EDI COMPANION GUIDES

X12N VERSION 4010A1 COMPANION GUIDE

DISCLOSURE STATEMENT

The information in this document is intended for billing providers and technical staff who wish to exchange electronic transactions with MO HealthNet. This document is to be used in conjunction with the ASC X12N Implementation Guides to define transaction requirements. It does not define MO HealthNet policy billing issues. These types of issues can be found in the MO HealthNet Provider Manuals through the MO HealthNet Division's website at http://dss.missouri.gov/mhd.

PREFACE

This Companion Guide to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content being requested when data is transmitted electronically to the MO HealthNet fiscal agent. Transmissions based on this companion document, used in tandem with the ASC X12N Implementation Guides, are compliant with both 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.

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 standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

HIPAA serves to:

- create better access to health insurance;
- limit fraud and abuse;
- reduce administrative costs.

PURPOSE OF THE COMPANION GUIDE

The X12 Version 4010A1 Companion Guide explains the procedures necessary for trading partners to successfully exchange transactions electronically with MO HealthNet in standard HIPAA compliant forms. These transactions include the following.

Health Care Eligibility Benefit Inquiry and Response	ASC X12N 270/271
Health Care Claim Status Request and Response	ASC X12N 276/277

Health Care Services Review-Request for Review and Response	ASC X12N 278
Payroll Deducted and Other Group Premium Payment for Insurance Products	ASCX 12N 820
Benefit Enrollment and Maintenance	ASC X12N 834
Health Care Claim Payment Advice	ASC X12N 835
Health Care Claim: Dental	ASC X12N 837D
Health Care Claim: Institutional	ASC X12N 837I
Health Care Claim: Professional	ASC X12N 837P
Functional Acknowledgement	ASC X12N 997

This Companion Guide is not intended to replace the ASC X12N Implementation Guides; rather it is intended to be used in conjunction with them. Additionally, the Companion Guide is intended to convey information that is within the framework and structure of the ASC X12N Implementation Guides and not to contradict or exceed them.

SCOPE

This Companion Guide provides information for populating data elements that are defined as payer or trading partner specific. In addition, it provides explanation of how claims are processed within the Missouri Medicaid Management Information System (MMIS) when specific data elements are populated with each of the valid choices (e.g., claim frequency type).

OVERVIEW

A summary of the sections in this Companion Guide follows:

Section 1—Getting Started: This section provides information for the completion of the necessary paperwork to begin testing with MO HealthNet.

Section 2—Testing With The Payer: This section provides a detailed description of the testing phase.

Section 3—Connectivity With The Payer: This section provides connectivity information.

Section 4—Contact Information: This section provides the contact information for technical assistance and billing issues.

Section 5—Control Segments/Envelopes: This section describes use of the interchange control and functional group control segments.

Section 6—Payer Specific Business Rules and Limitations: This section describes how to send transactions that have business rules specific to MO HealthNet.

REFERENCES

The ASC X12N Implementation Guides adopted under HIPAA that this document supplements can be found at www.wpc-edi.com. The MO HealthNet Provider Manuals can be accessed through the MO HealthNet Division's website at http://dss.missouri.gov/mhd/.

ADDITIONAL INFORMATION

Users of this Companion Guide must understand general EDI (Electronic Data Interchange) terminology. In addition, an understanding of the loop and segment structure within the ASC X12N Implementation Guides is helpful.

SECTION 1 - GETTING STARTED

WORKING WITH MO HEALTHNET

To begin exchanging EDI transactions with MO HealthNet, a biller must select one of two options for the exchange of electronic transactions. The first option is via an Internet connection through an ISP (Internet Service Provider) of the billers' choice. The second option utilizes Sterling Commerce's Connect:Direct software to link directly to Infocrossing Healthcare Services (IHS) Data Center.

Billers opting to use the Internet connection option are responsible for any costs involved in obtaining and use of the ISP to connect to the Internet. No additional cost is charged by MO HealthNet or its fiscal agent to use the Internet connection solution. A biller choosing this option must complete the Application for MO HealthNet Internet Access Account, which can be obtained at http://dss.missouri.gov/mhd/. For assistance with this form call the IHS Help Desk at (573) 635-3559.

Billers opting to use the Connect:Direct software solution should be aware that they are responsible for all setup and on-going cost involved in the purchasing and maintaining of the software, as well as for paying a monthly port charge to IHS as long as the connection is available for use. Billers should complete, sign and mail the Application for MO HealthNet Connect:Direct Access Account **and be contacted by technical support before** purchasing the software. This application is available at http://dss.missouri.gov/mhd/ or by calling the IHS Help Desk at (573) 635-3559. Upon receipt of the signed application, a IHS technical support person will contact you with the information needed to ensure the correct software is purchased.

TRADING PARTNER REGISTRATION

In addition to selecting a connection method, a biller must complete a Trading Partner Agreement form. The Trading Partner Agreement form is used to communicate trading partner identifiers and to indicate which transactions the biller wishes to exchange. The form is available at http://dss.missouri.gov/mhd/. For assistance with this form call the IHS Help Desk at (573) 635-3559.

An EDI Trading Partner is defined as any MO HealthNet customer (provider, billing service, software vendor, etc.) that transmits to, or receives electronic data from MO HealthNet.

CERTIFICATION AND TESTING OVERVIEW

Certification from a third party is not required to exchange EDI with MO HealthNet, however, doing so can help to speed the process of approval of the billers' transactions. Each type of transaction a biller wishes to send to MO HealthNet must pass test requirements before the biller is set up to send production transactions. Successful completion of test requirements requires, at a minimum, that the transactions are HIPAA compliant.

SECTION 2 - TESTING WITH THE PAYER

To test with MO HealthNet the appropriate access account application and Trading Partner Agreement form must be complete and on file with Infocrossing Healthcare Services.

Following completion of these forms, the Infocrossing Healthcare Services Help Desk notifies the biller that they are approved to send test transactions for those transactions they indicated on the Trading Partner Agreement form. In addition, the billers User ID and password is given to them at this time.

Until HIPAA is implemented into the production Missouri MMIS, billers may be required to send an additional test file for each transaction before being moved to production.

INTERNET OPTION

If the biller has chosen to exchange data through the Internet option:

- The biller logons to www.emomed.com.
- The biller selects "Send HIPAA test files" link.
- The biller populates the window with the test file name.
- The biller submits the information.
- A window appears either confirming successful receipt or notifying of non-receipt of the test file.
- If receipt was successful, the biller should check for appropriate responses in the "Receive HIPAA test files" area of the www.emomed.com website. Claim confirmation files (CC(TEST)) are generated automatically for all test 837 claim files.
- If receipt was not successful and the biller is unable to determine the reason for the non-receipt, contact the Infocrossing Healthcare Services (IHS) Help Desk at (573) 635-3559.
- If no claim confirmation file is available after 2 complete business days, contact the IHS Help Desk at (573) 635-3559.
- When the biller is satisfied with the results of the test (i.e., test claims are not rejected) and wants a specific transaction to be moved to production, the biller sends an e-mail to the IHS Help Desk at momedhelpdesk@momed.com. The biller must state in the e-mail what transaction they want to be moved to production. When IHS verifies that the biller has successfully submitted test claims, IHS moves the biller to production. IHS then returns the e-mail letting the biller know that they can send claims to production.

CONNECT:DIRECT OPTION

This section under construction

SECTION 3 - CONNECTIVITY WITH THE PAYER

TRANSMISSION ADMINISTRATIVE PROCEDURES

MO HealthNet processes batch transactions and Internet direct data entry (DDE) submissions every week night. Any expected response transactions can be accessed the following business day. Billers experiencing problems with sending or receiving files may contact the Infocrossing Healthcare Services Help Desk at (573) 635-3559.

COMMUNICATION PROTOCOL SPECIFICATIONS

The MO HealthNet Billing website, www.emomed.com, uses https (secured http) to send and receive transactions. Billers using Connect:Direct have a direct link to the fiscal agent, resulting in a secure connection.

PASSWORDS

In order to submit a batch transmission, a biller needs either their Internet User ID and password or their NDM ID and password. Passwords are not required within a transaction.

SECTION 4 - CONTACT INFORMATION

EDI CUSTOMER SERVICE

For questions pertaining to EDI processes, billers should first reference the appropriate Implementation Guides at www.wpc-edi.com or the Companion Guides at http://dss.missouri.gov/mhd/. If answers are not available within these guides, billers may contact the Infocrossing Healthcare Services Help Desk at (573) 635-3559.

PROVIDER SERVICE NUMBER

Billers with questions pertaining to MO HealthNet policies should first access the MO HealthNet Provider Manuals and MO HealthNet Electronic Billing Layout Manuals found through the MO HealthNet Division's website at http://dss.missouri.gov/mhd/. If answers are not available from these manuals, billers may contact the MO HealthNet Provider Relations hotline at (573) 751-2896.

APPLICABLE WEBSITES E-MAIL

- ANSI X12N HIPAA Implementation Guides are accessed at www.wpc-edi.com.
- This HIPAA Companion Guide is accessed at http://dss.missouri.gov/mhd/.
- MO HealthNet transaction and DDE submission and receipts are accessed at www.emomed.com.
- MO HealthNet Provider Manuals and MO HealthNet Electronic Billing Layout Manuals are accessed at http://dss.missouri.gov/mhd/.

SECTION 5 - CONTROL SEGMENTS/ENVELOPES

ISA-IEA

Batch

This section describes MO HealthNet's use of the interchange control segments specifically for batch transactions. It includes a description of expected sender and receiver codes and delimiters. NOTE: Uppercase lettering must be used in this segment.

Incoming Transactions to MO HealthNet

Loop	Segment	Data Element	Comments
NA	ISA	NA	Billers may use the data element separator and segment terminator of their choice, from the Basic Character Set or Extended Character Set, which are both defined in Appendix A of the ASC X12N Implementation Guide.
NA	ISA	ISA05	Use ‘ZZ’
NA	ISA	ISA06	Use the billers User ID provided upon successful completion of

			the Trading Partner Agreement.
NA	ISA	ISA07	Use ‘30’
NA	ISA	ISA08	Use ‘431754897’
NA	ISA	ISA13	This Unique Number must be identical to the Interchange Control Number in IEA02. Right justify, left pad with zeros to nine (9) bytes. Each submitter must start with a value of their choice and increment by at least one (1) each time a file is sent.
NA	ISA	ISA15	During the testing phase, billers must use "T." Once approved for production, use "P."
NA	ISA	ISA16	Billers may use the component element separator of their choice, from the Basic Character Set or Extended Character Set, which are both defined in Appendix A of the ASC X12N Implementation Guide.

Outgoing Transactions From MO HealthNet

Loop	**Segment**	**Data Element**	**Comments**
NA	ISA	NA	MO HealthNet uses ‘|’ as a data element separator and ‘~’ as a segment terminator.
NA	ISA	ISA05	MO HealthNet uses ‘30’
NA	ISA	ISA06	MO HealthNet uses ‘431754897’
NA	ISA	ISA07	MO HealthNet uses ‘ZZ’
NA	ISA	ISA08	MO HealthNet uses the 9-digit MO HealthNet provider ID.
NA	ISA	ISA16	MO HealthNet uses ‘!’ as a component element separator.

On-Line

This section describes MO HealthNet's use of the interchange control segments specifically for on-line transactions. It includes a description of expected sender and receiver codes and delimiters. NOTE: Uppercase lettering must be used in this segment. On-line transactions must be proceeded by a 4-byte CICS transaction ID, followed immediately by 'ISA'. A unique CICS transaction ID is assigned to each POS vendor for each on-line transaction. Contact Infocrossing Healthcare Services if you're unsure of the CICS transaction ID(s) for your company.

Incoming Transactions to MO HealthNet

Loop	Segment	Data Element	Comments
NA	ISA	NA	Billers may use the data element separator and segment terminator of their choice, from the Basic Character Set or

			Extended Character Set, which are both defined in Appendix A of the ASC X12N Implementation Guide.
NA	ISA	ISA05	Use ‘ZZ’
NA	ISA	ISA06	Use the CICS Tran ID of the transaction that you are sending.
NA	ISA	ISA07	Use ‘30’
NA	ISA	ISA08	Use ‘431754897’
NA	ISA	ISA15	During the testing phase, billers must use "T." Once approved for production, use "P."
NA	ISA	ISA16	Billers may use the component element separator of their choice, from the Basic Character Set or Extended Character Set, which are both defined in Appendix A of the ASC X12N Implementation Guide.

Outgoing Transactions From MO HealthNet

Loop	Segment	Data Element	Comments
NA	ISA	NA	MO HealthNet uses ‘|’ as a data element separator and ‘~’ as a segment terminator.
NA	ISA	ISA05	MO HealthNet uses ‘30’
NA	ISA	ISA06	MO HealthNet uses ‘431754897’
NA	ISA	ISA07	MO HealthNet returns value sent in ISA05 of incoming transaction.
NA	ISA	ISA08	MO HealthNet returns value sent in ISA06 of incoming transaction.
NA	ISA	ISA16	MO HealthNet uses ‘!’ as a component element separator.

GS-GE

Batch

This section describes MO HealthNet's use of the functional group control segments specifically for batch transactions. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how MO HealthNet expects functional groups to be sent and how MO HealthNet sends functional groups. These discussions describe how similar transaction sets are packaged and MO HealthNet's use of functional group control numbers. NOTE: Uppercase lettering must be used in this segment.

Incoming Transactions to MO HealthNet

Loop	**Segment**	**Data Element**	**Comments**

NA	GS	GS02	Use the billers user ID provided upon successful completion of the Trading Partner Agreement.
NA	GS	GS03	Use ‘431754897’
NA	GS	GS06	*This Unique Number must be identical to the Group Control Number in GE02. Each submitter should start with a value of their choice and increment by at least one (1) each time a file is sent.*

Outgoing Transactions From MO HealthNet

Loop	Segment	Data Element	Comments
NA	GS	GS02	MO HealthNet uses ‘431754897’
NA	GS	GS03	MO HealthNet uses the 9-digit MO HealthNet provider ID.

On-Line

This section describes MO HealthNet's use of the functional group control segments specifically for on-line transactions. It includes a description of expected application sender and receiver codes. Also included in this section is a description concerning how MO HealthNet expects functional groups to be sent and how MO HealthNet sends functional groups. These discussions describe how similar transaction sets are packaged and MO HealthNet's use of functional group control numbers. NOTE: Uppercase lettering must be used in this segment.

Incoming Transactions to MO HealthNet

Loop	Segment	Data Element	Comments
NA	GS	GS02	Billers can use the code of their choice.
NA	GS	GS03	Use ‘431754897’

Outgoing Transactions From MO HealthNet

Loop	Segment	Data Element	Comments
NA	GS	GS02	MO HealthNet uses ‘431754897’
NA	GS	GS03	MO HealthNet returns the value sent in ISA06 of incoming transaction.

SECTION 6 - PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

INTRODUCTION

Through the use of tables, this section describes how to bill or interpret MO HealthNet specific business rules (e.g., how to send/interpret diopters information or fluoride justification). It also describes how to populate or interpret trading partner or payer specific data elements. The tables contain a row for each segment or data element where MO HealthNet has something additional to convey. The intent is 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.

270/271 HEALTH CARE ELIGIBILITY BENEFIT INQUIRY AND RESPONSE

The MO HealthNet system requires certain situational fields in the 270 transaction in order to find a valid match. At a minimum, the MO HealthNet participant number or subscriber name and subscriber date of birth is required. Including the SSN offers an ever greater chance of finding a match in the system. If more that one of the search criteria fields are sent, a hierarchy is used to attempt to match. The first attempt is by participant number, then by name and date of birth, then by SSN and date of birth. Obviously, the more information that is given in the 270, the better the chance of finding a match. An alternate search method is by casehead ID and date of birth. This method can be used when the MO HealthNet number of someone with the same casehead ID as the subscriber is known. In this event, the casehead ID is sent in the 2100C/REF segment and the DOB of the subscriber is sent in the DMG segment. The NM1 segment only contains the NM101 and NM102 fields. The MO HealthNet system does not support the use of the 2100D dependent loop for casehead searches.

For online submissions of the 270 transactions, only 1 occurrence of the 2100B and 2100C loop is processed. Any additional iterations of these loops is ignored.

NOTE: MO HealthNet is following the required limitation of 99 subscriber requests per ST (transaction set) group as specified in Section 1.3.3 of the 270 implementation guide. Any requests over 99 are dropped.

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Loop	Segment	Data Element	Comments
NA	BHT	BHT02	'13'
2100A	NM1	NM101	PR
2100A	NM1	NM102	'2'
2100A	NM1	NM103	MO HEALTHNET
2100A	NM1	NM108	PI
2100A	NM1	NM109	'431754897'
2100B	NM1	NM108	This value should be XX. For Health Plans only, if the MO HealthNet provider number is sent, then the value should be SV.
2100B	NM1	NM109	This value is the NPI. For Health Plans only, if NM108 = SV,

			then the MO HealthNet provider number needs to be sent.
2100B	PRV	PRV03	Information Receiver Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers.
2100C	NM1	NM108	MI
2100C	NM1	NM109	MO HealthNet participant number of the subscriber. This information provides the greatest chance of finding a match in the MO HealthNet system.
2100C	REF	REF02	Use EJ, NQ or SY
2100C	REF	REF03	For EJ, use the patient account number For NQ, use the casehead ID if doing a casehead ID/date of birth search. (See the information at the beginning of this section for more details.) For SY, use the SSN if doing a SSN search. The SSN is only returned in the 271 if it used to find eligibility.
2100C	DMG	DMG02	This field is required for searches using the SSN, casehead or name. Use the DOB of the subscriber if using the name or SSN and the DOB of the dependent in the casehead search.
2100C	DTP	DTP01	MO HealthNet requires this segment. Use 307 in DTP01. If this segment is not used, the MO HealthNet system assumes a search of 307 and the date the transaction was sent. The first date of service cannot be more than one year old, nor can it be in a future calendar month. The last date of service cannot be in a future calendar month. Future dates through the end of the current calendar month are verified.
2110C	DTP		Because the eligibility request date is collected at the 2100C level, it is not necessary to use a date in this segment.

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Loop	Segment	Data Element	Comments
2100B	NM1	NM101-NM109	This data is populated with information contained in the MO HealthNet database.
2100B	REF	REF01	This data is populated with information received on the 270.
2100B	REF	REF02	This data is populated with information received on the 270.

2000C	TRN	TRN02	When TRN01=1, this field contains the authorization number.
2000C	TRN	TRN03	When TRN01=1, this field contains '9431754897'
2000C	TRN	TRN04	When TRN01=1, this field contains 'MO HealthNet'
2100C	NM1	NM103-NM109	This data is populated with information contained in the MO HealthNet database.
2100C	REF	REF01	If the SSN is used on the 270 and was used to find eligibility, SY is in this field. If the Patient-account number was used on the 270, EJ is in this field. If neither were used, this segment is not used.
2100C	REF	REF02	If the SSN is sent in on the 270 and was used to find eligibility, this field contains the SSN. If the patient account number was used on the 270, this field contains the patient account number. If neither were sent, this segment is not used.
2100C	N3	N301-N302	This data is populated with information contained in the MO HealthNet database.
2100C	N4	N401-N403	This data is populated with information contained in the MO HealthNet database.
2100C	N4	N406	This field contains the 3-digit county code along with a description of the county.
2110C	EB	EB	One EB segment is used for any change in eligibility. For both online and batch, the limit of EB segments is 20.
2110C	EB	EB05	This data is populated with two different types of numbers that identify the coverage of the EB segment. When EB01=1, B, or F, and EB04 = MC, this field contains the MO HealthNet Eligibility Code (ME Code). When EB01=R and EB04=OT, this field contains up to 5 TPL coverage codes delimited by commas. If there are more than 5 applicable coverage codes, another complete EB segment follows with another 5 codes, and again until all coverage codes are listed.
2120C	NM1	NM108	If MO HealthNet has the National Provider Identifier (NPI) available in the system, this value is XX. If not (applies to Health Plans only), it remains as is.
2120C	NM1	NM109	This number is the NPI. For Health Plans only, if NM108 is not XX, this is the MO HealthNet Provider number.
2120C	N3	N301-N302	This data is populated the street address.

2120C	N4	N401-N403	This data is populated the city name, state, and zip code.
2120C	PER	PER04	This data is populated by the health plan hotline number. For all other providers this is populated with the office number.

276/277 HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE

The MO HealthNet system utilizes certain fields in the 276 transaction in order to find a valid claim match. At a minimum, the National Provider Identifier (NPI), participant number, and claim first date of service are required to find a claim. The 276 transaction requires a subsequent date to fill in the date range in the 2200D loop, segment DTP. The subsequent date is handled as if it is the last date of service. If there wase no last date of service, then the first date of service is used to fill in the date range. Including the claim ICN (loop 2200D, segment REF) offers an ever-greater chance of finding a match in the system. If more than one of the search criteria fields are sent, a hierarchy is used to attempt to match. The first attempt is by the claim ICN, if it was sent. If the claim ICN was not sent then all claims are selected for the provider/participant/first date of service – last date of service combination.

It is stated in the 276 transaction that a claim status request may be requested at the Claim detail level (loop 2210D). The MO HealthNet system does not handle a request that is detail line specific at this time.

On the 277, the data found in loops 2100C and 2100D is from the MO HealthNet database files.

For Online submissions of the 276 transaction, only 1 occurrence of the 2100C and 2100D loop is processed. If an ICN is not used for selection, there is no limit on the actual date range of the 2200D loop, segment DTP; although, it should be noted that the larger the date range is, the greater the response time.

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Loop	Segment	Data Element	Comments
2100A	NM1	NM101	PR – Payer
2100A	NM1	NM102	2 – Non-person Entity
2100A	NM1	NM103	MO HEALTHNET
2100C	NM1	NM108	This value should be XX. For Health Plans only, this value may be SV - SV Provider Number.
2100C	NM1	NM109	This value should be the NPI. For Health Plans only, if the value in NM108 is SV, the MO HealthNet provider number needs to be sent.
2100D	NM1	NM108	MI – Member ID
2100D	NM1	NM109	MO HealthNet participant number
2200D	REF	REF01	1K
2200D	REF	REF02	Payer Claim Control # (this data element corresponds to the 837 CLM01)
2200D	DTP	DTP03	Claim Service Period - First date of service and Last date of

			service. There are no limits on the range at this time, but range may impact online response time if search is too large

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Loop	Segment	Data Element	Reference Designator	Comments
2100C	NM1	Entity Type Qualifier	NM102	2 – Non-Person Entity
2100C	NM1	Identification Code Qualifier	NM108	XX-NPI or for Health Plans only, SV – Service Provider Number.
2100C	NM1	Identification Code	NM109	MO HealthNet uses the National Provider Identifier (NPI). For Health Plans only, if NM108 = SV, the MO HealthNet provider number needs to be sent.

278 HEALTH CARE SERVICES REVIEW—REQUEST FOR REVIEW AND RESPONSE

This section is under construction.

820 PAYROLL DEDUCTED AND OTHER GROUP PREMIUM PAYMENT FOR INSURANCE PRODUCTS

Loop	Segment	Data Element	Comments
	TRN	TRN02	The RA number is used for the Reassociation Key.
2300B	RMR	RMR02	The ICN is used here for Capitation Claims and the Financial Control Number and ICN are used here for Financial transactions.

834 BENEFIT ENROLLMENT AND MAINTENANCE

Loop	Segment	Data Elements	Comments
2000	INS	INS03	Proprietary layout :PFX:-RECORD-TYPE, position 1 length 1. ***Conversion*** to X12 qualifiers
Header	ISA/GS	ISA08, GS03	Proprietary layout :PFX:-PROV-ID, position 2 length 10
2000	REF	REF02,REF02	Proprietary layout :PFX:-BASE-ID, position 11 length 8
2100A	NM1	NM103	Proprietary layout :PFX:-RECIP-LAST-NAME, position 19 length 19

2100A	NM1	NM104	Proprietary layout :PFX:-RECIP-FIRST-NAME, position 38 length 12
2100A	NM1	NM105	Proprietary layout :PFX:-RECIP-MI, position 50 length 1
2300	HD	HD04 (position 1, length 2)	Proprietary layout :PFX:-ME-CODE, position 51 length 2. Note: If field is spaces, defaults to 'XX'.
2100A	N4	N406	Proprietary layout :PFX:-PAY-CTY, position 53 length 3
2300	DTP	DTP03	Proprietary layout :PFX:-START-DATE, position 56 length 8. Note: Enrollments first loop, Me Code Change first loop, Weekly Recon first loop
2300	DTP	DTP03	Proprietary layout :PFX:-STOP-DATE, position 64 length 8. Note: Disenrollments first loop, Weekly Recon second loop (when applicable)
2300	HD	HD04 (position 3, length 1)	Proprietary layout :PFX:-AUTOASSGN-IND, position 72 length 1. Note: If field is spaces, defaults to 'X'.
2000	DTP	DTP03	Proprietary layout :PFX:-DATE-LAST-CHANGED, position 73 length 8. Note: For disenrollments: first loop For Me Code Change: first loop For Weekly Recon: first loop
2310	NM1	NM109	Proprietary layout :PFX:-LOCK-PCP-ID, position 81 length 10. Note: populated only when applicable. This field is National Provider Identifier (NPI).
2310	PLA	PLA03	Proprietary layout :PFX:-LOCK-PCP-EFF-DATE, position 90 length 8 Note: populated only when PCP-ID exists
2000	REF	REF02	Proprietary layout :PFX:-CASEHEAD-ID, position 98 length 10
2100G	NM1	NM103	Proprietary layout :PFX:-CASEHEAD-LNAME, position 108 length 19. Note: If :PFX:-RECIP-LAST-NAME not equal :PFX:-CASEHEAD-LNAME and :PFX:-RECIP-FIRST-NAME not equal :PFX:-CASEHEAD-FNAME then populate element

2100G	NM1	NM104	Proprietary layout :PFX:-CASEHEAD-FNAME, position 127 length 12. Note: If :PFX:-RECIP-LAST-NAME not equal :PFX:-CASEHEAD-LNAME and :PFX:-RECIP-FIRST-NAME not equal :PFX:-CASEHEAD-FNAME then populate element
2100G	N3	N301	Proprietary layout :PFX:-RECIP-ADDRESS, position 139 length 25. Note: If :PFX:-RECIP-ADDRESS > spaces or low values then element is populated else defaults :PFX:-RECIP-STREET. Also, if address is incorrect defaults to PO BOX 6500
2100G	N3	N302	Proprietary layout :PFX:-RECIP-STREET, position 164 length 25. If :PFX:-RECIP-STREET > spaces or low values then element is populated.
2100G	N4	N401	Proprietary layout :PFX:-RECIP-CITY, position 189 length 22. If city incorrect, defaults to Jefferson City.
2100G	N4	N402	Proprietary layout :PFX:-RECIP-STATE, position 211 length 2. If state incorrect, defaults to MO
2100G	N4	N403	Proprietary layout :PFX:-RECIP-ZIP-CODE, position 213 length 5. ZIP +4 has been added to the 834 layout. If zip code is incorrect, defaults to 65102-6500
2100A	DMG	DMG02	Proprietary layout :PFX:-DATE-OF-BIRTH, position 218 length 8
2100A	DMG	DMG03	Proprietary layout :PFX:-SEX-CODE, position 226 length 1. ***Conversion***

2100A	NM1	NM109	Proprietary layout :PFX:-SSN, position 227 length 9
2300	HD	HD04 (position 5, length 2)	Proprietary layout :PFX:-DISENROLL-IND, position 236 length 2. Note: Only when applicable for Disenrollment and defaults to 'XX' when field is spaces.
2000	DTP	Loop 2000: DTP03 second repeat	Proprietary layout :PFX:-ME-EFFECTIVE-DATE, position 238 length 8.
2100A	PER	PER04	Proprietary layout :PFX:-RECIP-PHONE-NUM, position 246 length 10
2100A	PER	PER03	Proprietary layout :PFX:-RECIP-PHONE-TYPE, position 256 length 1
2100A	LUI	LUI02 OR LUI03	Proprietary layout :PFX:-PRIM-LANG-IND, position 257 length 1. ***Conversion*** if no code found, the description is populated (LUI03/352) that is currently used by DFS
2300	HD	HD04 (position 4, length 1)	Proprietary layout :PFX:-DAY-SPEC-ELIG, position 258 length 1. Note: If field is spaces, defaults to 'X'.
2100A	DMG	DMG05	Proprietary layout :PFX:-RACE-CODE, position 259 length 1, ***Conversion***

835 HEALTH CARE CLAIM PAYMENT ADVICE

Loop	Segment	Data Element	Comments
1000B	N1	N103	XX.
1000B	N1	N104	National Provider Identifier.
2100	NM1	NM108	XX.
2100	NM1	NM109	National Provider Identifier.
2100	CLP	CLP01	If not sent on the incoming claim, this defaults to spaces, except for drug claims. Drug claims have the prescription number plugged here. If no prescription number is available it defaults to '999999999'.
2100	CLP	CLP06	If not sent on the incoming claim, this defaults to spaces, except for drug claims. Drug claims received through POS have '13' plugged. All other drug claims have 'MC' plugged.
2100	CLP	CLP08	If not sent on the incoming claim, this defaults to space, except for drug claims. Drug claims always have spaces.
2100	CLP	CLP09	If not sent on the incoming claim, this defaults to space, except for drug claims. Drug claims always have spaces.
2110	REF	NA	Service Identification Segment: If the line item control number is not sent on the incoming claim, this segment is not produced.
2110	SVC	SVC06	None of these composite data elements are used, the billed/adjudicated procedure is in SVC01.

837 GENERAL INFORMATION

- Claims submitted with more than 28 detail lines are split into multiple claims.
- Dollar amounts at the detail level in excess of 99,999.99 and at the header level in excess of 9,999,999.99 are truncated from the left.
- It is recommended to transmit only a maximum of 1,000 claims within an ST/SE transaction set envelope, due to the possibility that the entire envelope could be rejected if just one claim segment were found invalid by WTX.

- It is also recommended to limit the number of ST/SE transaction set envelopes to a maximun of 20 per GS/GE function group envelopes and a maximum of 1 GS/GE function group envelope per ISA/IEA interchange control envelope, due to WTX performance processing.
- Multiple ISA/IEA interchange control envelopes per transaction are acceptable.
- All FFS providers are required to use XX as the NM108 qualifier and their NPI as the NM109 value in all provider identification loops, where applicable to include, but not limited to: Professional – 2010AA, 2310A, 2310B, 2420A, 2420F; Dental – 2010AA, 2420A, 2310A, 2310B; Institutional – 2010AA, 2310A.
- Health Plans only: Health Plans may continue to submit MO HealthNet provider numbers for all provider identification loops except the 2010AA loop which must contain 'XX' in NM108 and their atypical NPI in NM109.

Loop	Segment	Data Element	Comments
NA	BHT	BHT02	Both values '00' and '18' are processed the same. If the file is a reissue, claims fail duplicate editing within the MMIS if they were previously processed.
NA	BHT	BHT06	When 'CH' is used claims are processed as fee for service claims. When 'RP' is used claims are processed as encounter claims.
1000B	NM1	NM109	Use '431754897'.
2010AA	NM1	NM108	Must use 'XX'.
2010AA	NM1	NM109	Fee for Service providers must use NPI. Health plans must use the atypical NPI you have been assigned (Mxxxxxxxxx).
2010BA	NM1	NM103	Uppercase letters must be used.
2010BA	NM1	NM104	Uppercase letters must be used.
2010BA	NM1	NM105	Uppercase letters must be used.
2010BA	NM1	NM107	Uppercase letters must be used.

837 PROFESSIONAL SPECIFIC INFORMATION

- If loop 2400 service dates are not populated, loop 2300 admit and discharge dates are used for the detail line dates of service. If loop 2400 service dates and loop 2300 admit and discharge dates are not populated, zeroes are used for the detail line service dates.

Loop	Segment	Data Element	Comments
NA	REF	REF02	During the testing phase, billers must use "004010X098DA1." Once approved for production, use "004010X098A1."

2000A	PRV	PRV03	Billing Provider Secondary Identifier segment: Provider's 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers.
2300	CLM	CLM05-3	When ‘1’ is used, the claim processes as an original claim. When ‘7’ is used, a credit is generated using the number found in 2300 REF02 when REF01 is F8. The new claim is processed as an original claim. If an incorrect original reference number is given, the new claim fails duplicate editing in the MMIS. When ‘8’ is used, a credit only is generated using the number found in 2300 REF02 when REF01 is F8. MO HealthNet Managed Care health plans should send the CLM05-3 as 1, 7, or 8 just the same as the fee for service claims. A MCVOID record is created from the 837 received.
2300	NTE	NTE01	This field is needed for Fee for Service claims only. For Optical claims with dates of service prior to June 15, 2009, where MO HealthNet policy requires submission of prescription information to process the claim, this segment can be used. If used, this element should be populated with ‘ADD’. Refer to the Optical Manual for specific requirements.
2300	NTE	NTE02	This field is needed for Fee for Service claims only. For Optical claims with dates of service prior to June 15, 2009, if NTE01 is populated with ‘ADD.’ This element should be populated according to the layout shown in Appendix A. For optical prescriptions, refer to the Optical Manual for specific requirements.
2300	REF	REF01	Value 'F8' is required when CLM-05-3 is '7' or '8.' Value 'F8' should also be used if the biller wishes to send a previous ICN to show timely filing conditions were met.
2300	REF	NA	The Service Authorization Exception Code Segment does not apply to MO HealthNet claims.
2310A	PRV	PRV03	Referring provider Provider's 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers

2310B	PRV	PRV03	Rendering provider Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers
2300	HCP	NA	The Claim Pricing/Repricing Information segment is not used by MO HealthNet
2400	SV1	SV101-1	Use Qualifier Code 'HC' for HCPCS Codes. Qualifier Code 'N4' for National Drug Code (NDC) should be used for J-Code procedure codes with a date of service of 2/1/08 or after. Retail pharmacies billing NDC codes for drugs should use the HIPAA compliant NCPDP V5.1 submission form. If the 'N4' Qualifier Code is used, it will be ignored except if the procedure code is a J-Code. No payment for that service occurs.
2400	SV1	SV101-2	Physicians billing for drugs should use the appropriate 'J' HCPCS procedure codes, but will also be required to use the NDC, Decimal Quantity, and Prescription Number if the date of service is on or after 2/1/08.
2400	SV1	SV101-3 SV101-4 SV101-5 SV101-6	Reference the appropriate MO HealthNet Provider Manual to determine when these are required
2400	SV1	SV104	Units and minutes containing decimals are truncated.
2400	LQ	LQ01	Use the 'UT' qualifier code for Health Care Financing Administration (HCFA) Durable Medical Equipment Regional Carrier (DMERC) Certificate of Medical Necessity (CMN) forms.
2400	LQ	LQ02	Use the '4842' form identifier for HCFA DMERC CMN oxygen forms.
2400	FRM	FRM01	For HCFA DMERC CMN oxygen data, use '5' on question 5.
2400	FRM	FRM02	For HCFA DMERC CMN oxygen data, answer with a 'Y' for yes, 'N' for no, or 'W' for not applicable
2420A	PRV	PRV03	Rendering at service level Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet

			legacy provider numbers.
2420F	PRV	PRV03	Referring at service level Providers 10 digit taxonomy code. (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers

837 DENTAL SPECIFIC INFORMATION

Loop	Segment	Data Element	Comments
NA	REF	REF02	During the testing phase, billers must use "004010X097DA1." Once approved for production, use "004010X097A1."
2000A	PRV	PRV03	Billing/Pay to Identifier segment: Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers
2300	REF	NA	The Service Authorization Exception Code segment is not used for MO HealthNet.
2300	NTE	NTE01	For fee-for-service (FFS) dental claims, where topical fluoride treatment for adults is done, enter 'ADD' here and provide the conditions or criteria for the treatment in NTE02. Up to 5 occurrences of the NTE segment are used. Reference the MO HealthNet Provider Manual: Section 15: Billing Instructions - Dental for additional information. For dental encounters containing capitated services, enter 'ADD' in NTE01 and 'CAPITATED SERVICES' in NTE02.
2300	NTE	NTE02	For fee-for-service (FFS) dental claims, where topical fluoride treatment for adults is done, enter 'ADD' in NTE01 and provide the conditions or criteria for the treatment here. Up to 5 occurrences of the NTE segment are used. Reference the MO HealthNet Provider Manual: Section 15: Billing Instructions - Dental for additional information. For dental encounters containing capitated services, enter 'CAPITATED SERVICES' in NTE02 and 'ADD' in NTE01.
2300	SV3	SV301-3 SV301-4 SV301-5	Procedure code modifiers are not used for claims billed on the dental 837.

		SV301-6	
2310A	PRV	PRV03	Referring provider Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers
2310B	PRV	PRV03	Rendering provider Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers
2300	SV3	SV306	Quantities with decimals are truncated.
2400	TOO	NA	Only one tooth number per detail line is processed by MO HealthNet. Additional tooth numbers are ignored.
2420A	PRV	PRV03	Rendering Provider Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers

837 INSTITUTIONAL SPECIFIC INFORMATION

For nursing home claims, each SV2 segment generates a separate claim.

Loop	Segment	Data Element	Comments
NA	REF	REF02	During the testing phase, billers must use "004010X096DA1". Once approved for production, use "004010X096A1".

2000A	PRV	PRV03	Billing/Pay to provider: Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers
2300	CLM	CLM05-3	When any value other than '7' or '8' is used, the claim processes as an original claim. When ‘7’ is used, a credit is generated using the number found in 2300 REF02 when REF01 is F8. The new claim is processed as an original claim. If an incorrect original reference number is given, the new claim fails duplicate editing in the MMIS. When ‘8’ is used, a credit only is generated using the number found in 2300 REF02 when REF01 is F8. MO HealthNet Managed Care health plans should send the CLM05-3 as 1, 7, or 8 just the same as the fee for service claims. A MCVOID record is created from the 837 received.
2300	CLM	CLM18	This data element is not used to determine whether a paper remittance advice is generated for this claim. Providers indicate in their Trading Partner Agreement whether remittance advices are to be generated on paper or electronically.
2300	CL1	CL101	Required for all inpatient claims. Also required for outpatient emergency room claims.
2300	REF	NA	The Service Authorization Exception Code segment is not used for MO HealthNet.
2300	REF	REF01	This field is needed for fee-for-service claims only. Peer Review Organization (PRO) Approval Number Segment: For inpatient claims requiring certification, enter the identification qualifier of G4. For these claims, the REF02 segment must be completed with the Health Care Excel (HCE) certification number. For all other claims, this segment is not used by MO HealthNet.
2300	REF	REF02	This field is needed for fee-for-service claims only. For inpatient claims, enter the unique 7-digit certification number supplied by HCE.

2300	NTE	NTE01	This field is needed for fee-for-service claims only. For home health claims, if submitting the "Home Health Certification and Plan of Treatment" **to prove medical necessity for two visits provided on the same date of service**, enter the applicable Note Reference Code identifying the functional area or purpose reported in NTE02.
2300	NTE	NTE02	This field is needed for fee-for-service claims only. For home health claims, if submitting the "Home Health Certification and Plan of Treatment" **to prove medical necessity for two visits provided on the same date of service**, enter the narrative information from the "Home Health Certification and Plan of Treatment" and the "Medical Update and Patient Information" forms clarifying the data elements reported in NTE01. Patient information to be reported, based on the Note Reference Code, may include: ALG—may report patient's allergies that are relevant to the care being given DCP—goals, rehab potential or discharge plans must be reported DGN—may report additional information concerning diagnosis DME—may report equipment and supplies that are relevant to the care being provided MED—may report patient's medications that are relevant to the care being provided NTR—may report patient's nutritional requirements that are relevant to the care being provided ODT—must report interim order by physician for applicable time frame, by discipline; first three (3) bytes of note must begin with SN-, AI-, PT-, OT-, or ST-, indicating the discipline the interim orders address RHB—reason homebound must be reported RLH—reasons patient leaves home-not applicable to MO HealthNet RLH—times and reasons patient not at home-not applicable to MO HealthNet SET—may report unusual home or social environment, or both, that are relevant to the care being provided SFM—may report safety measures taken that are relevant to the care being provided SPT—may report supplemental information in the plan of care

			UPI—must report information required by Home Health program policy, such as: date and time of birth and date and time of discharge if billing Y9505 or 99501; weight, height, and age of low birthweight child; documentation of deficient weight relative to the child's height for a failure-to-thrive child; patient's status on dates of service being billed; or other information home health agency deems important for adjudication decisions.
2300	CR6	CR601 - CR621	This field is needed for fee-for-service claims only. For home health claims, if submitting the "Home Health Certification and Plan of Treatment" **to prove medical necessity for two visits provided on the same date of service**, this segment is required to report information related to the certification of a home health care patient.
2300	CR6	CR610	This field is needed for fee-for-service claims only. For home health claims, if submitting the "Home Health Certification and Plan of Treatment" **to prove medical necessity for two visits provided on the same date of service**, the Product/Service ID Qualifier must always be 'HC" - HCPCS Codes.
2300	CR6	CR611	This field is needed for fee-for-service claims only. For home health claims, if submitting the "Home Health Certification and Plan of Treatment" **to prove medical necessity for two visits provided on the same date of service**, the surgical procedure code must always be reported using HCPCS Codes.
2300	CRC	CRC01 - CRC07	This field is needed for fee-for-service claims only. For home health claims, if submitting the "Home Health Certification and Plan of Treatment" **to prove medical necessity for two visits provided on the same date of service**, this segment is required to report 'Home Health Plan of Treatment' information on the home health care patient's conditions.
2300	CRC	CRC01	This field is needed for fee-for-service claims only. For home health claims, if submitting the "Home Health Certification and Plan of Treatment" **to prove medical necessity for two visits provided on the same date of service**, information must be reported for both Code Category '75' - Functional Limitations and '76' Activities Permitted.
2300	HI	HI01-1	Principal Procedure Information Segment: For inpatient claims, the surgical procedure code must always be represented using ICD-9-CM procedures. Therefore, this value should always be 'BR' for inpatient claims. For all other claims, use 'BP'.

2300	HI	HI01-2	Principal Procedure Information Segment: For inpatient claims, the surgical procedure code must always be represented using ICD-9-CM procedures. For all other claims, use CPT or HCPCS procedure codes.
2300	HI	HI01-1 through HI12-1	Other Procedure Information segment: For inpatient claims, the surgical procedure code must always be represented using ICD-9-CM procedures. Therefore, this value should always be 'BO' for inpatient claims. For all other claims, use 'BQ'.
2300	HI	HI01-2 through HI12-2	Other Procedure Information Segment: For inpatient claims, the surgical procedure code must always be represented using ICD-9-CM procedures. For all other claims, use CPT or HCPCS procedure codes.
2300	QTY	QTY02	Quantities containing decimals are truncated.
2300	HCP	NA	The Claim Pricing/Repricing Information segment is not used by MO HealthNet.
2305	CR7	CR01 - CR703	This field is needed for fee-for-service claims only. For home health claims, if submitting the "Home Health Certification and Plan of Treatment" **to prove medical necessity for two visits provided on the same date of service**, this segment is required to report information identifying the disciplines ordered by the physician.
2305	HSD	HSD01 - HSD08	This field is needed for fee-for-service claims only. For home health claims, if submitting the "Home Health Certification and Plan of Treatment" **to prove medical necessity for two visits provided on the same date of service**, this segment is required to report the amount, duration, and frequency of skilled services provided to the home health care patient.
2310A	NM1	NM101 - NM109	For fee-for-service home health claims, if submitting the "Home Health Certification and Plan of Treatment" **to prove medical necessity for two visits provided on the same date of service**, this segment is required to report the Primary Physician responsible on a Home Health Agency Plan of Treatment.

			This segment is required for home health and inpatient encounters.
2310A	PRV	PRV03	Attending Physician Specialty Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers
2310C	NM1	NM101	Other Provider Name This field is required for outpatient encounter claims. The **Entity Identifier Code** should be set to **73.**
2310C	NM1	NM102	Other Provider Name This field is required for outpatient and home health encounter claims. The **Entity Type Qualifier** should be set to **1 – for a person or 2 – for a non-person entity.**
2310C	NM1	NM103	Other Provider Name This field is required for outpatient and home health encounter claims. The **Individual last name or organizational name** should be populated here**.**
2310C	NM1	NM104	Other Provider Name This field is required for outpatient and home health encounter claims. The **Individual first name** should be populated here if NM102 was populated with a **1 – person**.
2310C	NM1	NM108	Other Provider Name This field is required for outpatient and home health encounter claims. The **Identification Code Qualifier** should be set to **XX – NPI, 24 – Employer's Identification number, or 34 – Social Security number**.
2310C	NM1	NM109	Other Provider Name This field is required for outpatient and home health encounter claims. The **Other Physician Primary ID** should be populated in this field.

2310C	REF	REF01	Other Provider Secondary Identification: For hospice claims, enter '1D' here and the NPI for the nursing home in REF02. For encounter claims, where the service was performed at an FQHC or RHC, enter '1D' here and the NPI in REF02.
2310C	REF	REF02	Other Provider Secondary Identification: For hospice claims, enter '1D' in REF01 and the NPI for the nursing home here. For encounter claims, where the service was performed at an FQHC or RHC, enter '1D' in REF01 and the NPI here.
2310E	NM1	NM101	Service Facility Name This field is required for inpatient encounter claims. The **Entity Identifier Code** should be set to **FA.**
2310E	NM1	NM102	Service Facility Name This field is required for inpatient encounter claims. The **Entity Type Qualifier** should be set to **2 – for a non-person entity.**
2310E	NM1	NM103	Service Facility Name This field is required for inpatient encounter claims. Any name can be populated here**.**
2310E	NM1	NM108	Service Facility Name This field is required for inpatient encounter claims. The **Identification Code Qualifier** should be set to **24 – Employer's Identification number**.
2310E	NM1	NM109	Service Facility Name This field is required for inpatient encounter claims. The **Employer's Identification Number** should be populated in this field. This number must match a managed care provider number on the managed care provider demographic file or an exception will be posted to the claim.

2400	SV2	SV201	For outpatient and hospice claims, refer to the MO HealthNet Policy manuals for specific requirements. For nursing home claims, select revenue code from one of the following categories: 1. Select revenue code to indicate reserve time periods: • 0180 equals non-covered leave of absence • 0182 equals home leave for patient convenience • 0183 equals home leave for therapeutic leave • 0184 equals hospital leave to an ICF/MR • 0185 equals hospital leave for non-ICF/MR facility • 0189 equals Medicare qualifying stay days 2. Select revenue code to indicate skilled nursing services: • 0190 equals subacute care general classification • 0191 equals subacute care - level I • 0192 equals subacute care - level II • 0193 equals subacute care - level III • 0194 equals subacute care - level IV • 0199 equals subacute care other Indicating any of the above revenue codes does not alter the amount of your per diem payment. Use these codes when you previously would have indicated a skilled nursing indicator of 'Y'. 3. Select revenue code to indicate non-skilled nursing time periods: • 0110 equals room-board/private • 0119 equals other/private • 0120 equals room-board/semi • 0129 equals other/2-bed Indicating any of these does not alter the amount of your per diem payment. Use these codes when you previously would have indicated a skilled nursing indicator of 'N' or blank.
2400	SV2	SV202-3 SV202-4 SV202-5 SV202-6	Reference the MO HealthNet Electronic Billing Layout Manuals for appropriate instructions on populating the procedure code modifiers.
2400	SV2	SV205	Quantities with decimals are truncated.

2420A	PRV	PRV03	Attending Physician Specialty Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers
2420B	PRV	PRV03	Operating Physician Specialty Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers
2420C	PRV	PRV03	Other Provider Name Providers 10 digit taxonomy code (Code designating the provider type, classification and specialization) This segment is situational, however, MO HealthNet requires this segment if provider is using one NPI for multiple MO HealthNet legacy provider numbers

997 FUNCTIONAL ACKNOWLEDGEMENT

The 997 is generated when a biller sends a transaction to MO HealthNet, if one was requested on the Trading Partner Agreement. The 997 indicates if the transaction received by MO HealthNet passed or failed X12 syntactical edits. Therefore, a 997 can report a transaction as Accepted, even though the transaction then kicks out later for semantic edits or MO HealthNet claim specific rules. For example, the date fields are defined in X12 syntax as alphanumeric fields. Therefore, an 'A' could be sent in a date field and a 997 would not report this as rejected because this is syntactically correct. Semantically the format qualifier D8 or RD8 has specific requirements for the date field following it; however, as previously mentioned, semantic edits are not identified through the 997.

APPENDICES

APPENDIX A OPTICAL

Optical NTE segment NTE02 Data element specifications:

NOTE: This NTE segment should be coded at the 2300 claim level loop, as specified in Section 6 of this companion guide.

START			

POSITION	LENGTH	FIELD DESCRIPTION	COMMENTS
1	2	Prescription indicator	Always enter 'RX'.
3	1	Filler	Always enter space.
4	2	Right eye indicator	Always enter 'OD'.
6	1	Filler	Always enter space.
7	1	Right eye first diopter sign	If right eye first diopter information is needed for this claim, value is '+' or '-'. Default is '+'.
8	5	Right eye first diopter	If right eye first diopter information is needed for this claim the format is 00.00. Default is '00.00'.
13	1	Filler	Always enter space.
14	1	Right eye second diopter sign	If right eye second diopter information is needed for this claim, value is '+' or '-'. Default is '+'.
15	5	Right eye second diopter	If right eye second diopter information is needed for this claim the format is 00.00. Default is '00.00'.
20	1	Filler	Always enter space.
21	1	Times indicator	Always enter 'X'.
22	3	Times field	If right eye times information is needed for this claim, enter times value. Default is '000'. This must be numeric, with three digits.
25	1	Filler	Always enter space.
26	3	Right eye ADD indicator	Always enter 'ADD'.
29	1	Right eye ADD Sign	If right eye ADD information is needed for this claim, value is '+' or '-'. Default is '+'.
30	5	Right eye ADD field	If right eye ADD information is needed for this claim the format is 00.00. Default is '00.00'.
35	1	Filler	Always enter space.
36	2	Left eye indicator	Always enter 'OS'.
38	1	Filler	Always enter space.
39	1	Left eye first diopter sign	If left eye first diopter information is needed for this claim, value is '+' or '-'. Default is '+'.
40	5	Left eye first diopter	If left eye first diopter information is needed for this claim, the format is 00.00. Default is '00.00'.
45	1	Filler	Always enter space.
46	1	Left eye second diopter sign	If left eye second diopter information is needed for

			this claim, value is '+' or '-'. Default is '+'.
47	5	Left eye second diopter	If left eye second diopter information is needed for this claim, the format is 00.00. Default is '00.00'.
52	1	Filler	Always enter space.
53	1	Left eye Times indicator	Always enter 'X'. Otherwise, value is spaces.
54	3	Left eye Times field	If left eye times information is needed for this claim, enter times value. Default is '000'. This must be numeric, with three digits.
57	1	Filler	Always enter space.
58	3	Left eye ADD indicator	Always enter 'ADD'.
61	1	Left eye ADD sign	If left eye ADD information is needed for this claim, value is '+' or '-'. Default is '+'.
62	5	Left eye ADD field	If left eye ADD information is needed for this claim, the format is 00.00. Default is '00.00'.

APPENDIX B - IMPLEMENTATION CHECKLIST

The following is a list of the steps required to begin sending production HIPAA compliant ASC X12N transactions to MO HealthNet:

1. Biller completes either the Application for MO HealthNet Internet Access Account or the Application for MO HealthNet Connect:Direct Access Account.
2. Biller completes the Trading Partner Agreement.
3. Infocrossing Healthcare Services (IHS) Help Desk approves documents in steps 1 and 2 and notifies the biller of User ID and password.
4. Biller sends test file(s).
5. Biller reviews results from test file(s). Results are available within 1-2 business days.
6. When the biller is satisfied with the results of the test (e.g., test claims aren't rejected), the biller contacts the IHS Help Desk to be moved to production for each specific transaction.

APPENDIX C - CHANGE SUMMARY

Updates to this guide can be accessed by clicking on the folder that says "Updated Manual List" in the table of contents. Then click on the "UPDATED MANUAL LIST" text underneath the folder to see a list of the Electronic Billing Layout Manuals in the document window. A link exists on a manual name if a revision has been made to that manual in approximately the last 6 months. After clicking on the manual name link, the sections with revisions show up in a "hit list" in the document window. Click on the section title in the hit list to jump to the revision. The revision is shown in green text. Click on the browser's back button to go back to the hit list. If there is just one section in the manual with a change in the last 6 months, then the link on the manual name in the Updated Manual List goes directly to the section with the revision (rather than showing the hit list first.)

NCPDP TELECOMMUNICATION V.5.1 AND BATCH TRANSACTION STANDARD V.1.1 COMPANION GUIDE

DISCLOSURE STATEMENT

The information in this document is intended for billing providers and technical staff who wish to exchange electronic transactions with MO HealthNet. This document is to be used in conjunction with the NCPDP Telecommunication Implementation Guide and the NCPDP Batch Standard Implementation Guide to define transaction requirements. It does not define MO HealthNet policy billing issues. These types of issues can be found in the MO HealthNet Provider Manuals through the MO HealthNet Division's website at http://dss.missouri.gov/mhd/.

PREFACE

This Companion Guide to the NCPDP Implementation Guides adopted under HIPAA clarifies and specifies the data content being requested when data is transmitted electronically to the MO HealthNet fiscal agent. Transmissions based on this companion document, used in tandem with the NCPDP Implementation Guides, are compliant with both NCPDP syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the NCPDP 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.

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 standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

HIPAA serves to:

- create better access to health insurance;
- limit fraud and abuse;
- reduce administrative costs.

PURPOSE OF THE COMPANION GUIDE

The NCPDP Transaction Standard Companion Guide explains the procedures necessary for trading partners to successfully exchange transactions electronically with MO HealthNet in standard HIPAA compliant forms. These transactions include the following.

NCPDP Telecommunication Standard	Version 5, Release 1
NCPDP Batch Standard	Version 1, Release 1

This Companion Guide is not intended to replace the NCPDP Implementation Guides; rather it is intended to be used in conjunction with them. Additionally, the Companion Guide is intended to convey information that is within the framework and structure of the NCPDP Implementation Guides and not to contradict or exceed them.

SCOPE

This Companion Guide provides information for populating data elements that are defined as payer or trading partner specific. In addition, it provides explanation of how claims are processed within the Missouri Medicaid Management Information System (MMIS) when specific data elements are populated with each of the valid choices.

OVERVIEW

A summary of the sections in this Companion Guide follows:

Section 1—Getting Started: This section provides information for the completion of the necessary paperwork to begin testing with MO HealthNet.

Section 2—Testing With The Payer: This section provides a detailed description of the testing phase.

Section 3—Connectivity With The Payer: This section provides connectivity information.

Section 4—Contact Information: This section provides the contact information for technical assistance and billing issues.

Section 5—Data Stream Headers/Batch Envelopes: This section describes use of data stream headers and batch envelopes.

Section 6—Payer Specific Business Rules and Limitations: This section describes how to send transactions that have business rules specific to MO HealthNet and MoRx.

REFERENCES

The NCPDP Implementation Guides adopted under HIPAA that this document supplements can be found at www.ncpdp.org. The MO HealthNet Provider Manuals can be accessed through the MO HealthNet Division's website at http://dss.missouri.gov/mhd/.

ADDITIONAL INFORMATION

Users of this Companion Guide must understand general EDI (Electronic Data Interchange) terminology. In addition, an understanding of the segment structure within the NCPDP Implementation Guides is helpful.

SECTION 1 - GETTING STARTED

WORKING WITH MO HEALTHNET

To begin exchanging EDI transactions with MO HealthNet, a biller must select one of three options for the exchange of electronic transactions. The first option utilizes 'switching companies' to facilitate transactions in a real-time environment (commonly known as Point of Service). The second option is via an Internet connection through an ISP (Internet Service Provider) of the billers' choice to facilitate transactions in a batch environment. The third option utilizes Sterling Commerce's Connect:Direct

software to link directly to Infocrossing Healthcare Services (IHS) Data Center. This option is restricted to MO HealthNet Managed Care health plans.

Billers opting to use a switching company should be aware that they are responsible for all setup and on-going costs involved in the purchase and maintenance of all software and licensing as well as any transaction fees assessed by the switching company. Information regarding available switching companies can be obtained by calling the IHS Help Desk at (573) 635-3559.

Billers opting to use the Internet connection option are responsible for any costs involved in obtaining and use of the ISP to connect to the Internet. No additional cost is charged by MO HealthNet or it's fiscal agent to use the Internet connection solution. A biller choosing this option must complete the Application for MO HealthNet Internet Access Account, which can be obtained at http://dss.missouri.gov/mhd/ . For assistance with this form call the IHS Help Desk at (573) 635-3559.

Billers opting to use the Connect:Direct software solution should be aware that they are responsible for all setup and on-going cost involved in the purchasing and maintaining of the software, as well as for paying a monthly port charge to IHS as long as the connection is available for use. Billers should complete, sign and mail the Application for MO HealthNet Connect:Direct Access Account **and be contacted by technical support before** purchasing the software. This application is available at http://dss.missouri.gov/mhd/ or by calling the IHS Help Desk at (573) 635-3559. Upon receipt of the signed application, an IHS technical support person will contact you with the information needed to ensure the correct software is purchased.

TRADING PARTNER REGISTRATION

In addition to selecting a connection method, a biller must complete a Trading Partner Agreement form. The Trading Partner Agreement form is used to communicate trading partner identifiers and to indicate which transactions the biller wishes to exchange. The form is available at http://dss.missouri.gov/mhd/ . For assistance with this form call the IHS Help Desk at (573) 635-3559.

An EDI Trading Partner is defined as any MO HealthNet customer (provider, billing service, software vendor, etc.) that transmits to, or receives electronic data from MO HealthNet. When a switching company is the transmitting entity, the Trading Partner Agreement form is not required. It is not necessary for the provider or software vendor to do so unless the provider or software vendor wishes to directly send or receive another type of electronic transaction from MO HealthNet (i.e. the X12N-835 Health Care Claim Payment Advice).

CERTIFICATION AND TESTING OVERVIEW

Certification from a third party is not required to exchange EDI with MO HealthNet, however, doing so can help to speed the process of approval of the billers' transactions. Each type of transaction an EDI Trading Partner wishes to send to MO HealthNet must pass test requirements before the Trading Partner is set up to send production transactions. Successful completion of test requirements requires, at a minimum, that the transactions are HIPAA compliant.

SECTION 2 - TESTING WITH THE PAYER

To test with MO HealthNet the appropriate access account application and Trading Partner Agreement form must be complete and on file with Infocrossing Healthcare Services (IHS).

Following completion of these forms the IHS Help Desk notifies the biller that they are approved to send test transactions for those transactions they indicated on the Trading Partner Agreement form. In addition, the Trading Partner's User ID and password (where applicable) is given to them at this time.

Until HIPAA is implemented into production Missouri MMIS, Trading Partners may be required to send an additional test file for each transaction before being moved to production.

POINT OF SERVICE OPTION

If the biller has chosen to exchange data through a POS switching company:

- the biller should contact the Infocrossing Healthcare Services Help Desk at 573 (635-3559) for information regarding which switching companies have an existing connection with MO HealthNet.
- the biller must contact the switching companies for startup procedures.

INTERNET OPTION

If the biller has chosen to exchange data through the Internet option:

- the biller logs on to www.emomed.com.
- the biller selects "Send HIPAA test files" link.
- the biller populates the window with the test file name.
- the biller submits the information.
- a window appears either confirming successful receipt or notifying of non-receipt of the test file.
- if receipt was successful, the biller should check for appropriate responses in the "Receive HIPAA test files" area of the www.emomed.com website. NCPDP response files (NCPDP(TEST)) are generated automatically for all test NCPDP claim files.
- If receipt was not successful and the biller is unable to determine the reason for the non-receipt, contact the Infocrossing Healthcare Services (IHS) Help Desk at (573) 635-3559.
- if no NCPDP response file is available after 2 complete business days, contact the IHS Help Desk at (573) 635-3559.
- when the biller is satisfied with the results of the test (i.e., test claims are not rejected), the biller contacts the IHS Help Desk at (573) 635-3559 to be moved to production for each specific transaction.

CONNECT:DIRECT OPTION

This section under construction

SECTION 3 - CONNECTIVITY WITH THE PAYER

TRANSMISSION ADMINISTRATIVE PROCEDURES

MO HealthNet processes batch transactions and Internet direct data entry (DDE) submissions every week night. Any expected response transactions can be accessed the following business day. Billers experiencing problems with sending or receiving files may contact the Infocrossing Healthcare Services Help Desk at (573) 635-3559.

COMMUNICATION PROTOCOL SPECIFICATIONS

The MO HealthNet website, www.emomed.com, uses https (secured http) to send and receive transactions. Switching companies and billers using Connect:Direct both have a direct link to the fiscal agent, resulting in a secure connection.

PASSWORDS

In order to submit a batch transmission, a biller needs either their Internet User ID and password or their NDM ID and password. Passwords are not required for switching companies or within a transaction.

SECTION 4 - CONTACT INFORMATION

EDI CUSTOMER SERVICE

For questions pertaining to EDI processes, billers should first reference the appropriate Implementation Guides at www.wpc-edi.com or the Companion Guides at http://dss.missouri.gov/mhd/. If answers are not available within these guides, billers may contact the Infocrossing Healthcare Services Help Desk at (573) 635-3559.

PROVIDER SERVICE NUMBER

Billers with questions pertaining to MO HealthNet policies should first access the MO HealthNet Provider Manuals and MO HealthNet Electronic Billing Layout Manuals found through the MO HealthNet Division's website at http://dss.missouri.gov/mhd/. If answers are not available from these manuals, billers may contact the MO HealthNet Provider Relations hotline at (573) 751-2896.

APPLICABLE WEBSITES E-MAIL

- NCPDP Implementation Guides are accessed at www.wpc-edi.com.
- This HIPAA Companion Guide is accessed at http://dss.missouri.gov/mhd/.
- MO HealthNet transaction and DDE submission and receipts are accessed at www.emomed.com.
- MO HealthNet Provider Manuals and MO HealthNet Electronic Billing Layout Manuals are accessed at http://dss.missouri.gov/mhd/.

SECTION 5 - DATA STREAM HEADERS/BATCH ENVELOPES

REAL-TIME DATA STREAM HEADER

This section describes MO HealthNet's use of data stream headers in the real-time environment.

Field Name	Field Position Start - Stop	Field Length	Comments
Transaction ID	1 - 4	4	This is the unique CICS transaction ID assigned to each switching company. Contact Infocrossing Healthcare Services Help Desk
User Identification	5 - 10	6	Unique number that may be used by the

			switching company to ensure accurate terminal return.

TRANSACTION HEADER, DETAIL AND TRAILER

This section describes MO HealthNet's use of the batch enveloping segments. It includes a description of expected sender and receiver codes.

Segment	Field	Field Name	Comments
Transaction Header	880-K1	Sender ID	Use your EMOMED Website User ID.
Transaction Header	880-K7	Receiver ID	Use ‘43-1754897' for MO HealthNet (the hyphen is required). Use 'P021011511 for MoRX.
Transaction Detail Definition		NCPDP Data Record	Use Version 5.1 Telecommunication Standard

SECTION 6 - PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

INTRODUCTION

Through the use of tables, this section describes how to bill or interpret MO HealthNet specific business rules. It also describes how to populate or interpret trading partner or payer specific data elements. The tables contain a row for each segment or data element where MO HealthNet has something additional to convey. The intent is to convey information that is within the framework of the NCPDP 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.

Segment	Field	Field Name	Comments
Transaction Header Segment	101-A1	BIN Number	MO HealthNet BIN number is '004047'. MoRx BIN number is '004047'.
Transaction Header Segment	103-A3	Transaction Code	MO HealthNet does not support the following transactions: E1—Eligibility Verification P1-P4—Prior Authorization Transactions N1-N3—Information Reporting Transactions C1-C3—Controlled Substance Reporting Transactions All other transactions are supported for fee-for-service billing. Transactions B2 (Reversal) and B3 (Rebill)

			are not supported for MO HealthNet Managed Care health plans billing encounters.
Transaction Header Segment	104-A4	Processor Control Number	MO HealthNet processor control number is '43-1754897' (the hyphen is required). For MO HealthNet Managed Care health plans billing encounters, this field should contain the plan's MO HealthNet Managed Care Health Plan Number MoRx processor control number is P021011511. Note: the 'P' in the first position is the only alpha character, all others are numeric
Transaction Header Segment	109-A9	Transaction Count	Maximum transaction count for MO HealthNet PCN is 4. Maximum transaction count for MoRx PCN is 1.
Transaction Header Segment	201-B1	Service Provider ID	Beginning May 12, 2008, the MO HealthNet provider number will no longer be allowed and the NPI must be submitted. MO HealthNet Managed Care health plans billing encounters must submit the 7-digit National Association of Boards of Pharmacy (NABP) identification number assigned to the pharmacy in this field.
Transaction Header Segment	110-AK	Software Vendor/ Certification ID	MO HealthNet does not require vendor certification, therefore no specific value is required in this field. Since this field is part of a fixed length record, the spaces must still be sent even though no specific value is required. However, the switching company may require certification and may have a specific value requirement for this field.
Claim Segment	455-EM	Prescription/ServiceReference Number Qualifier	MO HealthNet does not support the following: 2 - Service Billing
Claim Segment	442-E7	Quantity Dispensed	MO HealthNet requires this optional field for billing and rebilling transactions. MoRx requires this optional field for billing and rebilling transactions.

Claim Segment	403-D3	Fill Number	MO HealthNet requires this optional field for billing and rebilling transactions. MoRx requires this optional field for billing and rebilling transactions.
Claim Segment	405-D5	Days Supply	MO HealthNet requires this optional field for billing and rebilling transactions. MoRx requires this optional field for billing and rebilling transactions
Claim Segment	406-D6 407-D7 442-E7 409-D9	Compound Code Product/Service ID Quantity Dispensed Ingredient Cost Submitted	MO HealthNet supports the "Alternate Option"—Option 2, Scenario A (Most expensive legend drug) as described in the Telecommunication Version 5 Questions, Answers, and Editorial Updates, Appendix D, dated December 2002. This scenario allows compound billing using the Claim Segment without using the Compound Segment. (Option 1 is also supported. Reference Compound Segment Information in this section). The editorial document outlines the following instructions for Scenario A. Submit a compound entering a 2 in the Compound Code (field 406-D6). Submit the Product/Service ID (NDC for example) of the most expensive legend drug (field 407-D7). Enter the sum of all the individual quantities as Quantity Dispensed (field 442-E7). Enter the sum of all ingredient costs in the Ingredient Cost Submitted (field 409-D9)
Claim Segment	420-DK	Submission Clarification Code	MO HealthNet recognizes a value of '8 - Process Compound for Approved Ingredients' in this field.
Claim Segment	308-C8	Other Coverage Code	All valid values can be submitted in this field. A value of 8-Claim billing for copay, combined with qualifier '99' in Other Amount Claimed Submitted Qualifier (479-H8) and the copay amount in Other Amount Claimed Submitted (480-H9) is considered a copay only claim by MO

			HealthNet and MoRx. A value of 4-Other coverage exists-payment not collected, combined with an amount in Gross Amount Due (430-DU), is considered a deductible claim for MoRx. A value of 3 - Other coverage exists - this claim not covered, indicates a claim for a Medicare Part D excluded drug when billing MoRx.
Claim Segment	429-DT	Unit Dose Indicator	For certain billing situations, this is a required field. Consult the MO HealthNet Provider Manuals for more information.
Claim Segment	461-EU	Prior Authorization Type Code	For certain billing situations, this is a required field. Consult the MO HealthNet Provider Manuals for more information.
Claim Segment	462-EV	Prior Authorization Number Submitted	For certain billing situations, this is a required field. Consult the MO HealthNet Provider Manuals for more information.
Claim Segment	343-HD	Dispensing Status	MO HealthNet supports partial fill functionality with the following constraints: Multiple “P” transactions for a single dispensing are not supported. “P” and “C” transactions for the same date of service are supported.
Clinical Segment	491-VE	Diagnosis Code Count	MO HealthNet has adopted the recommendation to support a maximum count of 5. Clinical Segment not supported for MoRx.
Clinical Segment	493-XE	Clinical Information Counter	MO HealthNet has adopted the recommendation to support a maximum of 5 occurrences.
COB/Other Payments Segment	337-4C	Coordination of Benefits/Other Payments Count	MO HealthNet has adopted the recommendation to support a maximum count of 3. For MO HealthNet Managed Care health plans billing encounters, at least one occurrence is required. Additional occurrences can be used to report payments from private insurance. For MoRx, when billing for copay or

			deductible, at least one occurrence is required.
COB/Other Payments Segment	338-5C	Other Payer Coverage Type	For MO HealthNet Managed Care health plans billing encounters, at least one occurrence is required and should be used to report the MO HealthNet Managed Care health plan's payment
COB/Other Payments Segment	339-6C	Other Payer ID Qualifier	For MO HealthNet Managed Care health plans billing encounters, this is a required field in the occurrence being used to report the MO HealthNet Managed Care health plan's payment. Use a value of '99' to qualify the Payer ID.
COB/Other Payments Segment	340-7C	Other Payer ID	For MO HealthNet Managed Care health plans billing encounters, this is a required field in the occurrence being used to report the MO HealthNet Managed Care health plan's payment. Use the MO HealthNet Managed Care health plan's MO HealthNet Health Plan Number.
COB/Other Payments Segment	443-E8	Other Payer Date	For MO HealthNet Managed Care health plans billing encounters, this is a required field in the occurrence being used to report the MO HealthNet Managed Care health plan's payment.
COB/Other Payments Segment	341-HB	Other Payer Amount Paid Count	MO HealthNet has adopted the recommendation to support a maximum count of 9. For certain billing situations, this is a required field. Consult the MO HealthNet Provider Manuals for more information. For MO HealthNet Managed Care health plans billing encounters, at least one occurrence is required to report the MO HealthNet Managed Care health plan's payment. A second occurrence can be used to report dispensing fee. For MoRx, when billing for copay or deductible, at least one occurrence is required.
COB/Other Payments Segment	342-HC	Other Payer Amount Paid Qualifier	For certain billing situations, this is a required field. Consult the MO HealthNet Provider Manuals for more information. All values of this qualifier are supported.

			For MoRx, use 07-Drug Benefit, 08-Sum of all Reimbursment, or 99-Other, to qualify a PDP payment(s).
COB/Other Payments Segment	431-DV	Other Payer Amount Paid	For certain billing situations, this is a required field. Consult the MO HealthNet Provider Manuals for more information. For MO HealthNet Managed Care health plans billing encounters, this is a required field. At least one occurrence must be used to report the MO HealthNet Managed Care health plan's payment. A second occurrence can be used to report a dispensing fee. For MoRx, when billing for copay (Other Coverage Code = 8), amount paid by a PDP is required. For MoRx, when billing for deductible (Other Coverage Code=4), any amount paid by PDP should be reported. This field must be submitted, even if it is equal to Zero.
COB/Other Payments Segment	471-5E	Other Payer Reject Count	MO HealthNet has adopted the recommendation to support a maximum count of 5. Also applies to MoRx claims.
COB/Other Payments Segment	472-6E	Other Payer Reject Code	For MO HealthNet and MoRx, submit reject codes received from primary payer or PDP.
Compound Segment	447-EC	Compound Ingredient Component Count	MO HealthNet has adopted the recommendation to support a maximum count of 25. MO HealthNet supports Multi-Ingredient Compound functionality with the following constraints: Claims submitted in a real-time environment with more than 4 ingredients are captured for processing in a batch environment. The response contains a captured status. Those with 4 or less ingredients are adjudicated real-time. Claims submitted as compounds with more than one ingredient are split into multiple claims.

			Compound segment not supported for MoRx.
Coupon Segment	485-KE	Coupon Type	MO HealthNet does not support any type of billing with a coupon. Coupon Segment not supported for MoRx
DUR/PPS Segment	473-7E	DUR/PPS Code Counter	MO HealthNet has adopted the recommendation to support a maximum of 9 occurrences. DUR/PPS segment not supported for MoRx.
Insurance Segment	302-C2	Cardholder ID	For MO HealthNet, use MO HealthNet Participant ID. For MoRx, use MO HealthNet Participant ID or Medicare Beneficiary ID.
Insurance Segment	312-CC	Cardholder First Name	MO HealthNet requires this optional field for billing and rebilling transactions. MoRx requires this optional field for billing and rebilling transactions.
Insurance Segment	313-CD	Cardholder Last Name	MO HealthNet requires this optional field for billing and rebilling transactions. MoRx requires this optional field for billing and rebilling transactions.
Insurance Segment	309-C9	Eligibility Clarification Code	For certain billing situations, a value of 2-Override, can be submitted in the real-time environment and used to override specific transaction rejections. Consult the MO HealthNet Provider Manuals for more information.
Patient Segment	307-C7	Patient Location	For certain billing situations, this is a required field. Consult the MO HealthNet Provider Manuals for more information. Patient Segment not supported for MoRx.
Prescriber Segment	466-EZ	Prescriber ID Qualifier	MO HealthNet requires this optional field for billing and rebilling transactions. MoRx requires this optional field for billing and rebilling transactions. MO HealthNet and MoRx limits the qualifiers that are valid for claim payment

			to include values '05' and '12'
Prescriber Segment	411-DB	Prescriber ID	MO HealthNet requires this optional field for billing and rebilling transactions. MoRx requires this optional field for billing and rebilling transactions.
Pricing Segment	478-H7	Other Amount Claimed Submitted Count	MO HealthNet has adopted the recommendation to support a maximum count of 3.This also applies to MoRx.
Pricing Segment	479-H8	Other Amount Claimed Submitted Qualifier	A value of 99-Other, combined with the copay amount in Other Amount Claimed Submitted (480-H9) and 8-Claim billing for copay in Other Coverage Code (308-C8) is considered a copay only claim by MO HealthNet and MoRx
Pricing Segment	480-H9	Other Amount Claimed Submitted	An amount in this field qualified by 99-Other, combined with value 8-Claim billing for copay in Other Coverage Code (308-C8) is considered a copay only claim by MO HealthNet and MoRx. The amount in this field is the total amount that will be considered for payment under MoRx.
Pricing Segment	426-DQ	Usual and Customary Charge	MO HealthNet requires this optional field for billing and rebilling transactions.
Pricing Segment	430-DU	Gross Amount Due	MoRx requires this optional field for billing and rebilling transactions when billing for deductible (Other Coverage Code (308-C8) = 4). The amount in this field is the total amount that will be considered for payment under MoRx. Beginning March 22, 2008, the MO HealthNet Fee-For-Service (FFS) Pharmacy Program will begin using the Gross Amount Due (GAD) field (430-DU) along with the Usual and Customary (U&C) field (426-DH) to determine the total submitted charge for MO HealthNet Fee-For-Service Pharmacy Point of Sale (POS) claims. The Gross Amount Due field is not a required field for MO HealthNet claims, however, if you choose to submit a dollar amount in this field the total submitted charge will be interpreted as the

			lesser of the two fields.
Response Header Segment	102-A2	Version/Release Number	Response version equals the value submitted in the Request Header Segment.
Response Header Segment	103-A3	Transaction Code	Response value equals the value submitted in the Request Header Segment.
Response Header Segment	109-A9	Transaction Count	Response value equals the value submitted in the Request Header Segment.
Response Header Segment	501-F1	Header Response Status	All values supported
Response Header Segment	202-B2	Service Provider ID Qualifier	Response value equals the value submitted in the Request Header Segment.
Response Header Segment	201-B1	Service Provider ID	Response value equals the value submitted in the Request Header Segment.
Response Header Segment	401-D1	Date of Service	Response value equals the value submitted in the Request Header Segment.
Response Insurance Segment	301-C1	Group ID	MO HealthNet populates this optional field with the Group or Policy Number from the MO HealthNet Third Party Liability database when certain rejections occur to any of the transactions in the transmission in the real-time environment.
Response Message Segment	504-F4	Message	MO HealthNet and MoRx populate this field with various messages when applicable.
Response Status Segment	112-AN	Transaction Response Status	Values supported: 'A' - Approved, 'C' Captured, 'D' - Duplicate of Paid, 'P' - Paid, 'R' - Rejected
Response Status Segment	503-F3	Authorization Number	MO HealthNet and MoRx populate this optional field when the Response Status Segment is sent.
Response Status Segment	510-FA	Reject Count	MO HealthNet supports a maximum count of 20.This also applies to MoRx.
Response Status Segment	547-5F	Approved Message Code Count	MO HealthNet does not populate this optional field.
Response Status Segment	526-FQ	Additional Message Information	MO HealthNet includes the Insurance Company Name and Phone Number (if available) that corresponds to the Group or Policy number in field 301-C1 from the MO HealthNet Third Party Liability database for certain rejected transactions in

			the real-time environment. The format is as follows: The text OTHER PAYER NAME: is in position 14, followed by the name, which can be up to 40 characters. The text PHONE: is in position 71, followed by the 10 character phone number. Various other messages may be sent for both MO HealthNet and MoRx when applicable.
Response Status Segment	549-7F	Help Desk Phone Number Qualifier	MO HealthNet populates this optional field with a value of "03" in certain situations. MoRx does not populate this field.
Response Status Segment	550-8F	Help Desk Phone Number	MO HealthNet populates this optional field with the MO HealthNet Managed Care health plan help desk number in certain situations. MoRx does not populate this field.
Response Claim Segment	455-EM	Prescription/Service Reference Number Qualifier	Response value equals the value submitted in the Request Header Segment.
Response Claim Segment	402-D2	Prescription/Service Reference Number	Response value equals the value submitted in the Request Header Segment.
Response Claim Segment	551-9F	Preferred Product Count	MO HealthNet does not populate this optional field. This also applies to MoRx.
Response Pricing Segment	505-F5	Patient Pay Amount	MO HealthNet populates this optional field in applicable payment situations. This also applies to MoRx.
Response Pricing Segment	506-F6	Ingredient Cost Paid	MO HealthNet populates this optional field in applicable payment situations. This also applies to MoRx.
Response Pricing Segment	507-F7	Dispensing Fee Paid	MO HealthNet populates this optional field in applicable payment situations. This also applies to MoRx
Response Pricing Segment	563-J2	Other Amount Paid Count	MO HealthNet does not populate this optional field.This also applies to MoRx.
Response Pricing Segment	566-J5	Other Payer Amount Recognized	MO HealthNet populates this optional field in applicable payment situations. This also applies to MoRx

Response Pricing Segment	509-F9	Total Amount Paid	MO HealthNet populates this optional field in applicable payment situations. This also applies to MoRx
Response Pricing Segment	518-FI	Amount of Copay/Coinsurance	MO HealthNet populates this optional field in applicable payment situations. This also applies to MoRx
Response DUR/PPS Segment	567-J6	DUR/PPS Response Code Counter	MO HealthNet has adopted the recommendation to support a maximum of 9 occurrences.This also applies to MoRx.
Response DUR/PPS Segment	439-E4	Reason For Service Code	MO HealthNet populates this optional field in applicable situations. This also applies to MoRx
Response DUR/PPS Segment	528-FS	Clinical Significance Code	MO HealthNet populates this optional field in applicable situations. This also applies to MoRx
Response DUR/PPS Segment	529-FT	Other Pharmacy Indicator	MO HealthNet populates this optional field in applicable situations. This also applies to MoRx
Response DUR/PPS Segment	530-FU	Previous Date of Fill	MO HealthNet populates this optional field in applicable situations. This also applies to MoRx
Response DUR/PPS Segment	531-FV	Quantity of Previous Fill	MO HealthNet populates this optional field in applicable situations. This also applies to MoRx
Response DUR/PPS Segment	532-FW	Database Indicator	MO HealthNet populates this optional field in applicable situations. This also applies to MoRx
Response DUR/PPS Segment	533-FX	Other Prescriber Indicator	MO HealthNet populates this optional field in applicable situations. This also applies to MoRx
Response DUR/PPS Segment	544-FY	DUR Free Text Message	MO HealthNet populates this optional field in applicable situations. This also applies to MoRx
Response Prior Authorization Segment	111-AM	Segment Identification	MO HealthNet does not support this segment. MoRx does not support this segment.

APPENDICES

APPENDIX A OPTICAL

Optical NTE segment NTE02 Data element specifications:

NOTE: This NTE segment should be coded at the 2300 claim level loop, as specified in Section 6 of this companion guide.

START POSITION	LENGTH	FIELD DESCRIPTION	COMMENTS
1	2	Prescription indicator	Always enter 'RX'.
3	1	Filler	Always enter space.
4	2	Right eye indicator	Always enter 'OD'.
6	1	Filler	Always enter space.
7	1	Right eye first diopter sign	If right eye first diopter information is needed for this claim, value is '+' or '-'. Default is '+'.
8	5	Right eye first diopter	If right eye first diopter information is needed for this claim the format is 00.00. Default is '00.00'.
13	1	Filler	Always enter space.
14	1	Right eye second diopter sign	If right eye second diopter information is needed for this claim, value is '+' or '-'. Default is '+'.
15	5	Right eye second diopter	If right eye second diopter information is needed for this claim the format is 00.00. Default is '00.00'.
20	1	Filler	Always enter space.
21	1	Times indicator	Always enter 'X'.
22	3	Times field	If right eye times information is needed for this claim, enter times value. Default is '000'. This must be numeric, with three digits.
25	1	Filler	Always enter space.
26	3	Right eye ADD indicator	Always enter 'ADD'.
29	1	Right eye ADD Sign	If right eye ADD information is needed for this claim, value is '+' or '-'. Default is '+'.
30	5	Right eye ADD field	If right eye ADD information is needed for this claim the format is 00.00. Default is '00.00'.
35	1	Filler	Always enter space.

36	2	Left eye indicator	Always enter 'OS'.
38	1	Filler	Always enter space.
39	1	Left eye first diopter sign	If left eye first diopter information is needed for this claim, value is '+' or '-'. Default is '+'.
40	5	Left eye first diopter	If left eye first diopter information is needed for this claim, the format is 00.00. Default is '00.00'.
45	1	Filler	Always enter space.
46	1	Left eye second diopter sign	If left eye second diopter information is needed for this claim, value is '+' or '-'. Default is '+'.
47	5	Left eye second diopter	If left eye second diopter information is needed for this claim, the format is 00.00. Default is '00.00'.
52	1	Filler	Always enter space.
53	1	Left eye Times indicator	Always enter 'X'. Otherwise, value is spaces.
54	3	Left eye Times field	If left eye times information is needed for this claim, enter times value. Default is '000'. This must be numeric, with three digits.
57	1	Filler	Always enter space.
58	3	Left eye ADD indicator	Always enter 'ADD'.
61	1	Left eye ADD sign	If left eye ADD information is needed for this claim, value is '+' or '-'. Default is '+'.
62	5	Left eye ADD field	If left eye ADD information is needed for this claim, the format is 00.00. Default is '00.00'.

APPENDIX B - IMPLEMENTATION CHECKLIST

The following is a list of the steps required to begin sending production HIPAA compliant NCPDP transactions to MO HealthNet:

1. Biller completes either the Application for MO HealthNet Internet Access Account or the Application for MO HealthNet Connect:Direct Access Account.
2. Biller completes the Trading Partner Agreement.
3. Infocrossing Healthcare Services (IHS) Help Desk approves documents in steps 1 and 2 and notifies the biller of User ID and password.
4. Trading Partner sends test file(s). Results are available within 1-2 business days.

5. Trading Partner reviews results from test file(s), which were produced overnight, the following business day.
6. When the Trading Partner is satisfied with the results of the test (e.g., test claims aren't rejected), the Trading Partner contacts the IHS Help Desk to be moved to production for each specific transaction.

APPENDIX C - CHANGE SUMMARY

Updates to this guide can be accessed by clicking on the folder that says "Updated Manual List" in the table of contents. Then click on the "UPDATED MANUAL LIST" text underneath the folder to see a list of the Electronic Billing Layout Manuals in the document window. A link exists on a manual name if a revision has been made to that manual in approximately the last 6 months. After clicking on the manual name link, the sections with revisions show up in a "hit list" in the document window. Click on the section title in the hit list to jump to the revision. The revision is shown in green text. Click on the browser's back button to go back to the hit list. If there is just one section in the manual with a change in the last 6 months, then the link on the manual name in the Updated Manual List goes directly to the section with the revision (rather than showing the hit list first.)