

MMIS Replacement Project (MRP)

Health Care Claim Institutional (837) Transaction Standard Companion Guide

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

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Version 1.8

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.ncpdp.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 1 800-884-3222 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 can register to 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 \(msxix.net\)](#).

Submission of EDI Transactions via MOVEit, go to: [Mississippi Replacement Project \(msxix.net\)](#)

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.

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 go to 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](mailto:MS_EDI_Helpdesk@gainwelltechnologies.com)
 - Telephone: 1 800-884-3222
 - 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 yyyyymmddhhmm to uniquely identify the file and avoid duplicate files.
4. <filetypeext> – Use the file type extension to identify the file type (e.g. .txt)

Here are some examples of good file naming standards:

- TP01234567_837I_201708301140512.txt
- TP01234567_837I_TRANS01_20170830.txt
- TP01234567_837I_SMALL_FILE_2017_08.txt

When downloading batch files, the submitter files will be in the following format, example 271, 277, 278R, 835, TA1, 999:

- TP01234567_YYYYJJJ_(9 digit sequence).271
 - TP01234567_YYYYJJJ_(9 digit sequence).277
 - TP01234567_YYYYJJJ_(9 digit sequence).278R
 - TP01234567_YYYYJJJ_(9 digit sequence).835
 - TP01234567_YYYYJJJ_(9 digit sequence).TA1
 - TP01234567_YYYYJJJ_(9 digit sequence).999
- *Where YYYYJJJ is the 4-digit year and 3-digit Julian day.

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 CCOs, 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		“ADVANTAGE/MEDICARE-PART-C” for Medicare Advantage/ Part-C Claims” should ONLY be used for Medicare (Part A, Part B, Part C or Part D) claims.
	NM109	Submitter Identifier		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: 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		<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	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 CCOs, 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		“ADVANTAGE/MEDICARE-PART-C” for Medicare Advantage/ Part-C Claims” should ONLY be used for Medicare (Part A, Part B, Part C or Part D) claims
	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” NOTE: if Cert not submitted the Encounter would be rejected
1000B	NM1	Receiver Name		
	NM101	Entity Identifier Code	40	40 – Receiver
	NM103	Receiver Name		MISSISSIPPI DIVISION OF MEDICAID

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Loop ID	Reference	Name	Codes	Notes/Comments
	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
	N4	Billing Provider City, State, Zip Code		Required; Billing Provider City, State, Zip code

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Loop ID	Reference	Name	Codes	Notes/Comments
	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>
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
	SBR09	Claim Filing Indicator Code	MC	MC - Medicaid 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; Recipient Address details
	N4	Subscriber City, State, Zip Code		Required; Recipient City, State, Zip code
	DMG	Subscriber Demographic Information		Required; Recipient Demographic details
	REF	Subscriber Secondary Supplemental Identifier		REF
2010BB	NM1	Payer Name		
	NM101	Entity Identifier Code	PR	PR – Payer

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Loop ID	Reference	Name	Codes	Notes/Comments
	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 only for atypical, non-healthcare providers who are unable to obtain an NPI for NM109, and use an identification number other than NPI for the receiver to identify the Provider
	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 where an NPI is not assigned. For CCOs, 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	Facility Type Code		<i>Refer to TR3</i>
	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	1, 7, 8	<p>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</p> <p>1 - Original Claim 7 - Adjustment (Replacement for a Prior Paid Claim) 8 - Void (Void/Cancel for a Prior Claim)</p> <p>Note: See also 2300/REF02 The ICN/TCN to credit should be placed in the REF02, where REF01=F8. Providers must use the most recently paid ICN/TCN when voiding or adjusting a claim</p>
	CLM07	Assignment or Plan Participation Code	A, C	<p>A - Assigned C - Not Assigned</p>
	CLM08	Benefits Assignment Certification Indicator	N, W, Y	<p>N - No W - Not Applicable Y - Yes</p>
	CLM09	Release of Information Code	I, Y	<p>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</p>
	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		<i>Refer to TR3</i>
	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

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Loop ID	Reference	Name	Codes	Notes/Comments
	DTP03	Admission Date and Hour		<i>Refer to TR3</i>
	DTP	Date – Repricer Received		
	DTP01	Date Time Qualifier	050	050 - Received
	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		Use this segment if it is necessary to indicate supplemental information has been submitted for the claim This segment is required for FFS Sterilization claims or if Medicare denied the claim (Medicare EOMB denial indicates service is denied for ANY reason other than not medically necessary).
	PWK02	Attachment Transmission Code	BM	BM – By Mail The Claim Attachment Form located at: https://medicaid.ms.gov/wp-content/uploads/2022/12/Claim-Attachment-Form.pdf and mail to: Gainwell Technologies PO Box 23076 Jackson, MS 39225
	PWK05	Identification Code Qualifier	AC	AC – Attachment Control Number

Loop ID	Reference	Name	Codes	Notes/Comments
	PWK06	Attachment Control Number		<p>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</p> <p>Provider must create a unique Attachment Control Number (ACN) for each claim. The ACN must be entered in the 'PWK' segment of the transaction. In addition, a Claim Attachment Form must accompany each attachment and must identify the Provider NPI and ACN as it was entered in the 'PWK' segment. The Claim Attachment Form is located at: https://medicaid.ms.gov/wp-content/uploads/2022/12/Claim-Attachment-Form.pdf</p>
	REF	Prior Authorization		Required when claim requires a Prior Authorization Number, otherwise do not send segment.
	REF01	Reference Identification Qualifier	G1	G1 – Prior Authorization Number
	REF02	Reference Identification		Required when claim requires a Prior Authorization Number, otherwise do not send segment.
	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: The previously submitted CCO's encounter TCN can be obtained from either the electronic 835 (RA) or 277 Claim status response files</p> <p>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 CCYYMMDD format</p> <p>The sample value would look something similar: 'Y20110101'</p>
	HI	Claim Health Care Diagnosis Code		Mississippi process/uses twelve diagnosis codes.
	HI01-1	Code List Qualifier Code	ABK, BK	<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>
	HI01-2	Principal Diagnosis Code		<i>Refer to TR3</i>

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	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
	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		<i>Refer to TR3</i>
	NM104	Attending Provider First Name		<i>Refer to TR3</i>
	NM105	Attending Provider Middle Name or Initial		<i>Refer to TR3</i>

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Loop ID	Reference	Name	Codes	Notes/Comments
	NM107	Attending Provider Name Suffix		<i>Refer to TR3</i>
	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
	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		Required only for atypical, non-healthcare providers who are unable to obtain an NPI for NM109, and use an identification number other than NPI for the receiver to identify the Provider
	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		<i>Refer to TR3</i>
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

Loop ID	Reference	Name	Codes	Notes/Comments
2310E	NM1	Service Facility Location Name		<p>If not required by this companion guide, do not send</p> <p>Required when the location of health care service performed is different than the Service Address of the Billing Provider (Loop ID-2010AA) that is registered in MESA and is different than the Service Address of the Rendering Provider (Loop ID-2310D) as registered in MESA</p>
	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
2310E	N3	Service Facility Location Address		<p>If not required by this companion guide, do not send</p> <p>Required when the location of health care service performed is different than the Service Address of the Billing Provider (Loop ID-2010AA) that is registered in MESA and is different than the Service Address of the Rendering Provider (Loop ID-2310D) as registered in MESA</p>
	N4	Service Facility Location City, State, Zip Code		<p>If not required by this companion guide, do not send</p> <p>Required when the location of health care service performed is different than the Service Address of the Billing Provider (Loop ID-2010AA) that is registered in MESA and is different than the Service Address of the Rendering Provider (Loop ID-2310D) as registered in MESA</p>

Loop ID	Reference	Name	Codes	Notes/Comments
	REF	Service Facility Location Secondary Information		Required only for atypical, non-healthcare providers who are unable to obtain an NPI for NM109, and use an identification number other than NPI for the receiver to identify the Provider
	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>
2320	SBR	Other Subscriber Information		Required
	SBR01	Payer Responsibility Sequence Number Code	A, B, C, D, E, F, G, H, P, S, T, U	For Managed Care, CCO's information is always 'P' (Primary). This is also true for corresponding segment occurrences associated with Primary COB/CCO integration. For 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
	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	Do NOT use MC – Medicaid for this segment when reporting information about <u>another payer or payers</u> involved in this claim 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

Loop ID	Reference	Name	Codes	Notes/Comments
				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 Use a value of 'MA' (Medicare Part A), 'MB' (Medicare Part B) to identify Medicare Payers, '16' (Health Maintenance Organization (HMO) Medicare Risk) for Medicare Part C or 'OF' (Medicare Part D). Otherwise, use a value of 'ZZ' (Mutually Defined) to identify CCO payers 1st occurrence Use value 'CI' (Commercial Insurance Co.) to identify TPL Payer
	CAS	Claim Level Adjustments		Include this segment when Other Payer made payment at the claim level

Loop ID	Reference	Name	Codes	Notes/Comments
	CAS01	Claim Adjustment Group Code	CO, CR, OA, PI, PR	<p>CO - Contractual Obligations CR - Correction and Reversals OA - Other adjustments PI - Payor Initiated Reductions PR - Patient Responsibility</p> <p>Claim Adjustment Group Code: Used to report the general category of a claim level payment adjustment to identify claims in loop 2320 SBR09 value equals one of the following: 'MA' (Medicare Part A) 'MB' (Medicare Part B) '16' (Health Maintenance Organization (HMO) Medicare Risk) to identify Medicare Part C 'OF' (Medicare Part D)</p> <p>Required, when CCO reports denied encounters OR TPL coverage OR Prior payer adjustments at claim level. For CCOs, please ensure to report any 'Copay dollars' using Group Code 'PR' and Reason Code '3' (Co-payment)</p>
	CAS02	Adjustment Reason Code		<p>Adjustment Reason Code: Used to report the detailed reason the adjustment was made at claim level to identify claims in loop 2320 SBR09 value equals one of the following: 'MA' (Medicare Part A) 'MB' (Medicare Part B) '16' (Health Maintenance Organization (HMO) Medicare Risk) to identify Medicare Part C 'OF' (Medicare Part D)</p>
	CAS05			
	CAS08			
	CAS11			
	CAS14			
	CAS17			

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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 made at claim level to identify claims in loop 2320 SBR09 value equals one of the following: 'MA' (Medicare Part A) 'MB' (Medicare Part B) '16' (Health Maintenance Organization (HMO) Medicare Risk) to identify Medicare Part C 'OF' (Medicare Part D)
	CAS04 CAS07 CAS10 CAS13 CAS16 CAS19	Adjustment Quantity		Refer to TR3
	AMT	Coordination of Benefits (COB) Payer Paid Amount		Required for CCO and ADVANTAGE/MEDICARE-PART-C for Medicare Advantage/ Part-C Claims" (Part A, Part B, Part C or Part D) claims
	AMT01	Amount Qualifier Code	D	D - Payor Amount Paid
	AMT02	Payer Paid Amount		PAYER PAID AMT CCO Paid amount when primary, otherwise paid amount per COB.
	OI	Other Insurance Coverage Information		Required
	OI03	Benefits Assignment Certification Indicator	N, W, Y	N - No W - Not Applicable Y - Yes
	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
2330A	NM1	Other Subscriber Name		

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Loop ID	Reference	Name	Codes	Notes/Comments
	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
	DTP03	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		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#####
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		

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Loop ID	Reference	Name	Codes	Notes/Comments
	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>
	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
2400	HCP	Line Pricing/RePricing Information		Required

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Loop ID	Reference	Name	Codes	Notes/Comments
	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
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

Loop ID	Reference	Name	Codes	Notes/Comments
	SVD02	Service Line Paid Amount		<p>Service Line Paid Amount:</p> <p>Report any CCO Paid Line Amounts OR TPL payments at the Line Service Line Paid Amount</p> <p>Used to report paid amount if a Medicare 'B' or Medicare Advantage C Payer is identified in Loop 2320 (SBR09 = 'MB' or '16')</p>
	CAS	Claim Level Adjustments		Include this segment when Other Payer made payment at the service line level
	CAS01	Claim Adjustment Group Code	CO, CR, OA, PI, PR	<p>CO - Contractual Obligations CR - Correction and Reversals OA - Other adjustments PI - Payor Initiated Reductions PR - Patient Responsibility</p> <p>Claim Adjustment Group Code: Used to report the general category of a claim level payment adjustment to identify claims in loop 2320 SBR09 value equals one of the following:</p> <p>'MA' (Medicare Part A) 'MB' (Medicare Part B) '16' (Health Maintenance Organization (HMO) Medicare Risk) to identify Medicare Part C 'OF' (Medicare Part D)</p> <p>Required, when CCO reports denied encounters OR TPL coverage OR Prior payer adjustments at line level.</p> <p>For CCOs, please ensure to report any 'Copay dollars' using Group Code 'PR' and Reason Code '3' (Co-payment)</p>

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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 at claim level to identify claims in loop 2320 SBR09 value equals one of the following: 'MA' (Medicare Part A) 'MB' (Medicare Part B) '16' (Health Maintenance Organization (HMO) Medicare Risk) to identify Medicare Part C 'OF' (Medicare Part D)
	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	Adjustment Amount		Adjustment Amount: Used to report the amount of adjustment made at claim level to identify claims in loop 2320 SBR09 value equals one of the following: 'MA' (Medicare Part A) 'MB' (Medicare Part B) '16' (Health Maintenance Organization (HMO) Medicare Risk) to identify Medicare Part C 'OF' (Medicare Part D)
	CAS04 CAS07 CAS10 CAS13 CAS16 CAS19	Adjustment Quantity		<i>Refer to TR3</i>
	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>

Loop ID	Reference	Name	Codes	Notes/Comments
	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. Medicare Cross Over Claim Segment Examples

The logic differs depending on the 837 claim type.

- 1) There is no specific claim type logic for 837Ds. D = Dental Claim.
- 2) For 837Ps, the claim type is initially set to M = Professional Claim.
 If 2320 SBR09= MA (Medicare Part A) or MB (Medicare Part B) or 16 (Medicare Part C) and 2320 or 2430 CAS01 = PR and CAS02, 05, 08, 11, 14, or 17 = 1 or 2 or 3 or 122
OR
 If 2320 SBR09 = MA or MB or 16 & 2320 AMT01=D and AMT02 > 0
 Then the claim type is set to B = Professional Crossover claim type.
- 3) For 837I, the logic is similar to the 837P in that it still checks a) SBR09 for MA, MB, or 16, b) 2320 or 2430 CAS01 = PR and CAS02, 05, 08, 11, 14, or 17 = 1 or 2 or 3 or 122, and c) 2320 AMT01=D & AMT02 > 0.

The difference is that it also has to consider the 2300:CLM05-1 value when determining whether to set claim types to A = Inpatient Crossover or C = Outpatient Crossover.

- If CLM05-1 is = 11, 15, 16, 17 or 18 and Loop 2320 and SBR09 = MA, MB, or 16 and Loop 2320 or 2430 CAS01=PR and CAS02, 05, 08, 11, 14 or 17 = 1, 2, 3 or 66; or CLM05-1 is = 11, 15, 16, 17 or 18, and Loop 2320 SBR09 = MA, MB, or 16 and AMT02 >0 where AMT01=D, set claim type to A = Inpatient Crossover
- If CLM05-1 is = 12,13,14,19,22,23,24,29,31, or greater than 35 (except 65, 66, 86 and 89) and Loop 2320 SBR09 = MA, MB, or 16 and Loop 2320 or 2430 CAS01=PR and CAS02, 05, 08, 11, 14 or 17 = 1, 2, 3 or 66; or CLM05-1 is = 12,13,14,19,22,23,24,29,31, or greater than 35 (except 65 and 66) and Loop 2320 SBR09 = MA, MB, or 16 and AMT02 >0 where AMT01=D, set claim type to C = Outpatient Crossover
- If CLM05-1 is = 21, 25, 26, 27, 28, 65, 66, 86 or 89 and Loop 2320 SBR09 = MA, MB, or 16 and Loop 2320 or 2430 , CAS01=PR and CAS02, 05, 08, 11, 14 or 17 = 1, 2, 3 or 66; or CLM05-1 is = 21, 25, 26, 27, 28, 65, or 66 and Loop 2320 SBR09 = MA, MB, or 16 and AMT02 >0 where AMT01=D, set claim type to A = Inpatient Crossover
- If CLM05-1 is = 32, 33, or 34 and Loop 2320 SBR09 = MA, MB, or 16 and Loop 2320 or 2430 , CAS01=PR and CAS02, 05, 08, 11, 14 or 17 = 1, 2, 3 or 66; or CLM05-1 is = 11, 15, 16, 17 or 18, and Loop 2320 SBR09 = MA, MB, or 16 and AMT02 >0 where AMT01= D, set claim type to C = Outpatient Crossover

Examples:

Table 4. Professional Crossover Claims (837P)

Loop ID	Segment	Example
2320	SBR09	SBR*P*18**OTHER PAYER NAME*****MA, MB, OR 16
2320 or 2430	CAS	CAS*CO*45*110.73**253*2.64**144*-.64~ CAS*PR*2*32.85~

Loop ID	Segment	Example
2320	AMT	AMT*D*129.42~

Table 5. Outpatient Crossover Claims (837I)

Loop ID	Segment	Example
2300	CLM05-1	CLM* PATIENT CONTROL NUMBER*17359.41***FACILITY TYPE=13:A:1**A*Y*Y~
2320	SBR09	SBR*P*18**OTHER PAYER NAME*****MA, MB, OR 16
2430	CAS01	CAS*CO*45*144.68**253*1.93~
	CAS02	CAS*PR*2*24.07~
2320	AMT	AMT*D*94.32~

Table 6. Inpatient Crossover Claims (837I)

Loop ID	Segment	Example
2300	CLM05-1	CLM* PATIENT CONTROL NUMBER*17359.41***FACILITY TYPE=11:A:1**A*Y*Y~
2320	SBR09	SBR*P*18**OTHER PAYER NAME*****MA, MB, OR 16
2320	CAS	CAS*CO*253*112.91**97*14955.41~ CAS*OA*94*-4797.36~ CAS*PR*3*1556~
2320	AMT	AMT*EAF*1556~ AMT*D*5532.45~

Appendix B. 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 4 - Naming Your File Loop 2330B, REF02, Page 20 – CR #1476 CCO’s Subcontractor Identifier
0.2	2/15/2022	EDI Technical Team	Loop 2010BB, NM103 and NM109, Page 11, 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 19-20, 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 2320 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 Loop 2400 NTE, Page 22, Removed Mississippi Logo clean-up Copyright change from 2021 to 2022
0.5	8/10/2022	EDI Technical Team	Loop 2010BB NM109, Page 11 verbiage removed “For Managed Care, value is CCO Payer Identifier”
0.6	9/2/2022	EDI Technical Team	Section 9.1, Page 5 - Naming Your File .dat <filetypeext> removed.
0.7	9/30/2022	EDI Technical Team	Production connectivity URLs and contact information updated, Pages 2 and 4 Loop 2010BB REF02, Page 11 verbiage added for atypical and Non-Par providers, reads as For atypicals and Non-Par provider is required where an NPI is not assigned.

Version #	Date of release	Author	Description of change
0.8	10/18/2022	EDI Technical Team	Loops 2010BB, 2310A, and 2310E, REF, Pages 11 and 16 verbiage added “Required only for atypical, non-healthcare providers who are unable to obtain an NPI for NM109, and use an identification number other than NPI for the receiver to identify the Provider”
0.9	11/16/2022	EDI Technical Team	Loop 2300, PWK, Pages 13 of the 837D and 837I, and Page 16 of the 837P EOMB Attachment for Crossover Claims Required rules added
1.0	12/14/2022	EDI Technical Team	Loop 2300, PWK02, Page 13 of the 837D and 837I, Page 16 of the 837P Qualifier BM – By Mail, and Instructions added.
1.1	1/27/2023	EDI Technical Team	Secondary Claim Clarification Need - Loops 2320 and 2430, SBR, CAS and AMT Segments, Pages 18 thru 22, and 26 thru 28 of the 837D and 837I, Pages 21 thru 24, and 28 thru 30 of the 837P
1.2	4/14/2023	EDI Technical Team	Loop 2300, CLM05-3, Page 12 of the 837D, 837I and 837P Claim Frequency Codes and Notes/Comments clarification added PWK, Pages 13 and 14 of the 837D and 837I, Pages 16 and 17 of the 837P Notes/Comments updates and PWK05 rule added.
1.3	4/19/2023	EDI Technical Team	Secondary Claim Medicare Part C Clarification Needs - Loops 2320 and 2430, SBR and CAS Segments, Pages 18 thru 22, and 26 thru 28 of the 837D and 837I, Pages 21 thru 24, and 28 thru 30 of the 837P

Version #	Date of release	Author	Description of change
1.4	6/14/2023	EDI Technical Team	<p>Loop 2310E, NM1, N3 and N4, Pages 17 and 18 of the 837I and Loop 2310C Page 17 of the 837D, Pages 19 and 20 of the 837P Service Facility Location Notes/Comments added to read “If not required by this companion guide, do not send</p> <p>Required when the location of health care service performed is different than the Service Address of the Billing Provider (Loop ID-2010AA) that is registered in MESA and is different than the Service Address of the Rendering Provider (Loop ID-2310D) as registered in MESA”</p>
1.5	6/22/2023	EDI Technical Team	<p>Loops 2320 and 2340 CAS Notes/Comments corrected to read “Loop 2320 SBR01 and SBR09”....837I Pages 20, 21, 25 and 26, 837P Pages 23, 24, 29 and 30 and 837D Pages 20, 25 and 26</p>
1.6	10/6/2023	EDI Technical Team	<p><i>Page 28, ADDED Appendix A - Medicare Crossover Claim Segment Example</i></p> <p>Page 30 and beyond, MOVED Change History Log to Appendix B</p>
1.7	11/6/2023	EDI Technical Team	<p>Loop 2000B, SBR09, Page 9 and Loop 2320, SBR09, Page 18 Qualifier Clarification</p> <p>Loop 2300, Prior Authorization, REF Segment, Page 13 added</p>
1.8	2/15/2024	EDI Technical Team	<p>Loop 2300, PWK, Page 12, Medicare Denied Claim EOMB Notes/Comments rule added</p> <p>Loop 2300, REF/REF02, Page 13, Defect #18972 Prior Authorization Notes/Comments Clarification</p>