if a Medicare Advantage Payer is identified in Loop 2320 (SBR09 = 'MB')
	DTP	Line Check or Remittance Date		
	DTP01	Date Time Qualifier	573	573 – Date Claim Paid
	DTP02	Date Time Period Format Qualifier	D8	D8 – CCYYMMDD
	DTP03	Adjudication or Payment Date		Adjudication or Payment Date (CCYYMMDD)
	AMT	Remaining Patient Liability		
	AMT01	Amount Qualifier Code	EAF	EAF - Amount Owed
	AMT02	Payer Paid Amount		
	SE	Transaction Set Trailer		
	SE01	Transaction Segment Count		Refer to TR3
	SE02	Transaction Set Control Number		Refer to TR3
	GE	Functional Group Trailer		

Loop ID	Reference	Name	Codes	Notes/Comments
	GE01	Number of Transaction Sets Included		<i>Refer to TR3</i>
	GE02	Group Control Number		<i>Refer to TR3</i>
IEA		Interchange Control Trailer		
	IEA01	Number of Included Functional Groups		<i>Refer to TR3</i>
	IEA02	Interchange Control Number		<i>Refer to TR3</i>

Appendix A. Change History

Date	Change	Responsible Party
March 2022	Original Document	EDI Department