South Carolina Department of Health and Human Services

HIPAA Transaction
Standard Companion Guide

Refers to the Implementation Guides Based on X12 version 005010A1

Companion Guide Version Number: 1.6

February 2015

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Preface

This Companion Guide to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging electronically with South Carolina Department of Health and Human Services. Transmissions based on this companion guide, used in tandem with the 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.

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1. Introduction

This section describes how X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The table contains a row for each segment that South Carolina Department of Health and Human Services (SCDHHS) has something additional, over and above, the information in the IGs. That information can:

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

In addition to the row for each segment, one or more additional rows are used to describe SCDHHS usage for composite and simple data elements and for any other information. The following table is an example:

SHADED Rows represent "**segments**" in the X12N Implementation Guide.
NON-SHADED rows represent "**data elements**" in the X12N Implementation Guide.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
HDR	**ISA**	**INTERCHANGE CONTROL HEADER**		**1**	**R**	**Loop Repeat**	**Values**	**Requirement Description**
HDR	ISA01	Authorization Information Qualifier	ID	2-2	R		00, 03	
HDR	ISA03	Security Information Qualifier	ID	2-2	R		00, 01	
HDR	ISA05	Interchange ID Qualifier	ID	2-2	R		01, 14, 20, 27, 28, 29, 30, 33, ZZ	Use 'ZZ' – Mutually Defined

Scope

This Health Care Claim: Institutional Companion Guide (CG) is to be used in addition to the X12 Implementation Guide, adopted for use under HIPAA.

This Companion Guides contains two types of data; instructions for electronic communications with SCDHHS (Communications/Connectivity Instructions) and supplemental information for creating transactions for SCDHHS while ensuring compliance with the associated ASC X12 IG (Transaction Instructions).

The Transaction Instruction component is included in the CG when SCDHHS wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

Overview

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carry provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) 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 transactions 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

Compliance according to HIPAA

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

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked "not used" in the standard's implementation specifications or are not in the standard's implementation specification(s).

- Change the meaning or intent of the standard's implementation specification(s).

Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

References

The CORE v5010 Master Companion Guide Template has been adapted from the CAQH/WEDI Best Practices Companion Guide Template originally published January 1, 2003.

2. Getting Started

Working with SCDHHS

Should you intend to conduct electronic transactions with South Carolina Medicaid, you must first complete and return a Trading Partner Agreement (TPA) to the South Carolina Medicaid Provider Service Center. The TPA delineates the responsibilities of both the provider and SCDHHS.

Once South Carolina Medicaid Provider Service Center staff receives your completed TPA, they will contact you to give instructions on how to proceed. Should you intend to create files and send them yourself; the S.C. Medicaid EDI Support Center staff will set up an electronic mailbox for you, assign you a user I.D. and password, and notify you that you may submit a transaction for testing. The testing process evaluates both the format of content of your transaction to ensure it is HIPAA compliant.

If you plan to use a clearinghouse to conduct your transactions, it will not be necessary to set up a mailbox for you, nor for you to test with S.C. Medicaid.

Trading Partner Registration

Providers

Trading Partner Agreement Enrollment Instructions for Providers can be found on the scdhhs.gov website or http://www.scdhhs.gov/resource/hipaa-5010-project-status

Vendors/Clearinghouses

Trading Partner Agreement Enrollment Instructions for Vendors and Clearinghouses can be found on the scdhhs.gov website: http://www.scdhhs.gov/resource/hipaa-5010-project-status

The Trading Partner Agreement Enrollment (TPA) form may be found online at: http://www.scdhhs.gov/resource/hipaa-5010-project-status

Testing with the Payer

Becoming HIPAA compliant will require that most healthcare payers, clearinghouses and providers make significant changes to their existing Electronic Data Interchange (EDI) processes. Process change inevitably includes testing for results validation. This testing can be one of the most time consuming efforts in the development cycle. SC Medicaid expects the following approach will optimize test time and expedite our Trading Partners' transition from test to production status.

The following must be performed for each different transaction type that a Trading Partner is approved to submit to SC Medicaid.

The Trading Partner must complete testing for each of the transactions it will implement and shall not be allowed to exchange data with SCDHHS in production mode until testing is satisfactorily passed as determined by SCDHHS. Successful testing means the ability to successfully pass HIPAA compliance checking and to process PHI transmitted by Trading Partner to SCDHHS. SCDHHS will accept certification from any third-party testing and certification entity that has been identified by the Workgroup for Electronic Data Interchange, Strategic National Implementation Process (WEDI/SNIP) in lieu of a Trading Partner being tested by SCDHHS. Such certification must be at least level 4 as defined by WEDI.

Table 1. Payer Testing Table

Test Step	Description
Test Plan	The SC Medicaid EDI Support Center and the Trading Partner will agree to a predefined set of test data with expected results. The matrix will vary by transaction and Trading Partner. Also, we will develop a plan for test-to production transition that considers volume testing and transaction acceptance ratios.
Security	The SC Medicaid EDI Support Center will verify approved Trading Partners have a valid User ID and password.

Connectivity and Transmission Integrity	SC Medicaid Axiom translator-supported connectivity protocols are outlined in the "Understanding Access to SC Medicaid" section of this manual. This first level of testing is complete when the Trading Partner has successfully sent to and received from SC Medicaid Axiom translator a test file via one of the SC Medicaid Axiom translator-supported connectivity options. The SC Medicaid EDI Support Center suggests the Trading Partner limit transactions to small volume (one percent of estimated daily transactions) for this test phase.
Transaction Validation	The SC Medicaid EDI Support Center will verify that approved Trading Partners are submitting transactions allowed per our enrollment applications.
Data Integrity	Data integrity is determined by X12 and HIPAA Implementation Guide (IG) Level 4 compliance edits performed by the SC Medicaid Axiom translator. The SC Medicaid EDI Support Center will ask a Trading Partner to first submit low volume files. When these are successfully processed, the SC Medicaid EDI Support Center will ask for larger volume files (five percent of estimated daily transactions). The SC Medicaid Axiom translator returns transmission acknowledgement and edit result response transactions from this process. The Trading Partner should correct transactions reported as errors and resubmit them. Data integrity testing is successfully completed when the Trading Partner's data has no compliance errors; i.e., achieves 100% acceptance.
Acknowledgement and Response Transactions	Trading Partners must demonstrate the ability to receive acknowledgement and response transactions. The SC Medicaid Axiom translator expects Trading Partners will also implement balancing or reconciliation processes and report transmission discrepancies to us immediately.
Results Analysis	SC Medicaid EDI Support Center and the Trading Partner will review acknowledgement and response transactions for consistency with the predefined expected results.

Transition from Test to Production Status

The Trading Partner must complete testing for each of the transactions it will implement and will not be allowed to exchange data with SC Medicaid in production mode until testing is satisfactorily passed. SC Medicaid will accept certification from any third-party testing and certification entity that has been identified by the Workgroup for Electronic Data Interchange, Strategic National Implementation Process (WEDI/SNIP) in lieu of a Trading Partner being tested by SC Medicaid. Such certification must be at least level 4 as defined by WEDI.

When the test results have been satisfied, the Trading Partner's submission status will be changed from test to production. At this time, the Trading Partner can begin to send production transaction data to SC Medicaid.

3. Connectivity with the Payer/ Communications

EDI Gateway

McaidNET is the EDI gateway to SC Medicaid. Effective 03/01/2009, no new modem accounts will be created. Effective 07/01/2009, the modem server will no longer be available. The following are communication packages that will be supported:

- SecureFTP
- WS_FTP Pro v8.0 or higher

McaidNET is defaulted to send uncompressed files.

Note: *McaidNET supports file transfers via secure File Transfer Protocol (FTP). Specifications on these options are included later in this manual.*

SC Medicaid accepts the following ASC X12N Version 5010 (Errata) transactions, required with the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

- Dental Claim: ASC X12N 837D 005010X224A2 - Health Care Claim: Dental
- Professional Claim: ASC X12N 837P 005010X222A - Health Care Claim: Professional
- Institutional Claim: ASC X12N 837I 005010X223A2 - Health Care Claim: Institutional
- Health Claim Status: ASC X12N 276/277 005010X212 - Health Care Claim Status Request
- Eligibility for a Health Plan: ASC X12N 270/271 005010X279A1 - Health Care Eligibility Benefit Inquiry
- Premium Payment: ASC X12N 820 005010X218A1
- Enrollment: ASC X12N 834 005010X220A1
- Claim Payment: ASC X12N 835 005010X221A1

The McaidNET platform is available 24 hours a day, seven days a week, with the exception of infrequent maintenance performed on Sundays.

If you have any questions regarding the McaidNET platform, please call the SC Medicaid EDI Support Center toll-free at 1-888-289-0709, Option 1 then Option 1.

Access the Communications Guide online:
http://www1.scdhhs.gov/openpublic/hipaa/webfiles/Communication%20Guide%205010%20OCT2011.pdf

Contact Information

EDI Customer Service/Technical Assistance

The South Carolina Medicaid EDI Support Center can assist you with your questions about HIPAA-related transactions, code sets and related provider training opportunities.

Call 1-888-289-0709 or send Email to EDIG.OPS-MCAID@palmettogba.com

Provider Service Number

The South Carolina Provider Service department can assist you with your questions at 1-888-289-0709 or by submitting an inquiry at Provider Inquiry.

Applicable Websites / Email

Provider Services: http://www.scdhhs.gov/organizations

Contact a Provider Service Representative: http://www.scdhhs.gov/contact-us

To ensure receipt and processing of claims for services, providers are reminded that all hardcopy Medicaid claims and corrected Edit Correction Forms (ECF) must be mailed to:

Medicaid Claims Receipt
Post Office Box 1412
Columbia, South Carolina 29202-1412

Updates to provider information should be mailed to:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, South Carolina 29202-8809

Updates and changes will continue to be posted to our website at www.scdhhs.gov as we continue to improve the services that we provide to both Medicaid providers and

beneficiaries. Please continue to review your Medicaid Policy manual for additional policy changes and updates.

4. Control Segments / Envelopes

ASC X12 transaction envelopes (i.e., ISA, IEA, GS and GE segments) should be populated per instructions found in in the South Carolina Communications Manual. Transactions returned by SC Medicaid to the Trading Partner will be enveloped consistent with the specifications described in Example 1B. ASC X12 transaction record formats are available as downloads from the Washington Publishing Company (WPC) Web site, http://wpc-edi.com

5. Payer Specific Business Rules and Limitations

ISA and Case Requirements

1. Trading Partners must envelope (ISA-IEA) different transactions separately.
2. SC Medicaid's compliance edits reject the ISA-IEA content when any transaction within that ISAIEA is not 100% compliant.
3. SC Medicaid's processes will perform a case conversion (to UPPERCASE) on all EDI data.

Delimiter Rules

1. The delimiters for the inbound X12 transaction sets will be:
   CR/LF Carriage return and line feed for segment terminator (upon request the ~ Tilde can be used for those partners unable to process the CR/LF)

2. The delimiters set by SC Medicaid for the outbound X12 transaction sets will be:
   CR/LF Carriage return and line feed for segment terminator (upon request the ~ Tilde can be used for those partners unable to process the CR/LF)

6. Acknowledgments/Reports

SCDHHS will send an Acknowledgment Medic Report- an HTML summary of the transaction via 999 and 997.

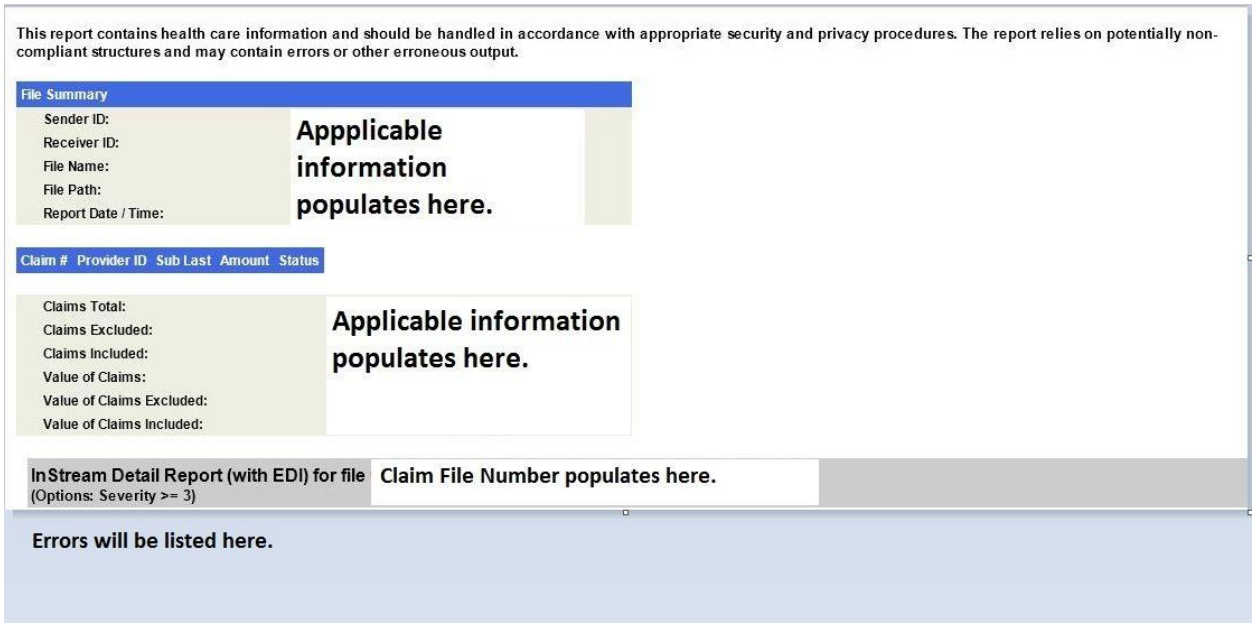

Figure 1. Medic Report Sample

7. Trading Partner Agreements

Trading Partners

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

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

Providers

Trading Partner Agreement Enrollment Instructions for Providers can be found on the scdhhs.gov website or http://www.scdhhs.gov/resource/hipaa-5010-project-status

Vendors/Clearinghouses

Trading Partner Agreement Enrollment Instructions for Vendors and Clearinghouses can be found on the scdhhs.gov website: http://www.scdhhs.gov/resource/hipaa-5010-project-status

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Completion of the S.C. Medicaid Trading Partner Agreement

Page 1

I.A.1., Name: Provider or organization name. The name must match the S.C. Medicaid Provider Number in I.A.2. For instance, if you have an organization name, you must provide a group ID; if you have an individual name, you must provide an individual ID. If you have both an individual and a group ID, you must complete two separate TPAs, one for each ID.

I.A.2., S.C. Medicaid Provider Number: The 6-digit provider ID. If you do not yet have a provider ID, you must contact South Carolina Medicaid Enrollment and apply for one before submitting a TPA to the EDI division. You may contact Enrollment at 803-788-7622, ext: 41650 to request an enrollment packet and to sign up for Electronic Funds Transfer.

I.A.4., Address: The provider's billing or street address.

I.A.5., Contact Name: The provider's enrollment officer, or anyone who can answer questions about the completed TPA.

I.A.6, 7, & 8, Contact Phone, E-mail and Fax: Please complete all information. If we cannot reach you by phone, we will try to contact you via e-mail and fax.

Page 5

Signing for EDI Partner: An original signature is required; stamps, copies, or faxes are not accepted. The signature must be either that of the provider or the providers authorized representative.

Page 6

Provider Name, Medicaid ID#, Address, and Phone: Must all be the same as the information provided on page 1.

NPI #: The National Provider ID for the provider ID listed. Do not leave this blank - we will not process the TPA without the NPI.

Name and Title: Must be the name and title of the person who signs pages 5 and 8.

The Provider will Submit Claim: If you would like a Web Tool ID, indicate the number of user IDs needed. Each person must have their own user ID.

Other Company or Software: If you are using a third party to submit your claims, list the name of your clearinghouse or software vendor. If you have your own S.C. Medicaid Submitter ID, you can list it here.

Page 8
Signature: Must be the same individual who signed page 5 and who was reflected under "Name and Title" section on page 6.

Appendix B
Sharing your NPI: If the TPA is for an individual provider, please complete the Individual Provider section only. If the TPA is for a group ID, complete the Group section only. It is very important that the NPI that you provide is for the provider ID listed.
Note: *The TPA will not be processed without the NPI information. Information for obtaining and NPI number is located on page 1 of the TPA.*

Additional Information:

- **Trading Partner Agreement Enrollment Instructions for Providers**
- **Trading Partner Agreement Enrollment Instructions for Vendors and Clearinghouses**
- **Trading Partner Agreement 01/01/2013**

8. Transaction Specific Information

This section describes how X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that SCDHHS has something additional, over and above, the information in the IGs. That information can:

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

Table 2. 837P 005010X223A2 Healthcare Claim Professional Table

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
HDR	**ISA**	**INTERCHANGE CONTROL HEADER**		**1**	**R**	**1**		
HDR	ISA01	Authorization Information Qualifier	ID	2-2	R		00, 03	Use Value ‘ “OO”
HDR	ISA03	Security Information Qualifier	ID	2-2	R		00, 01	Use Value ‘ “OO”
HDR	ISA05	Interchange ID Qualifier	ID	2-2	R		01, 14, 20, 27, 28, 29, 30, 33, ZZ	Use Value ‘ZZ’ – Mutually Defined
HDR	ISA06	Interchange Sender ID	AN	15-15	R			Use the SC Medicaid Assigned Submitter Number
HDR	ISA07	Interchange ID Qualifier	ID	2-2	R		01, 14, 20, 27, 28, 29, 30, 33, ZZ	Use Value ‘ZZ’ – Mutually Defined
HDR	ISA08	Interchange Receiver ID	AN	15-15	R			Use Value ‘SCMEDICAID ‘ –
HDR	ISA11	Repetition Separator	AN	1-1	R			Hardcode Caret ^
HDR	ISA14	Acknowledgement Requested	ID	1-1	R		0, 1	If your Trading Partner Agreement indicates that you will receive an Interchange Acknowledgement (TA1). Use '1' for Interchange Acknowledgement Requested If your Trading Partner Agreement does not indicate that you will receive an Interchange Acknowledgement (TA1). Use '0' for No Interchange Acknowledgement Requested
HDR	ISA15	Usage Indicator	ID	1-1	R		P, T	'Provider should use 'T' until testing of the Trading Partner is approved
HDR	ISA16	Component Element Separator	AN	1-1	R			Default :

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
HDR	**GS**	**FUNCTIONAL GROUP HEADER**		**1**	**R**	**>1**		
HDR	GS02	Application Sender Code	AN	2-15	R			Use the SC Medicaid Assigned Submitter Number
HDR	GS03	Application Receiver Code	AN	2-15	R			Use Value 'SCMEDICAID'
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
HDR	**BHT**	**BEGINNING OF HIERARCHICAL TRANSACTION**	**1**	**R**	**1**			
HDR	BHT02	Transaction Set Purpose Code	ID	2-2	R		00, 18	Use Value '00' - Original
HDR	BHT05	Transaction Set Creation Time	TM	4-8	R		HHMM, HHMMSS, HHMMSSD, CCYYMMDD	Format is HHMM
HDR	BHT06	Claim or Encounter ID	ID	2-2	R		31, CH, RP	Use value 'CH' – Chargeable 'RP' – Reporting for Encounters
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
1000A	**NM1**	**SUBMITTER NAME**		**1**	**R**	**1**		
1000A	NM109	Submitter Identifier	AN	2-80	R			Use your SC Medicaid Trading Partner ID. **FOR TRANSPORTATION BROKERS ONLY**: Use Value 'TT'

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
1000B	**NM1**	**RECEIVER NAME**		**1**	**R**	**1**		
1000B	NM103	Receiver Name	AN	1-60	R			Use value 'SC Medicaid'
1000B	NM109	Receiver Primary Identifier	AN	2-80	R			Use value 'SC Medicaid'
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2000A	**PRV**	**BILLING PROVIDER SPECIALTY INFORMATION**	**1**	**S**				
2000A	PRV03	Provider Taxonomy Code	AN	1-50	R			Submit the billing/pay-to Provider Taxonomy that was used for the SC Medicaid Provider Enrollment.
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2000B	**SBR**	**SUBSCRIBER INFORMATION**		**1**	**R**			
2000B	SBR09	Claim Filing Indicator Code	ID	1-2	S		11, 12, 13, 14, 15, 16, 17, AM, BL, CH, CI, DS, FI, HM, LM, MA, MB, MC, OF, TV, VA, WC, ZZ	Use Value 'MC' - Medicaid or "13" if Pharmacy provider.
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2010AA	**NM1**	**BILLING PROVIDER NAME**		**1**	**R**	**1**		
2010AA	NM108	Identification Code Qualifier	ID	1-2	S		XX	Use value 'XX' for NPI if typical provider. Else use value in Segment 2010BB.
2010AA	NM109	Billing Provider Identifier	AN	2-80	R			***Must*** contain the billing/pay-to provider's National Provider Identifier (NPI). An entry in

								this field ***REQUIRES*** an associated taxonomy be entered in Loop 2000A; Element - PROV03. **Important Notes:** -The taxonomy will match back to a specific provider type based on the provider type/ taxonomy table. -If SCDHHS does not have a legacy ID with that provider type on the provider roster, then a non-par entry ***must*** be provided with that provider type and NPI. -If the billing provider does not match to a legacy ID/provider type, the servicing provider legacy ID fields will be left blank on the flat file. This will cause the encounter to be rejected at the mainframe level with a 'SERVICE PROVIDER ID MISSING' edit.
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2010AA	**N4**	**BILLING PROVIDER CITY/STATE/ZIP CODE**	**1**	**R**				
2010AA	N403	Billing Provider Postal Zone or ZIP Code	ID	3-15	S			Submit Full 9 Digit Zip Code.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010BA	**NM1**	**SUBSCRIBER NAME**		**1**	**R**	**1**		
2010BA	NM108	Identification Code Qualifier	ID	1-2	R		II, MI	Use value 'MI' – Member Identification Number.
2010BA	NM109	Subscriber Primary Identifier	AN	2-80	R			Use the recipient's 10 Digit SC Medicaid Identification Number. This data element is required when NM102 equals one (1).
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2010BB	**NM1**	**PAYER NAME**		**1**	**R**	**1**		
2010BB	NM103	Payer Name	AN	1-60	R			Use value 'SC Medicaid'.
2010BB	NM108	Identification Code Qualifier	ID	1-2	R		PI, XV	Use value 'PI' – Payer Identification.
2010BB	NM109	Payer Identifier	AN	2-80	R			Use value 'SCXIX'.
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2010BB	**N3**	**PAYER ADDRESS**		**1**	**S**			
2010BB	N301	Payer Address Line	AN	1-55	R			Use value '1801 Main St'.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2010BB	**N4**	**PAYER CITY/STATE/ZIP CODE**		**1**	**R**			
2010BB	N401	Payer City Name	AN	2-30	R			Use value 'Columbia'.
2010BB	N402	Payer State Code	ID	2-2	S			Use value 'SC'.
2010BB	N403	Payer Postal Zone or ZIP Code	ID	3-15	S			Use value '29201'.
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2010BB	**REF**	**BILLING PROVIDER SECONDARY IDENTIFICATION**	**2**	**S**				
2010BB	REF01	Reference Identification Qualifier	ID	2-3	R		G2, LU	Atypical providers enter value "G2"= Provider Commercial Number (SC Medicaid Proprietary ID) Required when NM109 in Loop 2010AA is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.
2010BB	REF02	Payer Additional Identifier	AN	1-50	R			Atypical providers enter SC Medicaid Proprietary ID.
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2300	**CLM**	**CLAIM INFORMATION**		**1**	**R**	**100**		
2300	CLM01	Patient Control Number	AN	1-38	R			Use a new, unique Patient Control Number, preceded or succeeded by a 'v', when submitting a voided encounter. ***When voiding an encounter claim the submitter MUST also:*** **1.** Enter a value of '8' in Loop 2300; Data Element-

								CLM05-3. *If a new claim will be submitted later for the voided claim, enter a value of '1' in Loop 2300; Data Element – CLM05-3 in the new claim transmission.* **2.** Enter the original seventeen (17) byte encounter ID number you wish to void in Loop 2300; Data Element-REF02. **3.** Enter a value of 'F8' in Loop 2300; Data Element-REF01.
2300	CLM07	Provider Accept Assignment Code	ID	1-1	R		A, B, C	Use value "A" = Assigned
2300	CLM08	Yes/No Condition or Response Code	ID	1-1	R		N, W, Y	Use value "Y" = Yes

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	**REF**	**REFERRAL NUMBER**		**1**	**S**			
2300	REF01	Reference Identification Qualifier	ID	2-3	R		9F	Use Value "9F"
2300	REF02	Referral Number	AN	1-50	R			Referral Number
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2300	**REF**	**PRIOR AUTHORIZATION**		**1**	**S**			
2300	REF01	Reference Identification Qualifier	ID	2-3	R		G1	Use Value G1
2300	REF02	Prior Authorization	AN	1-50	R			Use Prior Authorization Number

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	**REF**	**PAYER CLAIM CONTROL NUMBER**		**1**	**S**			
2300	REF01	Reference Identification Qualifier	ID	2-3	R			Use F8 when voiding an encounter claim.
2300	REF02	Payer Claim Control Number	AN	1-50	R			Enter the original seventeen (17) byte encounter ID number of the claim being voided. *(See Loop 2300; Data Element-CLM01 for additional instructions.)* Note: When voiding a claim, the new, unique encounter ID, preceded or succeeded by a 'v', *must be* entered in Loop 2300; Data Element-CLM01.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	**NTE**	**CLAIM NOTE**		**1**	**S**			
2300	NTE01	Note Reference Code	ID	3-3	R		ADD, CER, DCP, DGN, TPO	TRANSPORTATION BROKERS ONLY: Use Value 'ADD' – Additional Information
2300	NTE02	Claim Note Text	AN	1-80	R			TRANSPORTATION BROKERS ONLY

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	**CRC**	**EPSDT REFERRAL**		**1**	**S**			
2300	CRC03	Condition Code	ID	2-3	R		AV, NU, S2, ST	S2 Under Treatment = Patient is currently under treatment for referred diagnostic or corrective health problem. (MMIS Value = 1 - Well child care with treatment of an

								identified problem treated by the physician] ST New Services Requested = Patient is referred to another provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals) OR Patient is scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals) [MMIS Value = 2 = Well child care with a referral made for an identified problem to another provider]

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2300	**HI**	**HEALTH CARE DIAGNOSIS CODE**		**1**	**R**			
2300	HI-1-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.

2300	H-2-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-3-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-4-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-5-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.

2300	HI-6-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-7-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.

2300	HI-8-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-9-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.

2300	HI-10-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-11-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
2300	HI-12-1	Diagnosis Type Code	ID	1-3	R		ABK, BK	-Use Value 'BK' – Principal Diagnosis (ICD-9) October 1, 2013 = ICD-10 implementation. At that time, Value ABK - Principal Diagnosis (ICD-10) will be used. The diagnosis listed in this element is assumed to be the principal diagnosis.
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2310A	**NM**	**REFERRING PROVIDER NAME**			**S**	**2**		
2310A	NM109	Referring Provider Identifier	AN	2-80	S			Use the National Provider Identifier (NPI) for the referring provider. A taxonomy code in the PRV segment is not required for referring providers.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2310B	**NM1**	**RENDERING PROVIDER NAME**			**S**	1		
2310B	NM109	Rendering Provider Identifier	AN		S	2-80		The rendering provider's National Provider Identifier (NPI) ***MUST*** be used when the rendering provider is different from the billing provider and is at the claim level. An entry in this field ***REQUIRES*** an associated taxonomy be entered in Loop 2310B; Element - PRV03. If at the line level, SEE Loop 2420A; Element NM109. If neither the line level (2420A) nor claim level (2310B) NPIs are entered, the system defaults to the billing/pay-to provider NPI (2010A NM109). **Important Notes:** -The taxonomy will match back to a specific provider type based on the provider type/ taxonomy table. -If SCDHHS does not have a legacy ID with that provider type on the provider roster, then a non-par entry ***must*** be provided with that provider type and NPI. -If the rendering provider does not match to a legacy ID/provider type, the rendering provider legacy ID fields will be left blank on the flat file. . This will cause the encounter to be rejected at the mainframe level with a 'SERVICE

								PROVIDER ID MISSING' edit.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2310B	**PRV**	**RENDERING PROVIDER SPECIALITY INFORMATION**			**S**			
2310B	PRV03	Provider Taxonomy Code	AN	1-50	R			Use the rendering provider's taxonomy code when an NPI is entered in Loop 2310B; Element NM109.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2310B	**REF**	**RENDERING PROVIDER SECONDARY IDENTIFICATION**			**S**			
2310B	REF01	Reference Identification Qualifier	ID	2-3	R		0B, 1G, G2, LU	Use value "G2" - Provider Commercial Number for atypical providers ONLY.
2310B	REF02	Rendering Provider Secondary Identifier	AN	1-50	R			Use the rendering provider's SC Medicaid provider number for atypical providers ONLY.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2320	**CAS**	**CLAIM LEVEL ADJUSTMENTS**		**1**	**S**	**5**		
2320	CAS01	Claim Adjustment Group Code	AN	1-2	R		PR	Claim adjustment data can be reported at the claim level. 2430 data will be used if sent.

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2330A	**NM1**	**OTHER SUBSCRIBER NAME**		**1**	**R**	**1**		
2330A	NM108	Identification Code Qualifier	ID	1-2	R		II, MI	Use Value "MI" = Member Identification Number The subscriber's identification number as assigned by the payer.
2330A	NM109	Other Insured Identifier	AN	2-80	R			Other Insured Identifier

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2330B	**NM1**	**OTHER PAYER NAME**		**1**	**R**	**1**		**Submitters are required to send all known information on other payers in this Loop ID-2330.**
2330B	NM108	Identification Code Qualifier	ID	1-2	R		PI, XV	Use value - " PI" = Payer Identification
2330B	NM109	Other Payer Primary Identifier	AN	2-80	R			This number must be identical to SVD01 (Loop ID-2430) for COB. Use the carrier codes assigned by SC Medicaid to identify other insurance carriers.
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2400	**LX**	**SERVICE LINE NUMBER**		**1**	**R**	**8**		**MCO Professional Encounter 2400 Loop limited to max 8**
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2400	**SV1**	**PROFESSIONAL SERVICE**		**1**	**R**			
2400	SV101	Composite Medical Procedure Identifier			R			
2400	SV101-1	Product or Service ID Qualifier	ID	2-2	R		ER, HC, IV, WK	Value "HC" = Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2400	**SV5**	**DURABLE MEDICAL EQUIPMENT SERVICE**	**1**	**S**				
2400	SV501-1	Procedure Identifier	ID	2-2	R		HC	Use Value 'HC' - Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes

Loop	Element Identifier	Description	ID	Min/Max	Usage	Loop Repeat	Values	Requirement Description
2420A	**NM1**	**RENDERING PROVIDER NAME**		**1**	**S**	**5**		
2420A	NM1	Rendering Provider Identifier	AN	2-80	S			The rendering provider's National Provider Identifier (NPI) ***MUST*** be used when the rendering provider is different from the billing provider and is at the line level. An entry in this field ***REQUIRES*** an associated taxonomy be entered in Loop 2420A; Element - PRV03. If at the claim level, SEE Loop 2310B; Element NM109. If neither the line level (2420A) nor claim level (2310B) NPIs are entered, the system defaults to the billing/pay-to provider NPI (2010A NM109). **Important Notes:** -The taxonomy will match back to a specific provider type based on the provider type/ taxonomy table. -If SCDHHS does not have a legacy ID with that provider type on the provider roster, then a non-par entry ***must*** be provided with that provider type and NPI. -If the rendering provider does not match to a legacy ID/provider type, the rendering provider legacy ID fields will be left blank on the flat file. This will cause the encounter to be rejected at the mainframe level with

								a 'SERVICE PROVIDER ID MISSING' edit.
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2420A	**PRV**	**RENDERING PROVIDER SPECIALTY INFORMATION**			**S**			
2420A	PRV03	Provider Taxonomy Code	AN	1-50	R			Use the rendering provider's taxonomy code when an NPI is entered in Loop 2420A; Element NM109.
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2420A	**REF**	**RENDERING PROVIDER SECONDARY IDENTIFICATION**	**20**	**S**				
2420A	REF01	Reference Identification Qualifier	ID	2-3	R		OB, 1G, G2, LU	Use value "G2" - Provider Commercial Number
2420A	REF02	Rendering Provider Secondary Identifier	AN	1-50	R			Use the rendering provider's SC Medicaid provider number for atypical providers ONLY.
Loop	**Element Identifier**	**Description**	**ID**	**Min/Max**	**Usage**	**Loop Repeat**	**Values**	**Requirement Description**
2430	**CAS**	**LINE ADJUSTMENTS**		**1**	**S**	**5**		
2430	CAS01	Claim Adjustment Group Code	AN	1-2	R		PR	Claim adjustment data can be reported in this loop.

Appendix

1. Frequently Asked Questions

To be updated as questions come in.

2. Change Summary

Version	Issue Date	Modified By	Comments / Reason
.1	05/02/2011	William Douglas	Original document 05/03 /2011
.2	06/13/2011	William Douglas	ISA14 update
.3	06/30/2011	William Douglas	Comments from Review and updates to ISA 16 should be a : and ISA11 should be ^
.4	01/01/2013	Tracie O'Donnell	Updated with Operating Rules Template
.5	07/03/2013	Peg Grilliot	Formatted documented – Sent out for internal review
.6	07/11/2013	Peg Grilliot	Updated documented with review comments
.7	07/11/2103	Peg Grilliot	Version update uploaded to SharePoint
1.0	09/16/2013	Peg Grilliot	Version update adding "LX" segment
1.1	12/17/2013	Peg Grilliot	Version update changing the comment description of element ISA06 and GS02 to be "Use your six (6) digit SC Medicaid assigned MCO ID. (This MCO ID will begin with the letters, "HM").
1.2	12/18/2013	Peg Grilliot	Retracted changes made on 12/17/13 to ISA06 and GS02 element comments per email from Jeff Helliges.
1.3	12/12/2014	Peg Grilliot	Added clarifying descriptions regarding the use of the NM1 segment and its association to the PRV segment to the comment sections of segments 2310A NM109, 2310B NAM109, 2420A NM109, and 2010AA NM109 per request from Jeff Helliges.
1.4	01/20/2015	Peg Grilliot	Added instructions for processing a voided 837P encounter claim (*See Section CLM01)*. Instructions provided per 1/29/15 email request from Jeff Helliges.
1.5	2/4/2015	Peg Grilliot	Corrected updates from 2/3/15. Revised the documentation to instruct the user to insert the letter 'v' in the new Patient Control Number (new encounter ID) entered in Loop 2300; Data Element-CLM01. The 'v' should either precede or succeed the new Patient Control Number; it should NOT be added to the original encounter ID entered in Loop 2300; Data Element – REF02.
1.6	02/19/2015	Hank Goff	In Table 3. 837I 005010X223A2 Healthcare Claim Institutional Table: Added a comment, in the request description field, that instructs the user to enter a value of '1' in Loop 2300; Data Element – CLM05-3 when submitting a new claim.