

MMIS Replacement Project (MRP)

Health Care Claim Dental (837) Transaction Standard Companion Guide

Companion to Health Care Claim ASC X12N 837 005010X224 Implementation Guide

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Version 0.4

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 005010X224 and the associated addendums 005010X224A1 and 005010X224A2 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 ([EDI Technical Documents | Mississippi Division of Medicaid \(ms.gov\)](#)) — click on the MOVEit Portal at [Mississippi Replacement Project \(msxix.net\)](#) page.

Questions may be directed to the EDI Helpdesk at 1 844-807-9449 or via the “Contact Us” link at the top of the Portal home page at: [Mississippi Medical Assistance Portal for Providers > Home \(msxix.net\)](#).

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 Medical Assistance Portal for Providers > Home \(msix.net\)](https://msix.net).

4.1. Passwords

Passwords are provided during initial enrollment and can be reset by contacting Provider Relations – Electronic Claims Submission (ECS) Department at 1 800-884-3222. These passwords may not be shared.

[EDI Technical Documents | Mississippi Division of Medicaid \(ms.gov\)](#)

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: [EDI Technical Documents | Mississippi Division of Medicaid \(ms.gov\)](#)
- For EDI Services (technical, enrollment, or setup questions):
 - E-mail: MS.EDI.Helpdesk@gainwelltechnologies.com
 - Telephone: 1 844-807-9449
 - 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, [Providers | Mississippi Division of Medicaid \(ms.gov\)](#).

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 can name their files using the following format for processing and tracking purposes:

1. <SubmitterId> – Use the trading partner ID (submitter ID) assigned. This is to be used by all providers, vendors, and clearinghouses submitting batch transactions.
2. <filetype> – Assign a file type – preferably transaction type, example 270, 276, 278Q, 837D, 837I, 837P.
3. <datetime>. – Use the date/time value format of yyymmddhhmm to uniquely identify the file and avoid duplicate files.
4. <filetypeext> – Use the file type extension to identify the file type (e.g. .dat, .txt)

Here are some examples of good file naming standards:

- TP01234567_837D_201708301140512.dat
- TP01234567_837D_TRANS01_20170830.dat
- TP01234567_837D_SMALL_FILE_2017_08.txt

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 |
|---------|----------------------------------|-----------------------------|-------|----------------|
| | 837D | Health Care Claim Dental | | |

| Loop ID | Segment/ Element Reference | Loop 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) |
| 2100A | NM1 | Submitter Name | | |
| | NM101 | Entity Identifier Code | 41 | 41 – Submitter |
| | NM102 | Entity Type Qualifier | | <i>Refer to TR3</i> |
| | NM103 | Submitter Last Name or Organization Name | | Submitter name should be "ADVANTAGE/MEDICARE-PART-C" for Medicare Advantage/ Part-C Claims |
| | NM109 | Submitter Identifier | Trading Partner ID | Value is Trading Partner ID that was provided during the EDI enrollment process |

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: Dental

Table 3. Health Care Claim Dental (837D)

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---------|--------------|--|--------------------|---|
| | 837D | Health Care Claim Dental | | |
| | 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 | | <i>Refer to TR3</i> |
| | ISA16 | Component Element Separator | : | Colon |
| | GS | Functional Group Header | | |
| | GS01 | Functional Identifier Code | | <i>Refer to TR3</i> |
| | 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 | 005010X224A2 | |
| | 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 | 005010X224A2 | |

| 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 |
| | NM102 | Entity Type Qualifier | | <i>Refer to TR3</i> |
| | 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 | | <i>Refer to TR3</i> |
| | PER03 | Communication Number Qualifier | EM, FX, TE | EM – Electronic Mail FX – Facsimile TE – Telephone |
| | PER04 | Communication Number | | <i>Refer to TR3</i> |
| | 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” Please note: if Cert not submitted, the Encounter would be rejected |
| 1000B | NM1 | Receiver Name | | |
| | NM101 | Entity Identifier Code | 40 | 40 – Receiver |

| 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 | | <i>Refer to TR3</i> |
| | NM104 | Billing Provider First Name | | <i>Refer to TR3</i> |
| | NM105 | Billing Provider Middle Name or Initial | | <i>Refer to TR3</i> |
| | NM107 | Billing Provider Name Suffix | | <i>Refer to TR3</i> |
| | 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 |

| 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 | | <i>Refer to TR3</i> |
| 2010AB | NM1 | Pay-to-Address Name | | |
| | NM101 | Entity Identifier Code | 87 | 87 - Pay-to Provider |
| | NM102 | Entity Type Qualifier | 1, 2 | 1 – Person 2 – Non-Person For CCOs, use 2 – Non-Person Entity |
| 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 a value of 'S' (Secondary) for Primary COB and 'T' (Tertiary) for Secondary COB for Encounter submissions |

| 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 MC – Medicaid |

| 2010BA | NM1 | Subscriber Name | |
|--------|-------|--|--|
| | NM101 | Entity Identifier Code | IL IL - Insured or Subscriber |
| | NM109 | 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; Subscriber Address details | |
| | N4 | Subscriber City, State, Zip Code Required; Subscriber City, State, Zip code | |
| | DMG | Subscriber Demographic Information Required; Subscriber Demographic details | |
| | REF02 | Subscriber Secondary Supplemental Identifier | |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---------------|------------|--|--------|--|
| 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 For Managed Care, value is CCO Organizational Name |
| | NM108 | Identification Code Qualifier | PI, XV | PI - Payor Identification XV - Centers for Medicare and Medicaid Services Plan ID |
| | NM109 | Payer Identifier | | MS_TXIX - Mississippi Title 19 For Managed Care, value is CCO Payer Identifier |
| | 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 | | <i>Refer to TR3</i> |
| | CLM02 | Total Claim Charge Amount | | <i>Refer to TR3</i> |
| | CLM05-1 | Place of Service Code | | <i>Refer to TR3</i> |
| | CLM05-2 | Facility Code Qualifier | B | B - Place of Service Codes for Professional or Dental |

| 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 |
| | CLM06 | Provider or Supplier Signature Indicator | N, Y | N – No Y - Yes |
| | 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 |
| | CLM11-1 | Related Causes Code | AA, EM, OA | AA - Auto Accident EM - Employment OA - Other Accident |
| | DTP | Date – Accident | | |
| | DTP01 | Date Time Qualifier | 439 | 439 – Accident |
| | DTP02 | Date Time Period Format Qualifier | D8 | D8 - CCYYMMDD |
| | DTP03 | Accident Date | | CCYYMMDD |
| | DTP | Date – Appliance Placement | | |
| | DTP01 | Date Time Qualifier | 452 | 452 – Appliance Placement |
| | DTP02 | Date Time Period Format Qualifier | D8 | D8 - CCYYMMDD |
| | DTP03 | Orthodontic Banding Date | | CCYYMMDD |
| | DTP | Date – Service Date | | |
| | DTP01 | Date Time Qualifier | 472 | 472 – Service Date |
| | DTP02 | Date Time Period Format Qualifier | D8 | D8 – CCYYMMDD |
| | DTP03 | Service Date | | CCYYMMDD |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---------|------------|--|-------|---|
| | DTP | Date – Repricer Received Date | | |
| | DTP01 | Date Time Qualifier | 050 | 050 – Received |
| | DTP02 | Date Time Period Format Qualifier | D8 | D8 - CCYYMMDD |
| | DTP03 | Repricer Received Date | | CCYYMMDD |
| | DN1 | Orthodontic Total Months of Treatment | | |
| | DN101 | Orthodontic Treatment Months Count | | <i>Refer to TR3</i> |
| | DN102 | Orthodontic Treatment Months Remaining Count | | <i>Refer to TR3</i> |
| | DN104 | Orthodontic Treatment Indicator | | <i>Refer to TR3</i> |
| | DN1 | Tooth Status | | |
| | DN201 | Tooth Number | | |
| | DN202 | Tooth Status Code | E, M | E – To Be Extracted M - Missing |
| | DN206 | Code List Qualifier 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 |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---------|--------------------------------------|-----------------------------------|-------------|---|
| | REF02 | Reference Identification | | <p>Please submit the 17-digit transaction control number (TCN) or MES 13-digit Identification Control Number (ICN), assigned by the MS MMIS adjudication system</p> <p>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</p> <p>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</p> |
| | NTE | Claim Billing Note | | Required for CCO Encounters Submissions |
| | NTE01 | Note Reference Code | ADD | Please use the qualifier 'ADD' to indicate additional information |
| | NTE02 | Description | | <p>Please submit a VALUE of 'Y/N' for PAR / NON-PAR value followed by a value for 'CLAIM RECEIVED DATE' IN CCYMMDD format.</p> <p>The sample value would look something similar: 'Y20110101'</p> |
| | HI | Health Care Diagnosis Code | | |
| | HI01-1 HI02-1 HI03-1 HI04-1 | Code List Qualifier Code | ABK, BK, TQ | <p>ABK - International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis</p> <p>BK - International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Diagnosis</p> <p>TQ - Systemized Nomenclature of Dentistry (SNODENT)</p> |
| | HI01-2 | Principal Diagnosis Code | | <i>Refer to TR3</i> |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|--------------|----------------------------|--|------------|--|
| | HI02-2 HI03-2 HI04-2 | Diagnosis Code | | <i>Refer to TR3</i> |
| 2310A | NM1 | Referring Provider Name | | Report Referring Provider Info on claims, if exists |
| | NM101 | Entity Identifier Code | DN, P3 | DN - Referring Provider P3 - Primary Care Provider For CCOs, use DN - Referring Provider |
| | NM102 | Entity Type Qualifier | 1 | 1 – Person |
| | NM103 | Referring Provider Last Name | | <i>Refer to TR3</i> |
| | NM104 | Referring Provider First Name | | <i>Refer to TR3</i> |
| | NM105 | Referring Provider Middle Name or Initial | | <i>Refer to TR3</i> |
| | NM107 | Referring Provider Name Suffix | | <i>Refer to TR3</i> |
| | NM108 | Identification Code Qualifier | XX | XX – NPI |
| | NM109 | Referring Provider Primary Identifier | | Value is 10-digit NPI of Referring Provider |
| | REF | Referring Provider Secondary Identification | | Indicate the Mississippi Division of Medicaid provider number |
| | REF01 | Reference Identification Qualifier | 0B, 1G, G2 | 0B - State License Number 1G - Provider UPIN Number G2 - Provider Commercial Number |
| | REF02 | Referring Provider Secondary Identification | | <i>Refer to TR3</i> |
| 2310B | NM1 | Rendering Provider Name | | Required. |
| | NM101 | Entity Identifier Code | 82 | 82 – Rendering Provider |
| | NM102 | Entity Type Qualifier | 1, 2 | 1 – Person 2 – Non-Person Entity |
| | NM103 | Rendering Provider Last Name | | <i>Refer to TR3</i> |
| | NM104 | Rendering Provider First Name | | <i>Refer to TR3</i> |
| | NM105 | Rendering Provider Middle Name or Initial | | <i>Refer to TR3</i> |
| | NM107 | Rendering Provider Name Suffix | | <i>Refer to TR3</i> |
| | NM108 | Identification Code Qualifier | XX | XX – NPI |
| | NM109 | Rendering Provider Primary Identifier | | Value is 10-digit NPI of Rendering Provider |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|--------------|------------|--|------------|--|
| | PRV | Rendering Provider Specialty Information | | The PRV segment is required by Mississippi Medicaid when the Rendering NPI represents multiple entities or sub-parts. |
| | PRV01 | Provider Code | RF | RF - Referring |
| | PRV02 | Reference Identification Qualifier | PXC | PXC - Health Care Provider Taxonomy Code |
| | PRV03 | Provider Taxonomy Code | | Use 10-byte taxonomy code that is on file with Mississippi Medicaid for the rendering provider |
| | REF | Rendering Provider Secondary Identification | | Indicate the Mississippi Division of Medicaid provider number |
| 2310C | 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 | | <i>Refer to TR3</i> |
| | 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 | | <i>Refer to TR3</i> |
| 2310D | REF | Assistant Surgeon Secondary Identification | | Indicate the Mississippi Division of Medicaid provider number |
| 2320 | SBR | Other Subscriber Information | | Required , 1st occurrence should always indicate the CCO Payer and 2nd occurrence (if any) should indicate other payers like TPL etc. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---------|-----------|--|---|--|
| | SBR01 | Payer Responsibility Sequence Number Code | A, B, C, D, E, F, G, H, P, S, T, U | <p>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</p> <p>For Managed Care, CCOs information is always 'P' (Primary). This is also true for corresponding segment occurrences associated with Primary COB/CCO integration. CCOs, use a value of 'P' (Primary) for Care Management Organizations (CMO), 'S' (Secondary) for Primary COB/TPL and 'T' (Tertiary) for Secondary COB/TPL</p> |
| | SBR03 | Insured Group or Policy Number | | CCOs should report their Medicaid Provider ID |
| | 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 | <p>Required for CCO and Medicare Advantage Part C/ Medicare Part-A and Part-B claims.</p> <p>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</p> |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---------|------------|---|---------|---|
| | | | | 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 'MA' (Medicare Part A), 'MB' (Medicare Part B) to identify Medicare Payers or '16' (Health Maintenance Organization (HMO) Medicare Risk) to identify Medicare C Advantage Plan. Otherwise, use a value of 'ZZ' (Mutually Defined) 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' (Commercial Insurance Co.) to identify TPL Payer. |
| | CAS | Claim Level Adjustments | | Situational, Required at Line Level, when submitting CCO Denied Encounter/reporting any TPL or adjustments |
| | 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 | | PAYER PAID AMT This is a required element and is used to report the CCO Paid amount for the Claim Individual Line item Payments may also be reported in Loop 2430 SVD02. (Payer Paid Amount) |
| | OI | Other Insurance Coverage Information | | Required |
| | OI03 | Benefits Assignment Certification Indicator | N, W, Y | N - No W - Not Applicable Y - Yes |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|--------------|------------|---|-------|---|
| | OI06 | 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 |
| 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 | Claim Check or Remittance Date | | Required. |
| | DTP01 | Date Time Qualifier | 573 | 573 – Date Claim Paid |
| | DTP02 | Date Time Period Format Qualifier | D8 | D8 - CCYYMMDD |
| | DPT03 | Date Time Period | | Value is CCO Claim paid date |
| | REF | Other Payer Prior Authorization Number | | Indicate Prior Authorization Number, if reported |
| | REF | Other Payer Claim Control Number | | Required. |
| | REF01 | Reference Identification Qualifier | F8 | F8 - Original Reference Number |
| | REF02 | Other Payer's Claim Control Number | | Value is CCO's assigned 2 Character Prefix plus Other Payer's Claim Control Number (2 Prefix Characters + COB TCN Num). Value would look something similar: AD##### |
| 2400 | LX | Service Line Number | | Required |
| | SV3 | Dental Service | | Dental Service |
| | TOO | Line Tooth Information | | MS DOM accepts one TOO segment per line item If multiple are sent, the MMIS will populate the last one to the claim |
| | DTP | Line Service Date | | Required |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|--------------|------------|---|-------|---|
| | REF | Service Predetermination Identification | | Pre-determination Identification Clarification Mississippi Division of Medicaid does not process pre-determination of Dental Benefits |
| | REF | Service Predetermination Identification | | |
| | REF02 | Reference Identification | | Original Reference Number: Will be using this match adjustments of previously received encounter claim number in the Gainwell system to cancel or adjust a previously submitted claim |
| | HCP | Line Pricing/Repricing Info | | Required |
| | HCP02 | Monetary Amount | | Use to report the CCO allowed amount. |
| 2420A | NM1 | Rendering Provider Name | | Required. |
| | NM101 | Entity Identifier Code | 82 | 82 -Rendering Provider |
| | NM102 | Entity Type Qualifier | 1, 2 | 1 – Person 2 - Non-Person Entity |
| | NM103 | Rendering Provider Last Name | | <i>Refer to TR3</i> |
| | NM104 | Rendering Provider First Name | | <i>Refer to TR3</i> |
| | NM105 | Rendering Provider Middle Name or Initial | | <i>Refer to TR3</i> |
| | NM107 | Rendering Provider Name Suffix | | <i>Refer to TR3</i> |
| | NM108 | Identification Code Qualifier | XX | XX – NPI |
| | NM109 | Rendering Provider Primary Identifier | | Value is 10-digit NPI of Rendering Provider |
| | PRV | Rendering Provider Specialty Information | | The PRV segment is required by Mississippi Medicaid when the Rendering NPI represents multiple entities or sub-parts |
| | PRV01 | Provider Code | PE | PE - Performing |
| | PRV02 | Reference Identification Qualifier | PXC | PXC - Health Care Provider Taxonomy Code |
| | PRV03 | Provider Taxonomy Code | | Value is the 10-byte taxonomy code applicable to the provider indicated in PRV01 |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|--------------|------------|--|----------------|---|
| | REF | Rendering Provider Secondary Identification | | SECONDARY ID segment is required by Mississippi Medicaid |
| | REF01 | Reference Identification Qualifier | 0B, 1G, G2, LU | 0B - State License Number 1G - Provider UPIN Number G2 - Provider Commercial Number LU - Location Number |
| | REF02 | Rendering Provider Secondary Identifier | | Indicate the Mississippi Division of Medicaid provider number |
| 2420B | NM1 | Assistant Surgeon Name | | |
| | NM101 | Entity Identifier Code | DD | DD – Assistant Surgeon |
| | NM102 | Entity Type Qualifier | 1, 2 | 1 – Person 2 - Non-Person Entity |
| | NM103 | Assistant Surgeon Last Name or Organization | | <i>Refer to TR3</i> |
| | NM108 | Identification Code Qualifier | XX | XX – NPI |
| | NM109 | Assistant Surgeon Primary Identifier | | Value is 10-digit NPI of Assistant Surgeon |
| | REF | Assistant Surgeon Secondary Identification | | Indicate the Mississippi Division of Medicaid provider number |
| 2420D | NM1 | Line 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 | | <i>Refer to TR3</i> |
| | NM108 | Identification Code Qualifier | XX | XX – NPI |
| | NM109 | Laboratory or Facility Primary Identifier | | Value is 10-digit NPI of Laboratory or Facility |
| | N3 | Line Service Facility Location Address | | Required; Line Service Facility Location Address details |
| | N4 | Line Service Facility Location City, State, Zip | | Required; Line Service Facility Location City, State, Zip code |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|-------------|------------|--------------------------------------|--------|---|
| | N403 | Postal Code | | Situational: A 9-digit Servicing postal codes are required and is utilized in the NPI crosswalk Logic. This is used as a tie breaker in our system, when more than 1 Medicaid provider is found on state provider file, and to ensure that the claim processes correctly. |
| 2430 | SVD | Line Adjudication Information | | COB Payer Line Paid Amount. |
| | 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') |
| | SVD03-1 | Product/Service ID Qualifier | AD, ER | AD - American Dental Association Codes ER – Jurisdiction Specific Procedure and Supply Codes For CCOs, use AD – American Dental Association Codes |
| | CAS | Claim Line Adjustment | | Required, when CCO reports denied encounters OR TPL coverage OR Prior payer adjustments |
| | CAS01 | Claim Adjustment Group Code | | 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 = 'MB') |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---------|--|--|-------|---|
| | 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 = 'MB') |
| | 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 = 'MB') |
| | 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 | | <i>Refer to TR3</i> |
| | SE02 | Transaction Set Control Number | | <i>Refer to TR3</i> |
| | GE | Functional Group Trailer | | |
| | 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

| Version # | Date of release | Author | Description of change |
|-----------|-----------------|--|--|
| 0.1 | 12/16/2021 | EDI Technical Team | Initial document creation. Section 9.1, Page 9 - Naming Your File Loop 2330B, REF02, Page 24 – CR #1476 CCO’s Subcontractor Identifier |
| 0.2 | 2/15/2022 | EDI Technical Team | Loop 2010BB, NM103 and NM109, Page 16, Additions for Managed Care CCOs |
| 0.3 | 4/29/2022 | EDI Technical Team DOM Approved 4/29/2022 | Loop 2000B SBR01 - “For CCOs, use T – Tertiary” and SBR09 – “For CCOs, use ZZ - Mutually Defined,” instructions, Pages 9-10, Removed Loop 2320, OI – Other Insurance Coverage Information, Pages 23-24, Added |
| 0.4 | 6/08/2022 | EDI Technical Team | Loop 2000B SBR01 and SBR09 clarification to CCO instructions due to compliance errors, pages 9 and 10 Loop 2030 SBR01 and SBR09 clarification to CCO instructions due to compliance errors, pages 17 and 18 Loop 2300 NTE – “Claim Billing Note”, Page 14 “Billing” added to header label Mississippi Logo clean-up Copyright change from 2021 to 2022 |