MMIS Replacement Project (MRP)

Health Care Claim Institutional (837) Transaction Standard Companion Guide

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

October 2025

Version 1.11

Disclosure Statement

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.

This page intentionally left blank.

Table of Contents

List of Tables

This page intentionally blank.

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 Porta 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
  - 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 yyyymmddhhmm 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		*Refer to TR3*
	ISA16	Component Element Separator	:	Colon
	GS	**Functional Group Header**		
	GS01	Functional Identifier Code		*Refer to TR3*
	GS02	Application Sender's Code	Trading Partner ID	Value should equal ISA06
	GS03	Application Receiver's Code	77032	Value should equal ISA08
	GS07	Responsible Agency Code	X	
	GS08	Version / Release / Industry / Identifier Code	005010X223A2	
	ST	**Transaction Set Header**		**Transactions (ST-SE envelopes) are limited to a maximum of 5000 CLM segments**
	ST01	Transaction Set Identifier Code	837	837 – Health Care Claim
	ST03	Implementation Convention Reference	005010X223A2	

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		*Refer to TR3*
	PER03	Communication Number Qualifier	EM, FX, TE	EM – Electronic Mail FX – Facsimile TE – Telephone
	PER04	Communication Number		*Refer to TR3*
	PER05	Communication Number Qualifier	EM, EX, FX, TE	EM – Electronic Mail EX – Telephone Extension FX – Facsimile TE – Telephone For CCOs, use the "EM" qualifier to indicate Certification Statement
	PER06	Communication Number		For CCOs, submit the Certification Statement: "TO MY KNOWLEDGE INFORMATION AND BELIEF, THE DATA IN THIS FILE IS ACCURATE COMPLETE AND TRUE" **NOTE**: if Cert not submitted the Encounter would be rejected
1000B	**NM1**	**Receiver Name**		
	NM101	Entity Identifier Code	40	40 – Receiver
	NM103	Receiver Name		MISSISSIPPI DIVISION OF MEDICAID

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		*Refer to TR3*
	NM104	Billing Provider First Name		*Refer to TR3*
	NM105	Billing Provider Middle Name or Initial		*Refer to TR3*
	NM107	Billing Provider Name Suffix		*Refer to TR3*
	NM108	Identification Code Qualifier	XX	XX - NPI
	NM109	Billing Provider Identifier		Value is 10-digit NPI of Billing Provider

Loop ID	Reference	Name	Codes	Notes/Comments
	N3	**Billing Provider Address**		**Required; Billing Provider Address details** **CMS/TR3 Notes the Billing Provider Address must be a street address. PO Box and Lock Box addresses are to be sent in the Pay-To Address Loop (2010AB) if necessary.**
	N4	**Billing Provider City, State, Zip Code**		**Required; Billing Provider City, State, Zip code**
	REF	**Billing Provider Tax Identification**		
	REF01	Reference Identification Qualifier	EI	EI - Employer's Identification Number
	REF02	Billing Provider Tax Identification Number		*Refer to TR3*
2000B	**HL**	**Subscriber Hierarchical Level**		
	HL03	Hierarchical Level Code	22	22 – Subscriber
	SBR	**Subscriber Information**		
	SBR01	Payer Responsibility Sequence Number Code	A, B, C, D, E, F, G, H, P, S, T, U	A – Payer Four B – Payer Five C – Payer Six D – Payer Seven E – Payer Eight F – Payer Nine G – Payer Ten H – Payer Eleven P – Primary S – Secondary T – Tertiary U – Unknown For CCOs, use 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

Loop ID	Reference	Name	Codes	Notes/Comments
	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
	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		*Refer to TR3*
	CLM02	Total Claim Charge Amount		*Refer to TR3*

Loop ID	Reference	Name	Codes	Notes/Comments
	CLM05-1	Facility Type Code		*Refer to TR3*
	CLM05-2	Facility Code Qualifier	A	A - Uniform Billing Claim Form Bill Type
	CLM05-3	Claim Frequency Code	1, 7, 8	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 1 - Original Claim 7 - Adjustment (Replacement for a Prior Paid Claim) 8 – Void (Void/Cancel for a Prior Claim) **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
	CLM07	Assignment or Plan Participation Code	A, C	A – Assigned C - Not Assigned
	CLM08	Benefits Assignment Certification Indicator	N, W, Y	N – No W - Not Applicable Y – Yes
	CLM09	Release of Information Code	I, Y	I - Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes Y - Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim
	DTP	**Discharge Hour**		
	DTP01	Date Time Qualifier	096	096 – Discharge Hour
	DTP02	Date Time Period Format Qualifier	TM	TM - Time Expressed in Format HHMM
	DTP03	Discharge Hour		*Refer to TR3*
	DTP	**Statement Dates**		
	DTP01	Date Time Qualifier	434	434 Statement
	DTP02	Date Time Period Format Qualifier	D8 RD8	D8 – CCYYMMDD RD8 - CCYYMMDD-CCYYMMDD
	DTP03	Statement From and To Date		CCYYMMDD
	DTP	**Admission Date/Hour**		

Loop ID	Reference	Name	Codes	Notes/Comments
	DTP01	Date Time Qualifier	435	435 – Admission
	DTP02	Date Time Period Format Qualifier	D8 DT	D8 – CCYYMMDD DT - CCYYMMDDHHMM
	DTP03	Admission Date and Hour		*Refer to TR3*
	DTP	**Date – Repricer Received**		
	DTP01	Date Time Qualifier	050	050 – Received
	DTP02	Date Time Period Format Qualifier	D8	D8 - CCYYMMDD
	DTP03	Repricer Received Date		CCYYMMDD
	CL1	**Institutional Claim Code**		
	CL101	Admission Type Code		*Refer to TR3*
	CL102	Admission Source Code		*Refer to TR3*
	CL103	Patient Status Code		*Refer to TR3*
	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		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 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
	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		Please submit the13-digit transaction control number (TCN), or MES 13-digit Identification Control Number (ICN), assigned by the MS MMIS adjudication system **Note**: The previously submitted CCO's encounter TCN can be obtained from either the electronic 835 (RA) or 277 Claim status response files PAYER CLAIM CONTROL NUMBER To cancel or adjust a previously submitted claim, please submit the 17-digit TCN, assigned by the MS MMIS adjudication system and printed on the remittance advice for the previously submitted claim that is being replaced or voided by this claim
	NTE	**Claim Billing Note**		**Required for CCO Encounters Submissions**
	NTE01	Note Reference Code	ADD	Please use the qualifier 'ADD' to indicate additional information
	NTE02	Description		Please submit a VALUE of 'Y/N' for PAR / NON-PAR value followed by a value for 'CLAIM RECEIVED DATE' IN CCYYMMDD format The sample value would look something similar: 'Y20110101'
	HI	**Claim Health Care Diagnosis Code**		**Mississippi process/uses twelve diagnosis codes.**
	HI01-1	Code List Qualifier Code	ABK, BK	ABK- International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis BK - International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Diagnosis
	HI01-2	Principal Diagnosis Code		*Refer to TR3*

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**
	HCP	**Claim Pricing/Repricing Information**		**FFS: Required when information is necessary by the repricer.** **Encounters: Required by Mississippi Medicaid for CCO Status.** **NOTE: 837I Encounter transactions will be rejected if both the 2300 HCP01 and HCP02 as well as the 2400 HCP01 and HCP02 are not sent.**

	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 For CCOs - Although the HCP segment has 15 qualifiers, DOM HPSS is utilizing the following qualifiers: HCP 01 Code 00-Zero Pricing (Not Covered Under Contract) with CCO paid amount of $0.00 (2430 SVD 02) will denote a denied claim and/or claim line. HCP 01 Code 04-Bundling Pricing with CCO paid amount of $0.00 (2430 SVD 02) will denote a zero ($0.00) paid claim and *not a denial*. HCP 01 Code 10-Other Pricing with CCO paid amount (2430 SVD 02) greater than zero will denote a paid claim and/or claim line. HCP 01 Code 14-Adjustment Pricing with CCO paid amount of $0.00 (2430 SVD 02) will denote a paid claim and/or claim line. NOTE: This would be when the CCO pays $0 but there was a TPL payment. This would not include a CCO denied claim/line regardless of TPL payments.

Loop ID	Reference	Name	Codes	Notes/Comments
				HCP 02 Monetary Amount should indicate the CCO allowed amount.
	HCP02	Repriced Allowed Amount		Allowed Amount: Use to report the CCO allowed amount
2310A	**NM1**	**Attending Provider Name**		**Report Attending Provider Info on Hospital Inpatient claims, if exists**
	NM101	Entity Identifier Code	71	71 – Attending Physician
	NM102	Entity Type Qualifier	1	1 – Person
	NM103	Attending Provider Last Name		*Refer to TR3*
	NM104	Attending Provider First Name		*Refer to TR3*
	NM105	Attending Provider Middle Name or Initial		*Refer to TR3*
	NM107	Attending Provider Name Suffix		*Refer to TR3*
	NM108	Identification Code Qualifier	XX	XX – NPI
	NM109	Attending Provider Primary Identifier		**Note**: When the Attending Physician is a healthcare provider populate this field with the NPI number The Attending Physician NPI is necessary to adjudicate the claim if the loop is applicable If missing from the 2310A loop, all claims in the 837 will be returned to submitter
	PRV	**Attending Provider Specialty Information**		**PRV segment is required by Mississippi Medicaid when the Attending NPI represents multiple entities or sub-parts**
	PRV01	Provider Code	AT	AT - Attending
	PRV02	Reference Identification Qualifier	PXC	PXC - Health Care Provider Taxonomy Code
	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**

Loop ID	Reference	Name	Codes	Notes/Comments
	REF01	Reference Identification Qualifier	0B, 1G, G2, LU	0B - State License Number 1G - Provider UPIN Number G2 - Provider Commercial Number LU - Location Number
	REF02	Attending Provider Secondary Identification		*Refer to TR3*
2310B	**REF02**	**Operating Physician Secondary Identification**		**Indicate the Mississippi Division of Medicaid provider number**
2310C	**REF02**	**Other Operating Physician Secondary Identification**		**Indicate the Mississippi Division of Medicaid provider number**
2310D	**REF02**	**Rendering Provider Secondary Information**		**For atypicals and Non-Par provider is required** **Indicate the Mississippi Division of Medicaid provider number**
2310E	**NM1**	**Service Facility Location Name**		**If not required by this companion guide, do not send** **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**
	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

Loop ID	Reference	Name	Codes	Notes/Comments
	N3	**Service Facility Location Address**		**If not required by this companion guide, do not send** **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**
	N4	**Service Facility Location City, State, Zip Code**		**If not required by this companion guide, do not send** **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**
	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		*Refer to TR3*
2320	**SBR**	**Other Subscriber Information**		**Required**

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	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 another payer or payers 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 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

Loop ID	Reference	Name	Codes	Notes/Comments
				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**
	CAS01	Claim Adjustment Group Code	CO, CR, OA, PI, PR	CO - Contractual Obligations CR - Correction and Reversals OA - Other adjustments PI - Payor Initiated Reductions PR - Patient Responsibility Claim Adjustment Group Code: Used to report the general category of a claim level payment adjustment 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) **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)**

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		*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

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
2330A	**NM1**	**Other Subscriber Name**		
	NM109	Other Insured Identifier		Value is 9-digit Mississippi Division of Medicaid Recipient/Beneficiary ID This field can be ten characters long if you are including your co-pay indicator
2330B	**NM1**	**Other Payer Name**		
	NM101	Entity Identifier Code	PR	PR – Payer
	NM108	Identification Code Qualifier	PI	PI - Payor Identification
	NM109	Other Payer Primary Identifier		Value is 'CCO Provider number OR Other Payer (if any)' This number must be identical to SVD01 (Loop ID-2430) for COB
	DTP	**Other Payer Claim Check or Remittance Date**		**Encounters: Required by Mississippi Medicaid when CCOs adjudicated or paid the claim in their system**
	DTP01	Date Time Qualifier	573	573 – Date Claim Paid
	DTP02	Date Time Period Format Qualifier	D8	D8 - CCYYMMDD
	DTP03	Date Time Period		Encounters: Value should reflect the date the CCO paid the provider for the claim or adjustment, or the date a recoupment was received from the provider for any voids. If no payment was made to the provider, the paid date would reflect the adjudication date. All Others Refer to TR3
	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**

Loop ID	Reference	Name	Codes	Notes/Comments
	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 + CCO 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**		
	LX01	Assigned Number		*Refer to TR3*
	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		*Refer to TR3*
	SV202-2	Procedure Code		*Refer to TR3*
	SV203	Lien Item Charge Amount		*Refer to TR3*
	SV204	Unit or Basis for Measurement Code	DA, UN	DA – Days UN – Units For CCOs, use UN - Units
	SV205	Service Unit Count		*Refer to TR3*
	PWK	**Line Supplemental Information**		***Refer to TR3***

Loop ID	Reference	Name	Codes	Notes/Comments
	DTP	**Date – Service**		***Refer to TR3***
	REF	**Line Item Control Number**		***Refer to TR3***
	REF	**Repriced Line Item Reference Number**		***Refer to TR3***
	REF	**Adjusted Repriced Line Item Reference Number**		***Refer to TR3***
	AMT	**Service Tax Amount**		***Refer to TR3***
	AMT	**Facility Tax Amount**		***Refer to TR3***
	HCP	**Claim Pricing/Repricing Information**		**FFS: Required when information is necessary by the repricer.** **Encounters: Required by Mississippi Medicaid for CCO Status.** **NOTE: 837I Encounter transactions will be rejected if both the 2300 HCP01 and HCP02 as well as the 2400 HCP01 and HCP02 are not sent.**

	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 For CCOs - Although the HCP segment has 15 qualifiers, DOM HPSS is utilizing the following qualifiers: HCP 01 Code 00-Zero Pricing (Not Covered Under Contract) with CCO paid amount of $0.00 (2430 SVD 02) will denote a denied claim and/or claim line. HCP 01 Code 04-Bundling Pricing with CCO paid amount of $0.00 (2430 SVD 02) will denote a zero ($0.00) paid claim and *not a denial*. HCP 01 Code 10-Other Pricing with CCO paid amount (2430 SVD 02) greater than zero will denote a paid claim and/or claim line. HCP 01 Code 14-Adjustment Pricing with CCO paid amount of $0.00 (2430 SVD 02) will denote a paid claim and/or claim line. NOTE: This would be when the CCO pays $0 but there was a TPL payment. This would not include a CCO denied claim/line regardless of TPL payments.

Loop ID	Reference	Name	Codes	Notes/Comments
				HCP 02 Monetary Amount should indicate the CCO allowed amount.
	HCP02	Repriced Allowed Amount		Allowed Amount: Use to report the CCO allowed amount
2410	**LIN**	**Drug Identification**		***(Note: Required when Loop 2400 procedure code is a drug-related HCPCS code.)***
	LIN03	National Drug Code		NDC code Please use to specify billing/reporting of drugs provided that may be a part of the service described in SV1
2420A	**REF**	**Operating Physician Secondary Identifier**		**Indicate the Mississippi Division of Medicaid provider number**
2420C	**REF**	**Rendering Provider Secondary Identification**		**Only Required for atypicals or non-par Providers**
	REF02	Rendering Provider Secondary Identifier		Indicate the Mississippi Division of Medicaid provider number, if reported
2430	**SVD**	**Line Adjudication Information**		**Required for Medicare Advantage/ Part-C Claims**
	SVD01	Identification Code		Value is CCO assigned Provider Number OR this number should match NM109 in Loop ID-2330B identifying Other Payer
	SVD02	Service Line Paid Amount		Service Line Paid Amount: Report any CCO Paid Line Amounts OR TPL payments at the Line Service Line Paid Amount Used to report paid amount if a Medicare ‘B’ or Medicare Advantage C Payer is identified in Loop 2320 (SBR09 = ‘MB’ or ‘16’)
	CAS	**Claim Level Adjustments**		**Include this segment when Other Payer made payment at the service line level**

Loop ID	Reference	Name	Codes	Notes/Comments
	CAS01	Claim Adjustment Group Code	CO, CR, OA, PI, PR	CO - Contractual Obligations CR - Correction and Reversals OA - Other adjustments PI - Payor Initiated Reductions PR - Patient Responsibility Claim Adjustment Group Code: Used to report the general category of a claim level payment adjustment 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) **Required, when CCO reports denied encounters OR TPL coverage OR Prior payer adjustments at line level.** **For CCOs, please ensure to report any 'Copay dollars' using Group Code 'PR' and Reason Code '3' (Co-payment)**
	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)

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*
	DTP	**Line Check or Remittance Date**		
	DTP01	Date Time Qualifier	573	573 – Date Claim Paid
	DTP02	Date Time Period Format Qualifier	D8	D8 – CCYYMMDD
	DTP03	Adjudication or Payment Date		Adjudication or Payment Date (CCYYMMDD)
	AMT	**Remaining Patient Liability**		
	AMT01	Amount Qualifier Code	EAF	EAF - Amount Owed
	AMT02	Payer Paid Amount		
	SE	**Transaction Set Trailer**		
	SE01	Transaction Segment Count		*Refer to TR3*
	SE02	Transaction Set Control Number		*Refer to TR3*
	GE	**Functional Group Trailer**		
	GE01	Number of Transaction Sets Included		*Refer to TR3*
	GE02	Group Control Number		*Refer to TR3*
	IEA	**Interchange Control Trailer**		
	IEA01	Number of Included Functional Groups		*Refer to TR3*
	IEA02	Interchange Control Number		*Refer to TR3*

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 must 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 CAS02	CAS*CO*45*144.68**253*1.93~ 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	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** **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"**
1.5	6/22/2023	EDI Technical Team	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
1.6	10/6/2023	EDI Technical Team	*Page 28, ADDED Appendix A - Medicare Crossover Claim Segment Example* Page 30 and beyond, MOVED Change History Log to Appendix B
1.7	11/6/2023	EDI Technical Team	Loop 2000B, SBR09, Page 9 and Loop 2320, SBR09, Page 18 Qualifier Clarification Loop 2300, Prior Authorization, REF Segment, Page 13 added
1.8	2/15/2024	EDI Technical Team	Loop 2300, PWK, Page 12, Medicare Denied Claim EOMB Notes/Comments rule added Loop 2300, REF/REF02, Page 13, Defect #18972 Prior Authorization Notes/Comments Clarification

Version #	Date of release	Author	Description of change
1.9	4/11/2025	EDI Technical Team	CR 2417 Companion Guide Updates/Additions for CCOs Loop 2010AA, N3, Page 9, Notes/Comments rule updates for PO Box/Lock Box address rule Loop 2330B, DTP, Page 22, Notes/Comments rule updated for Encounter CCO Paid Date value. Loop 2400, PWK, DTP, REF, AMT, Pages 23 thru 24 Note/Comments rule updates “Refer to TR3”
1.10	10/12/2025	EDI Technical Team	CR 2407 Companion Guide Additions for CCOs. Loop 2300, HCP01 and HCP02, Page 16 thru 17 Loop 2400, HCP01 and HCP02, Page 25 thru 27
1.11	10/22/2025	EDI Technical Team	CR 2407 Companion Guide Additions for CCOs. Loop 2300, HCP01 and HCP02, Clarification Page 16 thru 17 Loop 2400, HCP01 and HCP02, Clarification Page 25 thru 27