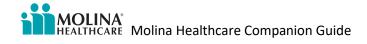# Molina Healthcare
HIPAA Transaction Standard Companion Guide

**Refers to the Implementation Guides
Based on ASC X12 version 005010**

Molina

Healthcare, Inc.

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March 30, 2021 005010 Version 1.23

Preface

This Companion Guide to the v5010 ASC X12N Implementation Guides and associated errata adopted under HIPAA clarifies and specifies the data content when exchanging electronically with Molina Health Care. Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.
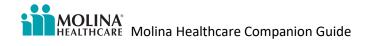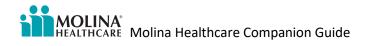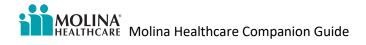
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1   INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance organizations in the United States comply with the electronic data interchange standards for health care as established by the Department of Health and Human Services. The ASC X12N implementation guides have been established as the standards for compliance. The ASC X12 TR3s that detail the full requirements for these transactions are available at **www.wpc-edi.com** .

The following information is intended to serve solely as companion documents to the ASC X12 transactions. The use of this document is only for the purpose of clarification allowed within the HIPAA transaction sets.

Electronic submitters should use the Implementation Guide and Molina Healthcare Companion Guide for format and code set information when submitting or receiving files directly with Molina Healthcare. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina HealthCare Web site at under EDI>Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate State from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the State Health Plan specific companion guides, which are also available on our Molina Healthcare website for your convenience (remember to choose the appropriate state from the drop-down list).

1.1   Benefits of using EDI

Electronic Data Interchange is the electronic interchange of business information using a standardized format; a process which allows one company to send information to another company electronically rather than with paper. Business entities conducting business electronically are called Trading Partners. Molina supports our Providers & Trading Partners, and as such would like to highlight the many benefits of electronic claims submission that will have direct impact on your time. EDI will help:

•Efficient information delivery

•Reduce operational costs associated with paper claims (printing, correlating, and postage)

•Increase accuracy of data

•Ensure HIPAA compliance

2   GETTING STARTED

Vendors or entities enrolling with Molina Healthcare as an electronic Trading Partner or submitter should first contact the Molina Healthcare EDI Team for instructions on how to enroll with Molina Healthcare for sending or receiving Electronic Data Interchange (EDI). The EDI Team is responsible for assisting vendors with questions regarding Trading Partner Enrollment, Testing, and Connectivity Setup.

3 CONTACT INFORMATION

To reach the EDI Customer Support Center, call 1-866-409- 2935; however, for a much faster response, please email the appropriate EDI team below:

ASCX12 837 I/P/D HEALTHCARE CLAIM/ENCOUNTER	Sent to Molina	EDI.Encounters@molinahealthcare.com (Encounters) EDI.Claims@molinahealthcare.com (Claims)
ASCX12 835 REMITTANCE	Sent by Molina	EDI.Eraeft@molinahealthcare.com
ASCX12 834 ENROLLMENT	Sent by Molina	EnrollmentProductionSupport@molinahealthcare.com
ASCX12 277CA HEALTH CARE CLAIM/ENCOUNTER ACKNOWLEDGMENT	Sent by Molina	EDI.Encounters@molinahealthcare.com (Encounters) EDI.Claims@molinahealthcare.com (Claims)
ASCX12 999 IMPLEMENTATION CLAIM/ENCOUNTER ACKNOWLEDGMENT	Sent by Molina	EDI.Encounters@molinahealthcare.com (Encounters) EDI.Claims@molinahealthcare.com (Claims)

If you have a concern or complaint regarding Molina's HIPAA Transactions & Code Sets compliance or any other HIPAA issue, please contact our HIPAA Provider Hotline toll free at 1-866-MOLINA2 (1-866-665-4622) or email us at HIPAAMailbox@MolinaHealthcare.com .

3.1 Other Important Links/Website

- Molina Provider Web Portal

- Molina HIPAA Resource Center

- California Department of Health Services

- Florida Medicaid A Division of the Agency for Health Care Administration

- Illinois Department of Healthcare and Family Services

- Michigan Department of Community Health

- Missouri Health Net Division

- New Mexico Human Services Department

- Ohio Department of Job and Family Services

- Texas Medicaid Healthcare Partnership

- Utah Department of Health

- Washington State Department of Social and Health Services

- Wisconsin Department of Health Services

- South Carolina Department of Health and Human Services

- Puerto Rico Administración de Seguros de Salud (ASES)

4 CONNECTIVITY/TESTING

The easiest method to submit EDI claims to Molina Healthcare is through a Clearinghouse. You may submit the EDI claims through your own clearinghouse or use Molina's contracted clearinghouses by State. You may contact the clearinghouse directly if you have questions regarding connectivity setup or testing.

If you do not have a Clearinghouse, Molina offers additional electronic claims submissions options as shown by logging on to Molina's Provider Services Web Portal.

4.1 File Size and Specifications

Molina Healthcare requires that the file size and limitations be limited to the following specifications:

- **Maximum Volume per File:** *1000 claims per file.*

- **Character Set:** *Molina cannot accept a quote (") within the file either surrounding a word or phrase or single quote in the file.*

- **Acknowledgement:** *Molina Healthcare does not support the transmission of a TA1, regardless of the value submitted.*

- **Attachment:** *Molina Healthcare does not support attachments at this time.*

- **Functional Group Header and Trailer:** *Only "1" GS Functional Group Header and GE Functional Group Trailer can be accepted per file.*

- **ISA15 Usage Indicator:** *Use "T" indicator during testing. Use "P" during production*

4.2 Types of Transactions Supported

This is a list of the transaction types that can be sent or received at Molina Healthcare.

X112 Assigned ID	Trans Set ID	Version		Guide Name
220A1	ASCX12 834 Enrollment	005010	P	Errata for Benefit Enrollment and Maintenance
221A1	ASCX12 835 Remittance	005010	P	Errata for Health Care Claim Payment/Advice
222A1	ASCX12 837Health Care Claim/EncounterPROFESSIONAL	005010	P	Errata for Health Care Claim: Professional
223A2	ASCX12 837 Health Care Claim/Encounter INSTITUTIONAL	005010	P	Second Type 1 Errata for Health Care Claim: Institutional
224A2	ASCX12 837 Health Care Claim/Encounter DENTAL	005010	P	Second Type 1 Errata for Health Care Claim: Dental
214	ASCX12 277 Health Care Claim ACKNOWLEDGMENT	005010	P	Health Care Claim Acknowledgement
231A1	ASCX12 999 Implementation ACKNOWLEDGMENT	005010	P	Errata for Implementation Acknowledgment For Health Care Insurance

5 CONTROL SEGMENTS/ENVELOPES

Healthcare Claims & Encounters - ASCX12 837 Professional, Institutional, Dental

5.1 ISA-GS and BHT segment

Loop	Segment	Data Element	Comments
	ISA – Interchange Control Header	ISA01 -- Authorization Information Qualifier	"00"
		ISA02 – Authorization Information	Space Fill
		ISA03 – Security Information Qualifier	"00"
		ISA04 – Security Information	Space Fill
		ISA05 – Interchange ID Qualifier	"ZZ"
		ISA06 – Interchange Sender ID	The Sender ID is assigned by Molina for direct submitters. Please contact Molina if you have not obtained your Submitter Trading Partner ID. All others -- contact your Clearinghouse for this information.
		ISA07 – Interchange ID Qualifier	"ZZ"
		ISA08 – Interchange Receiver ID	See **Molina Receiver ID's**
		ISA11 -- Interchange Control Standards Identifier Repetition Separator	Use '^'
		ISA12 -- Interchange Control Version Number	"00501"
		ISA13 – Interchange Control Number	This Number must be unique and 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.

Loop	Segment	Data Element	Comments
		ISA14 – Acknowledgment Requested	Recommended value -- "0" Molina does not support the transmission of TA1 regardless of the value submitted.
	GS -- Functional Group Header	GS02 -- Application Sender's Code	The Sender ID is assigned by Molina for direct submitters. Please contact Molina if you have not obtained your Submitter Trading Partner ID. All others -- contact your Clearinghouse for this information.
		GS03 -- Application Receiver's Code	See **Molina Receiver ID's**
	BHT – (Header) Beginning of Hierarchical Transaction	BHT06 – Transaction Type Code	The following values are processed by Molina: Use "**RP**" – for **Encounters**. Use "**CH**" -- for **FFS claims**

5.2 Sender/Receiver Information

Loop	Segment	Data Element	Comments
1000A	NM1 – Submitter Name	NM109 – Submitter Identifier	**Trading Partner ID assigned by Molina**
1000B	NM1 – Receiver Name	NM103 – Receiver Name	See **Molina Receiver ID's** —Molina Organization Name
1000B	NM1 – Receiver Name	NM109 – Receiver Primary Identifier	See section **Molina Receiver ID's**

5.3 Molina Receiver ID's by State

This is a list of receiver ID's (by State) that should be entered within the electronic transaction. This information is populated in the ISA-08 (Interchange Receiver) and GS03 (Application Receiver) fields of the 837 and 834 transactions.

Molina Organization Name	Molina as Receiver Interchange Receiver (ISA08) Application Receiver (GS03)	
	837	834
Molina Healthcare of California	MHC330342719	MHCA330342719
Molina Healthcare of Florida	MHFL261055137	260155137
Molina Healthcare of Idaho	MHID330617992	330617992
Molina Healthcare of Illinois	MHIL281823188	MHIL281823188
Molina Healthcare of Michigan	MHM383341599	MHMI383341599
Molina Healthcare of New Mexico	MHNM850408506	MHNM850408506
Molina Healthcare of New York	MHNY271603200	MHNY271603200
Molina Healthcare of Ohio	MHO200750134	MHOH200750134
Molina Healthcare of Puerto Rico	MHPR660817946	MHPR660817946
Molina Healthcare of South Carolina	MHSC462992125	MHSC462992125
Molina Healthcare of Texas	MTX201494502	MHTX201494502
Molina Healthcare of Utah	HT001363-001	MHUT33061799
Molina Healthcare of Washington	MHW91128479	MHWA911284790
Molina Healthcare of Wisconsin	MHWI200813104	MHWI200813104
Molina Medicare	MAPD134204626	

5.4 **Molina Sender ID's by State**

This is the sender ID or Submitter ID (by state) that is populated in the ISA-06 (Interchange Sender) and GS-02 (Application Sender) of the 999 and 835 transactions only**.**

Note: This is not the sender ID that the enrolled trading partner should use when sending 837/834 transactions.

Molina Organization Name	Molina as Sender Interchange Sender (ISA06) Application Sender (GS02)	
	999 277CA	835
Molina Healthcare of California	MHC330342719	ISA06 - ALEGEUS GS02 - MHC330342719 If using clearinghouse. Please contact your clearinghouse for this value
Molina Healthcare of Florida	MHFL261055137	ISA06 - ALEGEUS GS02 - MHF260155137 If using clearinghouse. Please contact your clearinghouse for this value
Molina Healthcare of Illinois	MHIL281823188	ISA06 – ALEGEUS GS02 - MHIL271823188 If using clearinghouse. Please contact your clearinghouse for this value
Molina Healthcare of Michigan	MHM383341599	ISA06 – ALEGEUS GS02 - MHM383341599 If using clearinghouse. Please contact your clearinghouse for this value
Molina Healthcare of Missouri	MHMO431743902	

Molina Organization Name	Molina as Sender Interchange Sender (ISA06) Application Sender (GS02)	
	999 277CA	835
Molina Healthcare of New York	NYSOH-ENC	ISA06 – ALEGEUS GS02 - MHNY271603200 If using clearinghouse. Please contact your clearinghouse for this value
Molina Healthcare of Nevada	MHNV203567602	ISA06 – ALEGEUS GS02 – HT001363-001 If using clearinghouse. Please contact your clearinghouse for this value
Molina Healthcare of New Mexico	MHNM850408506	ISA06 – ALEGEUS GS02 - MNM850408506 If using clearinghouse. Please contact your clearinghouse for this value
Molina Healthcare of Ohio	MHO200750134	ISA06 – ALEGEUS GS02 - MHO200750134 If using clearinghouse. Please contact your clearinghouse for this value
Molina Healthcare of Puerto Rico	MHPR660817946	ISA06 – ALEGEUS GS02 - MHPR660817946 If using clearinghouse. Please contact your clearinghouse for this value

Molina Organization Name	Molina as Sender Interchange Sender (ISA06) Application Sender (GS02)	
	999 277CA	835
Molina Healthcare of South Carolina	MHSC462992125	ISA06 - ALEGEUS GS02 - MHSC462992125 If using clearinghouse. Please contact your clearinghouse for this value
Molina Healthcare of Texas	MTX201494502	ISA06 – ALEGEUS GS02 - MHT201494502 If using clearinghouse. Please contact your clearinghouse for this value
Molina Healthcare of Utah	HT001363-001	ISA06 - HT001363-001 for files delivered through UHIN. All others ISA06 is ALEGEUS GS02 - HT001363-001 If using clearinghouse. Please contact your clearinghouse for this value
Molina Healthcare of Washington	MHW91128479	ISA06 – ALEGEUS GS02 - MHW91128479 If using clearinghouse. Please contact your clearinghouse for this value

Molina Organization Name	Molina as Sender Interchange Sender (ISA06) Application Sender (GS02)	
	999 277CA	835
Molina Healthcare of Wisconsin	MHWI200813104	ISA06 – ALEGEUS GS02 - MHWI200813104 If using clearinghouse. Please contact your clearinghouse for this value
Molina Medicare	MAPD134204626	ISA06 - ALEGEUS GS02 - MPD134204626 If using clearinghouse. Please contact your clearinghouse for this value

6 ASCX12 837 TRANSACTIONS- FEE FOR SERVICE CLAIMS ONLY

6.1 Spinal Manipulation – Florida Only – FFS CLAIMS

ASCX12 837 PROFESSIONAL

Loop	Segment	Data Element	Comments
2300	CR2 -- Spinal Manipulation Service Information	CR208 -- Patient Condition Code	Used for adjudication

7 ASCX12 837 TRANSACTIONS - ENCOUNTERS ONLY

7.1 Claim Header Loop – Encounters Only.

7.1.1 All States.

ASCX12-837-PROFESSIONAL And DENTAL

Loop ID	Segment	Data Element	Comments
2300	DTP01 - DATE - REPRICER RECEIVED DATE	DTP01 -- Repricer Received Date Qualifier.	Use D8: Send the date when provider submitted claim to vendor. Example: DTP*050*D8*CCYYMMDD.
2300	DTP03 - DATE - REPRICER RECEIVED DATE	DTP02 -- Repricer Date Time Period Format Qualifier .	Use 050: Send the date when provider submitted claim to vendor. Example: DTP*050*D8*CCYYMMDD.

7.1.2 New York State only.

ASCX12-837-DENTAL

Loop ID	Segment	Data Element	Comments
2300	REF*F8 - PAYER CLAIM CONTROL NUMBER	REF*F8 - PAYER CLAIM CONTROL NUMBER	This element does not exist in the PACDR 837D format. The NY Healthplan Molina must report the REF*F8 at 2330B.
2330B	REF*F8 - OTHER PAYER CLAIM CONTROL NUMBER	REF*F8 - OTHER PAYER CLAIM CONTROL NUMBER	Used in place of REF*F8 for the PACDR 837D format.

7.1.3 Texas State only.

Out of Network Exception to TX MPF Validation

ASCX12-837-PROFESSIONAL and DENTAL

Loop ID	Segment	Data Element	Comments
2300	HCP	15	HCP15 Exception Code: • Required only when rendering and billing provider are non-contracted • Accepted values to bypass state edit: 3 – Services or Specialist not in Network 4 – Out-of Service Area (contracted provider, not enrolled in member area)

7.2   Billing Provider Loop – Encounters Only

ASCX12 837 INSTITUTIONAL, PROFESSIONAL, DENTAL

Loop ID	Segment	Data Element	Comments
2010AA	REF – Billing Provider Tax Identification	REF01 – Billing Provider Tax Identification Number	Usage of "EI" is required
		REF02 – Reference Identification	Provider's Tax Id is required
2010AA	N3 – Billing Provider Address	N301/N302 - Billing Provider Address Line	Street address must be used. Post Office Box or Lock Box addresses are to be sent in the Pay-To Address Loop (Loop 2010AB) if necessary.

7.3   Attending Provider Loop – Encounters Only

ASCX12 837 INSTITUTIONAL ONLY

Loop	Segment	Data Element	Comments
2310A	NM1 – Attending Provider Name	NM101 – Entity Identifier Code	Required for non-ambulance encounters. Use "71"
		NM102 – Entity Type Qualifier	Required for non-ambulance encounters. Use "1"
		NM103 – Attending Provider Last Name	Required for non-ambulance encounters.
		NM104 – Attending Provider First Name	Required for non-ambulance encounters.
		NM109 – Attending Provider Primary Identifier	Required for non-ambulance encounters. Use Attending Provider NPI
2400	DTP – Service Date	DTP03 – Service Date	Use date on or after 1/1/2014
	SV2 – Institutional Service Line	SV201 – Service Line Revenue Code	Use any non- Ambulance Revenue Codes (any code except 540-549)

7.4   COB Information

As per 5010 standards , the COB information must be provided in the 837 file with multiple iterations of 2320/2430 loops. Each iteration must correspond to one payer. Molina must be the first sequence iteration in both header and line. This section excludes bundling / unbundling scenarios and DRG (Diagnostic Related Group) pricing.

Any submitters that are currently submitting COB information will continue to submit encounters as they are presently. Any changes to a submitters current process or a submitter who has not provided COB information to-date, a testing and approval process must be performed and validated by Molina.

Below is an example of how COB information will be processed in the Molina system.

Loop ID	Reference	Name
2320	SBR	Other Subscriber Identification
2320	SBR09	Claim Filling Indicator Code
2320	CAS	Claim Level Adjustment
2320	AMT	COB Payer Paid Amount
2320	AMT	COB Total Non-Covered Amount
2320	AMT	Remaining Patient Liability
2320	MIA	Inpatient Adjudication Information

Loop ID	Reference	Name
2320	MOA	Outpatient Adjudication Information
2330B	NM1	Other Payer Name
2330B	NM109	Other Payer Identifier
2330B	DTP	Claim Check or Remittance Date
2430	SVD01	Other Payer Primary Identifier
2430	SVD02	Service Line Paid Amt
2430	CAS	Line Adjustment

Refer to the 5010 example at the end of this section for more information. (Check Denied section to maintain consistency)

Molina's process will perform the following for on-boarded submitters using this COB structure:

- Molina must be the first sequence iteration in both header and line. The receiver ID for Molina (refer to the Receiver ID) *hyperlink* must be in the 2330B NM109 Element and 2430 SVD01.

  For those submitters who have not been on-boarded, the first iteration for the COB information will be used as Molina. Those submitters that have been on-boarded will be validated against the first bullet-point.

- Compare all the values in 2330B NM109 within an encounter. If any value is repeated then the encounter has to be rejected with error "Duplicate COB Payer Identification reported at the header".

- Ensure that the payer ID's are consistent from header to line. I.e. if payer ID submited is 123 for Molina at the header level, then that same ID must be used at the line level for Molina, and if payer ID submited is ABC (secondary payer) at the header level, then that same ID (ABC) must be used at the line level. I.e. information should be consistent across iterations/sequences.

- Compare all the values received in 2430 SVD01 (Payer Identification) to the values received in 2330B NM109 (Payer Identification). If any of the 2430 SVD01 values does not match with one the 2330B NM109 values then the encounter will be rejected with error "Service Level COB cannot be reported without a Header COB".

  The vice versa is allowed. The inbound encounter process should <u>not</u> reject an encounter if any of the 2330B NM109 (Payer Identification) values does not have a corresponding match in 2430 SVD01 (Payer Identification).

For Example: If the Other Payer paid using the DRG payment method, then the vendor will only send us the header level COB (or) if the Other Payer did not pay, then the vendor might send the Other Payer only at the header level without payment information.

Compare all the values received in 2430 SVD01 (Payer Identification) to the values received in 2330B NM109 (Payer Identification) and check if the AMT*D (Header Payment) segment is reported in the corresponding 2320 loop. If AMT*D segment is not found, then the encounter has to be rejected with error "Service Level COB cannot be reported without a payment at the Header COB".

Again the vice versa is allowed. The vendor can report payment at the Header COB alone (i.e., AMT*D) and not report the Service Level COB. The inbound process should <u>not</u> reject the encounter in this case.

For Example: If the Other Payer paid using the DRG payment method, then the vendor will only send us the header level COB.

Molina COB Balancing Rules:

Using the following example:

Example:

	Total Billed Amt	Total Other Payer Paid Amt	Total Other Payer Adjusted Amt
Claim Header	$100	$75	$5

	Service Billed Amt	Other Payer Service Paid Amt	Other Payer Service Adjusted Amt
Service Line 01	$50	$40	$10
Service Line 02	$30	$26	$4
Service Line 03	$20	$14	$6

Balancing Rule 1:

Total Billed Amt = Sum of all Service Billed Amts

i.e., $100 = ($50 + $30 + $20)

Balancing Rule 2:

Total Other Payer Paid Amt = Sum of all Other Payer Service Paid Amt – Total Other Payer Adjusted Amt

i.e., $75 = ($40 + $26 + $14) - $5

Balancing Rule 3:

Other Payer Service Paid Amt + Other Payer Service Adjustment Amt = Service Billed Amt Amt

i.e., $40 + $10 = $50

and $26 + $4 = $30

and $14 + $6 = $20

Balancing Rule 4:

Total Billed Amt = Total Other Payer Paid Amt – Total Other Payer Adjusted Amt

WHERE

Total Billed Amt" is reported in CLM02 in both 837P and 837D.

Total Other Payer Paid Amt" is reported in AMT*D (2320) in both 837P and 837D.

Total Other Payer Adjusted Amt" is reported in CAS (2320) in both 837P and 837D.

Service Billed Amt" is reported in SV102 in 837P and SV302 in 837D.

Other Payer Service Paid Amt" is reported in SVD02 (2430) in both 837P and 837D.

Other Payer Service Adjusted Amt" is reported in CAS (2430) in both 837P and 837D.

Below is an example of claim/lines that pass balancing rules:

Header	Header Billed Amt	Molina Paid Amt	Molina Adjusted Amt	Other Payer Paid Amt	Other Payer Adjusted Amt
Claim A	$100	$11	$0	$80	$0

Line	Service Billed Amt	Molina Paid Amt	Molina Adjusted Amt	Other Payer Paid Amt	Other Payer Adjusted Amt
Service Line: 01	$50	$7	$43	$40	$10
Service Line: 02	$30	$3	$27	$26	$4
Service Line: 03	$20	$1	$19	$14	$6

5010 Example:

CLM*17173969608*100***13:A:1**A*Y*Y~

DTP*434*RD8*20170225-20170225~

CL1*2*1*01~

REF*EA*3040748;6519052;10199238;65790~

HI*ABK:S0121XA~

HI*APR:S0121XA~

HI*ABN:W208XXA~

HI*BH:05:D8:20170225~

HI*BE:80:::1*BE:45:::21~

NM1*71*1*PROVIDER1*PROVIDER2****XX*111111111~

PRV*AT*PXC*207P00000X~

NM1*82*1*PRVIDER2*PROVIDER3****XX*222222222~

SBR*S*18*******HM~-------**First Iteration of 2320 loop**

AMT*D*11~-------------------**Vendor Paid amount (first occurrence is always vendor (Molina) paid amount)**

OI***Y***Y~

NM1*IL*1*MEMBER1*MEMBER2*M***MI*4444444444~

N3*ADDRESS123~

N4*CITY*WI*53118~

NM1*PR*2*MOLINA HEALTH CARE OF WISCONSIN*****PI*69004600~

N3*123 ADDRESS1*ADDRESS2~

N4*CITY2*WI*53227~

SBR*P*18*******11~--------**Second Iteration of 2320 loop**

AMT*D*80~ ---------------**Second occurrence onwards other payer information**

OI***Y***Y~

```
NM1*IL*1*MEMBER1*MEMBER2*M***MI*99~
N3*123 ADDRESS4~
N4*CITY3*WI*53118~
NM1*PR*2*BLUE CROSS BLUE SHIELD OF ILLINOIS*****
PI*001~N3*NO ADDRESS FOUND~
N4*NO CITY*WI*53227~
LX*1~
SV2*0456*HC:99212*188*UN*1~
DTP*472*D8*20170225~
REF*6R*17173969608001~
SVD*69004600*7*HC:99212*0456*1~----First Iteration of 2430 loop
CAS*CO*45*43~
DTP*573*D8*20170717~
SVD*001*40*HC:99212*0456*1~ ----------Second Iteration of 2430 loop
CAS*CO*10*137.89~
DTP*573*D8*20170717~
LX*2~
SV2*0637**12.11*UN*1**12.11~
DTP*472*D8*20170225~
```

7.5 Header Level Paid Amounts & Other Insurance – Encounters Only

See Molina Paid Amounts Encounter Examples

ASCX12 837 INSTITUTIONAL, PROFESSIONAL, DENTAL

Loop	Segment	Data Element	Comments
2320	SBR – Other Subscriber Information	SBR01 -- Payer Responsibility Sequence Number Code	Use "S" if 2000B SBR01 is "P" Use "P" if 2000B SBR01 is "S"
		SBR02 -- Individual Relationship Code	Use same value as 2000B SBR02
	AMT – Coordination Of Benefits COB Payer Paid Amount	AMT01 – Amount Qualifier Code	Use "D"
		AMT02 – Payer Paid Amount	Submit the Amount Paid for the Claim
	OI – Other Insurance Coverage Information	OI03 -- Yes/No Condition or Response Code	Use "W"
		OI06 -- Release of Information Code	Use "I"
2330A	NM1 – Other Subscriber Name		Enter the Other Subscriber's Name and Subscriber ID

Loop	Segment	Data Element	Comments
	N4 – Other Subscriber City, State, Zip Code		Enter Other Subscribers City, State, and Zip Code
2330B	NM1 – Other Payer Name		Enter the Other Payer Name (This is not the destination Payer in Loop 2010BB.)
	N4 – Other Payer City, State, Zip Code		Enter the Other Payer's City, State, Zip Code (This is not the destination payer address in Loop 2010BB).
	DTP -- Claim Check or Remittance Date	DTP01 – Date Time Qualifier	Use "573"
		DTP02 – Date Time Period Format Qualifier	Use "D8"
		DTP03 Claim Check or Remittance Date	Submit the Claim Check or Remittance date in CCYYMMDD format

7.6   Line Level Paid Amounts & Other Insurance - Encounters

See Molina Paid Amounts Examples

ASCX12 837 INSTITUTIONAL, PROFESSIONAL, DENTAL

Loop	Segment	Data Element	Comments
2430	SVD – Line Adjudication Information	SVD02 -- Service Line Paid Amount	Submit the Paid Amount for the service line of the Claim. Zero "0" is an acceptable value for this element.
2430	DTP – Line Check Or Remittance Date	DTP01 --Date Time Qualifier	Use "573"
2430	DTP -- Line Check Or Remittance Date	DTP02 – Date Time Period Format Qualifier	Use "D8"
2430	DTP -- Line Check Or Remittance Date	DTP03 – Line Check Or Remittance Date	Submit the Line Check Or Remittance Date in CCYYMMDD format. This element should be submitted when the adjudication date is available at the line level.

7.7   Atypical Providers - Encounters

7.7.1   Atypical Billing Provider Loop - Encounters

ASCX12 837 INSTITUTIONAL, PROFESSIONAL, DENTAL

CALIFORNIA, FLORIDA, ILLINOIS, MICHIGAN, NEW MEXICO, OHIO, SOUTH CAROLINA, TEXAS, UTAH, & MEDICARE ONLY

Loop	Segment	Data Element	Comments
2010AA	NM1 – Billing Provider Name	NM108-NM109 – Billing Provider ID Qualifier and Billing Provider Identifier	Do not send these elements for Atypical Billing Provider
2010BB	REF – Billing Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use "G2"
	REF -- Billing Provider Secondary Identification	REF02 – Billing Provider Secondary Identifier	Submit Atypical Billing Provider Commercial Number

WASHINGTON ONLY

Loop	Segment	Data Element	Comments
2010BB	REF -- Billing Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use "G2"
	REF – Billing Provider Secondary Identification	REF02 – Billing Provider Secondary Identifier	Use "5108005500"

WISCONSIN ONLY

Loop	Segment	Data Element	Comments
2010AA	NM1 – Billing Provider Name	NM109 – Billing Provider Identifier	Do not send element for Atypical Billing Provider
2400	SV1 – Professional Service	SV101 - 2 – Procedure Code	See **Wisconsin Exclusion Code list**

7.7.2 Atypical Rendering Provider Loop - Encounters

ASCX12 837 INSTITUTIONAL, PROFESSIONAL, DENTAL

CALIFORNIA, FLORIDA, ILLINOIS, MICHIGAN, NEW MEXICO, OHIO, SOUTH CAROLINA, TEXAS, UTAH, & MEDICARE ONLY

Loop	Segment	Data Element	Comments
2310B	NM1 – Rendering Provider Name	NM108-NM109 – Rendering Provider ID Qualifier and Rendering Provider Identifier	Do not send these elements for Atypical Rendering Provider
	REF – Rendering Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use "G2"
	REF – Rendering Provider Secondary Identification	REF02 – Rendering Provider Secondary Identifier	Submit Atypical Rendering Provider Commercial Number

WISCONSIN ONLY

Loop	Segment	Data Element	Comments
2310B	NM1 – Rendering Provider Name	NM109 – Rendering Provider Identifier	Do not send element for Atypical Rendering Provider
2400	SV1 – Professional Service	SV101 - 2 – Procedure Code	See Wisconsin Exclusion Code list

7.7.3 Atypical Operating Provider Loop - Encounters

ASCX12 INSTITUTIONAL

WISCONSIN ONLY

Loop	Segment	Data Element	Comments
2310B	NM1 – Other Payer Service Facility	NM109 – Operating Physician Identifier	Do not send element for Atypical Rendering Provider
2400	SV1 – Professional Service	SV101 - 2 – Procedure Code	See Wisconsin Exclusion Code list

7.7.4 **Atypical Attending Provider Loop - Encounters**

ASCX12 837 INSTITUTIONAL

ALL STATES INCLUDING MEDICARE

Loop	Segment	Data Element	Comments
2310A	NM1 – Attending Provider Name	NM108-NM109 – Attending Provider ID Qualifier and Attending Provider Identifier	Do not send these elements for Atypical Attending Provider
	REF – Attending Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use "G2"
	REF – Attending Provider Secondary Identification	REF02 – Attending Provider Secondary Identifier	Submit Atypical Attending Provider Commercial Number

7.8 Transportation Providers – Encounters

7.8.1 ASCX12 837 Professional – All States

Loop	Segment	Data Element	Comments
2300	CLM – Claim Information	CLM05 - 01 – Place Of Service Code	Use "41","42" or "99".
2300	CR1 – Ambulance Transport Information	CR105- Transportation Qualifier	Enter 'DH' qualifier for Miles
2300	CR1 – Ambulance Transport Information	CR106 – Transport Distance	Entity transport distance in miles.
	NM1-Ambulance Pickup Location	NM101-Entity Identifier Code	Enter 'PW' qualifier for Pickup Location Address. This will indicate that the information entered in this loop pertains to the Pickup Address of where the patient was picked up from. Note: 2310E is the Header Level and 2420G is the Line Level (Situational and should be used only if the information is different than the information entered at the Header level).
2310E or 2420G	N3-Ambulance Pickup Location Address	N301-02	Enter the Pickup Address of where the patient is being picked up from. Note: 2310E is the Header Level and 2420G is the Line Level which is Situational and should be used only if the information is different than the information entered at the Header level).
2310E or 2420G	N4-Ambulance Pickup Location City, State, Zip	N401-03	Enter the City (up to 30 characters), State Code (2 digits), and Zip Code (5 or 9 numeric) Note: 2310E is the Header Level and 2420G is the Line Level which is Situational and should be used only if the information is different than the information entered at the Header level).

Loop	Segment	Data Element	Comments
2310F or 2420H	NM1-Ambulance Drop Off Location	NM101-Entity Identifier Code	Enter '45' qualifier for Drop Off Location Address. This will indicate that the information entered in this loop pertains to the Drop Off Location Address of where the Patient was taken to. Note: 2310F is the Header Level and 2420H is the Line Level which is Situational and should be used only if the information is different than the information entered at the Header level).
2310F or 2420H	N3-Ambulance Drop Off Location Address	N301-02	Enter the Drop-off Address of where the patient is being dropped-off from. Note: 2310F is the Header Level and 2420H is the Line Level which is Situational and should be used only if the information is different than the information entered at the Header level).
2310F or 2420H	N4-Ambulance Drop off Location City, State, Zip	N401-03	Enter the City name (up to 30 characters), Valid US State Code (2 digits), and Zip Code (5 or 9 numeric). Note: 2310F is the Header Level and 2420H is the Line Level which is Situational and should be used only if the information is different than the information entered at the Header level).
2400	SV1 -- Professional Service	SV101 - 02 –Procedure Code	Use a valid HCPCS procedure code for the service provided.
2400	SV1-Professional Service	SV105 – Place of Service Code	Use "41", "42" or "99" (if the Place of Service Code at the line level is different than the Place of Service Code at claim header level in Loop 2300 CLM05-1); otherwise, leave blank. *SITUATIONAL FIELD* *This field should only be used when the value is different than the value carried in CLM05-1 in Loop ID-2300).*

Loop	Segment	Data Element	Comments
2400	SV1-Professional Service	SV101-03 through SV101-06 Procedure Code modifier	Transportation providers must include the Place of Origin Code and the Destination Code in this field. The one-digit modifiers are combined to form two-digit modifiers that identify the transportation providers' place of origin with the first digit and the destination with the second digit. **Valid Codes:** 　The valid values of these modifiers that can be combined to form a two digit place of origin and destination code are as follows: 　　"D"= Diagnostic/Treatment Site other than P or H when used an 　　　origin code. 　　"E" = Residential Facility. 　　"G" = Hospital Based ESRD Facility. 　　"H" = Hospital. 　　"I" = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport. 　　"J" = Freestanding ESRD facility. 　　"N" = Skilled Nursing Facility. 　　"P" = Physician's Office. 　　"R" = Residence. 　　"X" = Intermediate stop at Physician's Facility on the way to the Hospital. 　For IL only 　　"L" = Pharmacy Note: the following 2 digit procedure code modifier combinations are NOT acceptable by the state of IL HFS: 　II 　RR 　SS 　XX
2400	CR1 – Ambulance Transport Information	CR105- Transportation Qualifier	Enter 'DH' for Miles (enter only if different than information entered in Loop 2300 CR1 segment).

Loop	Segment	Data Element	Comments
	CR1 – Ambulance Transport Information *SITUATIONAL FIELD* *(This field should only be used if the data at the line level is different than the data entered at the header level- Loop 2300 CR1 segment).*	CR106 – Transport Distance	Entity transport distance in miles (enter only if different than information entered in Loop 2300 CR1 segment).

7.8.2 ASCX12 837 Professional – Illinois & OHIO Only

See IL & OH Transportation Encounter Example

Loop	Segment	Data Element	Comments
2000A	Billing Provider Specialty Information	PRV03 – Billing Provider Taxonomy Code	The Billing Provider Taxonomy code must be present and contain 10 alpha numeric digits in length. The following taxonomy codes are acceptable for IL Transportation encounters: • 343800000X- Secured Medical Transport (VAN) • 343900000X- Non-emergency Medical Transport (VAN) • 344600000X- Taxi • 347C00000X - Private Vehicle ' • 341600000X- Ambulance (Emergent & Non-Emergent Behavioral Health Services) The following taxonomy codes are acceptable for OH Transportation encounters (Situational): • 343900000X- Non-emergency Medical Transport (VAN) • 341600000X- Ambulance (Emergent & Non-Emergent Behavioral Health Services)
	NTE Claim Note	NTE01 – Note Reference Code	Use "ADD"

Loop	Segment	Data Element	Comments
	NTE Claim Note	NTE02 -- Claim Note Text	Semi-colon separated string of notes. Each note contains a list of comma separated fields. **Note separator:** ; (semi-colon) **Field separator:** ,(comma) **Transportation Fields:** • <u>Note Type</u> – Use "TR" • <u>State Id</u> -- 2 character state code. Must be a valid US state code. • <u>Vehicle License Number-</u> maximum 8 characters in length • <u>Origin Time</u> - Time expressed in a valid 24-hour clock time as follows: HHMM, where H = hours (00-23), M = minutes (00-59). The Origin Time cannot be equal to the Destination Time. • <u>Destination Time</u> - Time expressed in a valid 24-hour clock time as follows: HHMM, where H = hours (00-23), M = minutes (00-59). The Destination time cannot be equal to the Origin Time. **<u>Examples</u>:** State Id: IL Vehicle License Number: TEMP1 Origin Time: 1305 Destination Time: 1347 NTE*ADD*TR,IL,TEMP1,1305,1347; State Id: OH Vehicle License Number: TEMP1 Origin Time: 1305 Destination Time: 1347 NTE*ADD*TR,OH,TEMP1,1305,1347;

Loop	Segment	Data Element	Comments
2300	HI-Healthcare Diagnosis Code	HI01-1-Diagnosis Type Code [Note: HI01-01 is Required; however, the 5010 TR3 guide allows up to 12 diagnosis code types to be entered between HI01-1 thru HI12-1].	Enter 'ABK' to indicate whether the diagnosis code is an ICD-10 code, OR enter 'BK' to indicate whether the code is an ICD-9 code.
2300	HI-Healthcare Diagnosis Code	HI01-2 – Diagnosis Code [Note: H101-2 is required; however, the 5010 TR3 guide allows up to 12 diagnosis codes to be entered between HI01-2 thru HI12-2].	Enter a valid ICD-10 code (for dates of service on or after 10/1/2015), OR Enter a valid ICD-9 code (for dates of service on or before 9/30/2015). **Illinois ONLY:** If there is no valid diagnosis code submitted by the provider, then transportation providers should use the default IL transportation diagnosis codes: Use ICD-9 Code '799.9' for dates of service on or before 9/30/2015 Use ICD-10 code 'R69' for dates of service on or after 10/1/2015. **Ohio ONLY:** Valid diagnosis code must be submitted. No defaults are available.

Loop	Segment	Data Element	Comments
2400	SV1-Professional Service	SV101-03 through SV101-06 Procedure Code modifier	Transportation providers must include the Place of Origin Code and the Destination Code in this field. The one-digit modifiers are combined to form two-digit modifiers that identify the transportation providers' place of origin with the first digit and the destination with the second digit. **Ohio Valid Codes:** U4,U7,U5, DD,DE,DG,DH,DI,DJ,DN,DP,DR, ED,EG,EH,EI,EJ,EP,ER, GD,GE,GH,GI,GN,GP,GR, HD,HE,HG,HH,HI,HJ,HN,HP,HR,HS, ID,IE,IG,IH,II,IJ,IN,IP,IR,IS,JD, JE,JH,JI,JN,JP,JR, ND,NG,NH,NI,NJ,NN,NP,NR, PD,PE,PG,PH,PI,PJ,PN,PP,PR, RD,RE,RG,RH,RI,RJ,RN,RP, SH,SI UA, UB, U3 and U6 – These modifiers should be billed in combination with another modifier and billed alone.
2400	SV1-Professional Service	SV103- Units/Basis of Measurement	Transportation providers should use 'UN' (Units) to enter the number of trips. Molina will reject when SV1*UN field is greater than 1 and two sets of location modifiers was not submitted. In other words, for each unit there must be at least 1 set of modifiers entered in Sv101-03 through SV101-06.
	NTE – Line Note **SITUATIONAL FIELD** *(This field should only be used if the data at the line level is different than the data entered at the header level-Loop 2300 NTE segment).*	NTE01 – Note Reference Code	Use "ADD"

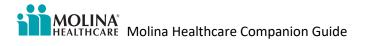| Loop	Segment	Data Element	Comments
	NTE – Line Note *SITUTATIONAL FIELD* *(This field should only be used if the data at the line level is different than the data entered at the header level- Loop 2300 NTE segment).*	NTE02 -- Line **Note** Text	Semi-colon separated string of notes. Each note contains a list of comma separated fields. **Note separator:** ; (semi-colon) **Field separator:** ,(comma) **Transportation Fields:** • Note Type – Use "TR" • State Id -- 2 character state code. Must be a valid US state code. • Vehicle License Number -maximum 8 characters in length • Origin Time - Time expressed in a valid 24-hour clock time as follows: HHMM, where H = hours (00-23), M = minutes (00-59). Origin Time cannot be equal to the Destination Time. • Destination Time - Time expressed in a valid 24-hour clock time as follows: HHMM, where H = hours (00-23), M = minutes (00-59). Destination Time cannot be equal to the Origin Time. **Examples:** State Id: IL Vehicle License Number: TEMP1 Origin Time: 1305 Destination Time: 1347 NTE*ADD*TR,IL,TEMP1,1305,1347; State Id: OH Vehicle License Number: TEMP1 Origin Time: 1305 Destination Time: 1347 NTE*ADD*TR,OH,TEMP1,1305,1347;

For more information on Ohio requirements and codes, to the **Appendix**:

7.8.3   ASCX12 837 Professional – Florida only

Loop	Segment	Data Element	Comments
2400	SV1 -- Professional Service	SV101 - 02 –Procedure Code	Enter procedure code '99998' for Public Transportation Claims.

7.9   Acute Care and Long Term Care (LTC) Providers – Encounters

ASCX12 837 PROFESSIONAL – TEXAS ONLY

Loop	Segment	Data Element	Comments
2300	NTE – Claim Note	NTE01 – Note Reference Code	Use "ADD"

Loop	Segment	Data Element	Comments
		NTE02 – Claim Note Text	Care Type Code Financial Arrangement Code To be submitted as semi-colon separated string of notes. Each note contains a list of comma separated fields. **Note separator:** ; (semi-colon)* **Field separatorou:** ,(comma) *Semi-colon cannot be used as file terminators or separators (Repetition, Component Element, Element)* **Care Type Code:** • <u>Note Type</u> – Use "CT" • <u>Care Type Code</u> – Use ○ "L" - Long Term Care (Transaction contains Long Term Care Services ○ "A" - Acute Care (Transaction does not contain Long Term Care Services **Financial Arrangement Code:** • <u>Note Type</u> – Use "FC" • <u>Financial Arrangement Code</u> – ○ Use "01" - Delegated Behavior Health Subcontract. ○ Use "02" - Delegated Vision Subcontract. ○ Use "03" – Delegated Disease Management Subcontract. ○ Use "05" - Delegated Long Term Care Service Contract. ○ Use "06" - Capitaed Providers. ○ Use "15" - Delegated Other Medical Expenses Subcontract. **Example:** Care Type Code: L Financial Arrangement Code: 02 NTE*ADD*CT,L;FC,02
2400	SV1 – Professional Service	SV104 – Service Unit Count	Required. Value must not be Zero "0"

Loop	Segment	Data Element	Comments
2430	SVD – Line Adjudication Information	SVD05 – Paid Service Unit Count	Required. Value must not be Zero "0"

ASCX12 837 DENTAL – TEXAS ONLY

Loop	Segment	Data Element	Comments
2300	NTE – Claim Note	NTE01 – Note Reference Code	Use "ADD"

Loop	Segment	Data Element	Comments
		NTE02 – Claim Note Text	Care Type Code Financial Arrangement Code To be submitted as semi-colon separated string of notes. Each note contains a list of comma separated fields. **Note separator:** ; (semi-colon)* **Field separator:** ,(comma) *Semi-colon cannot be used as file terminators or separators (Repetition, Component Element, Element)* **Care Type Code:** • <u>Note Type</u> – Use "CT" • <u>Care Type Code</u> – "L": Long Term Care or "A": Acute Care ○ Use "L" – Transaction contains Long Term Care Dental Code (see 2400 SV301-02 Procedure Code) ○ Use "A" - Transaction does not contain Long Term Care Dental Codes (see 2400 SV301-02 Procedure Code) **Financial Arrangement Code:** • <u>Note Type</u> – Use "FC" • <u>Financial Arrangement Code</u> – ○ Use "04" - Delegated Dental Services Subcontract ○ Use "05" - Delegated Long Term Care Service Contract **Example:** Care Type Code: L Financial Arrangement Code: 04 NTE*ADD*CT,L;FC,04

Loop	Segment	Data Element	Comments
2400	SV3 – Dental Service	SV301-02 – Procedure Code	For Long Term Care Dental Code Use: "D7240", "D9110", "D0230", "D0220", "D0140", "D9220", "D9215", "D7520", "D7250", "D7241", "D7230", "D7220", "D7210", "D9221", "D7510", "D9999", "D7140"
		SV306 – Procedure Count	Required. Value must not be Zero "0"
2430	SVD – Line Adjudication Information	SVD05 – Paid Service Unit Count	Required. Value must not be Zero "0"

7.10 Medicare Providers - Encounters

7.10.1 ASCX12 837 Institutional- Medicare Only - Encounters

Loop	Segment	Data Element	Comments
2300	DTP – DATE	DTP01 – Admission Date	Admission date entered (where DTP01=435) cannot be a future date.
2300	CL1-Claim Code	CL103- Patient Status Code	If patient status code entered is '20' (Expired), '40' (Expired at Home), '41' (Expired in a Medical Facility), or '42' (Expired in an Unknown Facility), then at least one Occurrence Code '55' (date of death) is also required in Loop 2300 HI01-2 through HI12-2.
2300	HI – Occurrence Information	HI01-2 thru HI12-2- Occurrence Code	When HI01-1 is BH, then the Occurrence Codes used must be in 01-39, 41- 49, 40, 50, 51, 55, or A0-L9. If the Bill Type is 81X and 82X, then the occurrence codes must be in 40, 50, and 51.
2300	HI- Occurrence Information	HI01-2 thru HI12-2- Occurrence Span Code	When HI01-01 is BI, then the Occurrence Span Codes used must be in 70, 71, 72, 74, 75, 76, and 77.
2310D	NM1- Rendering Provider Name	NM105 – Rendering Provider Middle Name	If the Rendering Provider Middle Name is entered, then it must begin with an alpha character.
2310F	NM1- Referring Provider Name	NM105– Referring Provider Middle Name	If the Referring Provider Middle name is entered, then it must begin with an alpha character.

Loop	Segment	Data Element	Comments
2400	SV2 – Institutional Service Line	SV202-2 – Procedure Code	When SV202-1=HC, then the Procedure Code entered in SV202-2 must be a valid Medicare HCPCS code. If any of the Medicare HCPCS codes listed in the **Medicare Exclusion list** are billed, then the encounter will be rejected.
2400	SV2 – Institutional Service Line	SV202-3 – Procedure Code Modifier	If a Procedure Code modifier is used, then it must be a valid Medicare procedure code modifier. Refer to the **Medicare HCPCS Procedure Code Exclusion Modifier List** for list of modifiers that are not allowed.
2400	SV2 – Institutional Service Line	SV204- Units or Basis of Measurement	Service Units cannot exceed 99999.9
2400	SV2 – Institutional Service Line	SV201- Service Line Revenue Code	When any service line has a revenue code entered in 2400 SV201 that is equal to 045x, 0516, or 0526, then the Patient Reason Code for Visit 2300 H102-2 (HI02-1=PR) must be present. Refer to **CMS publication 100-04 (3031.10 page 5)** for additional information. For Outpatient Bill Type, if any revenue code shown in the **Medicare Revenue Code List** are used, then they must have a HCPCS code billed.

Loop	Segment	Data Element	Comments
2300	CLM – Claim Information	CLM05-1 – Facility Type Code	Type of Bill (TOB) '33'-Home Health Outpatient is not allowed in Loop 2300 CLM05-1. Refer to the **CMS Publication 100-04** for additional information regarding the discontinuation of TOB 33.
2310A	NM1- Attending Provider Name	NM105-Attending Provider Middle Name	When the Attending Provider Middle Name is entered, it must begin with an alpha character.
2310A	PRV – Attending Provider Specialty Information	PRV03 – Attending Provider Taxonomy Code	If the Attending Provider taxonomy code is entered, then it must be a valid 10 digit taxonomy code. **Refer to the Medicare Provider Taxonomy Code Crosswalk.**

7.10.2 **ASCX12 837 Professional – Medicare Only - Encounters**

Loop	Segment	Data Element	Comments
2300	AMT – Patient Paid Amount	AMT02 – Patient Amount Paid	When Patient Paid Amount is entered (Loop 2300 AMT01=F5), then the patient paid amount entered cannot be less than 0 and cannot be greater than 99,999.99 when CLM05-03 is '1' (Original), or '7' (Adjustment).
2300	CLM – Claim Information	CLM02– Total Claim Charge Amount	Total claim charge amount entered must be greater than or equal to '0' and cannot exceed a total claim charge amount of '99,999.99' when CLM05-03 is '1' (original), or '7' (adjustment).
2300	CLM – Claim Information	CLM05-1 – Place of Service Code	When Place of Service code in 2300 CLM05-01 is equal to '21', '51', or 61, then the admission date is also required in Loop 2300 where DTP01=435.

Loop	Segment	Data Element	Comments
2300	DTP – DATE	DTP01 – Admission Date	Admission date entered (where DTP01=435) cannot be a future date.
2310A	NM1- Referring Provider Name	NM105– Referring Provider Middle Name	If the Referring Provider Middle name is entered, then it must begin with an alpha character.
2310B	NM1- Rendering Provider Name	NM105 – Rendering Provider Middle Name	If the Rendering Provider Middle Name is entered, then it must begin with an alpha character.
2310B	PRV- Rendering Provider Specialty	PRV03 – Rendering Provider Taxonomy Code	If the Rendering Provider taxonomy code is entered, then it must be a valid 10 digit taxonomy code as shown in the **Medicare Provider Taxonomy Code Crosswalk**.
2400	SV1 – Professional Service	SV101-2 – Procedure Code	When SV101-1=HC, then the Procedure Code entered in SV101-2 must be a valid Medicare HCPCS code. If any of the Medicare HCPCS codes listed in the **Medicare Exclusion list** are billed, then the encounter will be rejected.
2400	SV1 – Professional Service	SV101-3 – Procedure Code Modifier	If a Procedure Code modifier is used, then it must be a valid Medicare procedure code modifier. Refer to the **Medicare HCPCS Procedure Code Exclusion Modifier List** for list of modifiers that are excluded (0not allowed) by Medicare.

Loop	Segment	Data Element	Comments
2400	SV1 – Professional Service	SV102 – Line Item Charge Amount	Line item charge amount entered must be equal to or greater than zero and cannot exceed $99,999.99 (applicable for Original and Adjustments only).
2400	SV1-Professional Service	SV103 - Unit or Basis of Measurement Code	When SV103 has a service unit code of 'MJ' (Minutes), then the procedure modifier codes entered in 2400 SV01-3 must be AA, AD, QK, QS, QX, QY, or QZ. Service Units entered in SV103 cannot exceed 9999.9
2400	SV1- Professional Service	SV105 – Facility Code	When Place of Service Code in 2400 SV105 is equal to '21', '51', or 61, then the admission date is also required in Loop 2300 where DTP01=435 (admission date cannot be a future date).
2400	SVD – Line Adjudication	SVD02 – Service Line Paid Amount	When service line paid amount is entered, it should not be less than '0' and should not be greater than '99,999.99' (applicable for Original and Adjustment only).

7.10.3 **ASCX12 837 Professional – Medicare Spinal Manipulation Only - Encounters**

Loop	Segment	Data Element	Comments
2300	DTP – DATE - ACUTE MANIFESTATION	DTP01 – DTP03	Required when Loop ID-2300 CR208 = "A" or "M", the claim involves spinal manipulation, and the payer is Medicare
	CR2 -- SPINAL MANIPULATION SERVICE INFORMATION	CR208 – Patient Condition Code	Loop ID-2300 DTP Acute Manifestation Segment is required when Patient Condition Code = "A" or "M"

Loop	Segment	Data Element	Comments
2400	SV1 -- Professional Service	SV101 - 02 –Procedure Code	Use "98940" or "98941" or "98942" or "22505"

7.11 Other Special Requirements- Encounters Only

7.11.1 Duplicate Encounter Validation (All states except CA & Medicare and Marketplace)

In order to ensure encounters submitted are not duplicates of encounters previously submitted or duplicates of encounters in the same file, Molina will perform header and service level duplicate checking. If all service lines are determined to be duplicates, the encounter is denied at the header level and an error will be returned to the submitter. Encounters with Claim Frequency Code (CLM05 – 03) of "7" or "8" will not be processed for duplicate check. Historical check is processed against original encounters accepted during the past 36 months.

Note: In cases where a vendor has to correct an encounter which has been previously denied (rejected) by Molina, Molina recommends that vendors resubmit the encounter to Molina using frequency code '7' (Adjustment).

The following values are the minimum set of elements used for matching encounters:

7.11.1.1 Duplicate Matching Elements- *Institutional Only*- Encounters (All states except CA & Medicare and Marketplace)

Loop	Segment	Data Element
Control	ISA – Interchange Control Header	ISA06 - Interchange Sender ID
2010AA – Billing Provider Name	REF- Billing Provider Tax Identification	REF02 - Billing Provider Tax Identification Number, where Employer's Identification Number (REF01) is EI
	NM1 – Billing Provider Name	NM103 - Billing Provider Organizational Name
		NM109 - Billing Provider Identifier
2310D – Rendering Provider Name	NM1 – Rendering Provider Name	NM103 - Rendering Provider Last Name
		NM104 - Rendering Provider First Name
		NM109 - Rendering Provider Id
2300 – Claim Information	CLM – Claim Information	CLM05 - 01 - Facility Type Code
		CLM05 - 03 - Claim Frequency Code

Loop	Segment	Data Element
	HI – Diagnosis Related Group (DRG) Information	HI01-02 - Diagnosis Related Group (DRG) Code, where Code List Qualifier Code (HI01-01) is DR
	HI – Principal Diagnosis	HI01 - 02 - Principal Diagnosis Code, where Code List Qualifier Code (HI01-01) is ABK
	HI – Other Diagnosis	[HI01 - HI12]-02 - Other Diagnosis, where Code List Qualifier Code ([HI02-HI12]-01) is ABF
2400 – Service Line Number	DTP – Date – Service Date	DTP03 - Service Dates, where Date Time Qualifier (DTP01) is 472
	SV2 – Institutional Service	SV201 - Service Line Revenue Code
		SV202 - 01 - Procedure Code
		SV202 - [03-06] – Procedure Modifier (Service Line Revenue Code)
		SV203 - Line Item Charge Amount
		SV205 - Service Unit Count

7.11.1.2 Duplicate Encounter Matching Elements – *Professional & Dental Only (All states except CA & Medicare and marketplace)*

Loop	Segment	Data Element
Control	ISA – Interchange Control Header	ISA06 - Interchange Sender ID
2010AA – Billing Provider Name	REF- Billing Provider Tax Identification	REF02 - Billing Provider Tax Identification Number, where Employer's Identification Number (REF01) is EI

Loop	Segment	Data Element
	NM1 – Billing Provider Name	NM103 - Billing Provider Organizational Name
		NM109 - Billing Provider Identifier
2310D – Rendering Provider Name	NM1 – Rendering Provider Name	NM103 - Rendering Provider Last Name
		NM104 - Rendering Provider First Name
		NM109 - Rendering Provider Id
2300 – Claim Information	CLM – Claim Information	CLM05 - 03 - Claim Frequency Code
	HI – Diagnosis Related Group (DRG) Information	HI01-02 - Diagnosis Related Group (DRG) Code, where Code List Qualifier Code (HI01-01) is DR
	HI – Principal Diagnosis	HI01 - 02 - Principal Diagnosis Code, where Code List Qualifier Code (HI01-01) is ABK
	HI – Other Diagnosis	[HI01 - HI12]-02 - Other Diagnosis, where Code List Qualifier Code ([HI02-HI12]-01) is ABF
2400 – Service Line Number	DTP – Date – Service Date	DTP03 - Service Dates, where Date Time Qualifier (DTP01) is 472
	SV1 – Professional Service	SV101 - 02 - Procedure Code
		SV101 - [03-06] - Procedure Modifier
		SV102 - Line Item Charge Amount
		SV104 - Service Unit Count

Loop	Segment	Data Element
		SV105 - Place of Service Code
	SV3 – Dental Service	SV301 - 02 - Procedure Code
		SV301 - [03-06] - Procedure Modifier
		SV302 - Line Item Charge Amount
		SV303 – Place of Service Code
		SV306 - Procedure Count

7.11.1.3 Encounter Duplicate Logic for California Medicaid Only:

Below are the columns that Molina will be considering to identify the duplicate encounters for the state of California Only. This is common for both Institutional and Professional encounters only.

Encounter Duplicate Logic for California Medicaid	
Professional	**Institutional**
Client Identification Number (CIN) or Molina's Member ID	Client Identification Number (CIN) or Molina's Member ID
Dates of Service (From & To Dates)	Dates of Service (From & To Dates)
Procedure Code	Admission Date/Hour
Procedure Code Modifier	Discharge Hour
NDC Drug Code*	Attending Provider NPI
Rendering Provider NPI	Procedure Code
	Procedure Code Modifier

Note: * Conditional usage of Drug Code - When a submitted encounter is compared to previously submitted encounters and all other key fields match but one of the encounters has a drug code and the other does not – this situation is still identified as a duplicate. If all other key fields match and the drug codes are different, the situation is not a duplicate.

7.11.1.4 *Duplicate Logic for Medicare (including Dual Members with eligibility for both Medicare & Medicaid)- Encounters Only:*

Below are the columns that Molina will be considering to identify the duplicate encounters for Medicare and Duals (aka Members with Dual Eligibility for Medicare and Medicaid). This is common for both Institutional and Professional encounters only.

Molina – Encounter Duplicate Logic for Medicare, and Duals		
Professional & DME	**Institutional (Outpatient)**	**Institutional (Inpatient)**
QNXT Member ID	QNXT Member ID	QNXT Member ID
Dates of Service (From & To Dates)	Dates of Service (From & To Dates)	Dates of Service (From & To Dates)
Procedure Code and up to 4 Modifiers	Procedure Code and up to 4 Modifiers	Bill Type is 11X, 18X, 21X, or 41X
Paid Amounts (Both Header and Line)	Paid Amounts (Both Header and Line)	Billing Provider NPI
Claim Charge Amount (Header)	Claim Charge Amount (Header)	
Place of Service/ Location	Bill Type (Facility Code + Bill Class Code)	
Rendering Provider Name and NPI	Billing Provider ID (QNXT)	
	Revenue Code	

7.11.1.5 *Dental Duplicate Criteria for all Dental Vendors:*

- Same Member (Member match logic criteria has to be completed to uniquely identify member)
- Same Rendering Provider NPI
- Same Billing Provider NPI
- Overlapping/Same claim line Date Of Service
- Same Procedure code
- Same Modifiers (regardless of order)
- Same Tooth number (regardless of order)
- Same Tooth Surfaces (regardless of order)
- Same Quadrant or Arches (regardless of Order)

7.11.2 Duplicate Encounter Validation (Marketplace States Only)

In order to ensure encounters submitted are not duplicates of encounters previously submitted or duplicates of encounters in the same file, Molina will perform header and service level duplicate checking. If all service lines are determined to be duplicates, the encounter is denied at the header level and an error will be returned to the submitter. Encounters with Claim Frequency Code (CLM05 – 03) of "7" are considered for Marketplace line of business. Encounters with Claim Frequency Code (CLM05 – 03) of "8" will not be processed for duplicate check. Historical check is processed against original & Adjustement encounters accepted during the past 36 months.

Vendor denied encounters will bypass header level duplicate checks. If any encounter line fails line level duplicate validations, deny only the duplicate line. Non-duplicate encounter lines will be consumed and entered as "Paid" encounter lines. Any encounter with at least 1 paid line will be entered as "Paid" at the header level.

Below are the columns that Molina will be considering to identify the duplicate encounters for Marketplace (aka Members with Marketpalce). This is common for both Institutional and Professional encounters only.

Encounter Duplicate Logic for marketplace	
Professional	Institutional (Outpatient)
Client Identification Number (CIN) or Molina's Member ID	Client Identification Number (CIN) or Molina's Member ID
Rendering Provider NPI	Rendering Provider NPI
Dates of Service (From & To Dates)	Bill Type (Facility Code + Bill Class Code) Other than 11X,18X,21X, 41X
Service Code	Revenue Code
POS Code	Service Code
Service Code Modifiers	Service Code Modifiers
	Dates of Service (From & To Dates)

7.11.2.1   Adjustment Encounters

Encounters with Claim Frequency code (CLM05 – 03) of " 7" with cross family will be considered in Duplicate logic and if all required paramters are matched, then Molina will trigger DENY edit with description " *Exact Duplicate Adjustment claim* " for Duplicated adjustment encounters.

This Edit will trigger only if all lines of the adjustment encounters matches the original and hence validation will Occur at line level

Encounters with Claim Frequency code (CLM05 – 03) of " 7" on child adjustment claims against their own parent claim and Encounters with Claim Frequency code (CLM05 – 03) of " 8" will by pass the duplicate checks

7.11.2.2   *Same Service Rendered Multiple Times on the Same Day without a Service Code Modifier*

Duplicate services on multiple lines within a single claim will be accepted with or without an exception modifier .The same service is rendered multiple times on the same day without one of the exception Service Code Modifiers and both services are submitted in a single claim. The Duplicate logic will accept this encounter

7.11.2.3   *Inclusive modifiers not allowed on the same day:*

Professional and outpatient institutional Encounters will identify as duplicate because the submitted service is part of a more inclusive service submitted on the same day. Duplicate process will consider below list of inclusive Modifiers

- 26 or TC - Issuers should not submit global services (no modifier) and professional (26 mod) or technical (TC mod) components on different claims.
- 50 – Issuers should not submit a claim for the same service with a modifier 50 and a claim with a modifier RT or LT or Blank.
- LT/RT - Issuers should not submit a claim for the same service with a modifier RT or LT and a claim with a modifier 50 or no modifier.
- RR, NU, UE -Issuers should not submit claims with Service Code Modifiers RR, NU, and UE for the same time period. And these modifiers cannot be billed with blank modifier as this is considered as duplicate billing.

These services are also subject to exception modifiers. For example, if a service line has a Service Code Modifier 26 and 25, it will be accepted because Service Code Modifier 25 is an exception to the duplicate logic.

Examples for Inclusive servcice code modifiers

When the following elements are present on a stored active claim	…and the following elements are submitted on a new claim …	…the new claim is rejected
Service Code Service Code Modifier 26 or TC The reverse is also true: Service Code and Service Code Modifier	Matching Service Code No Service Code Modifier Matching DOS Matching Service Code and Service Code Modifier 26 or TC and Matching DOS	Original Claim: DOS: 1/15/2014 Service: 71020-26 EDGE Accepted New Claim: DOS: 1/15/2014 Service: 71020 Rejected: Duplicate service
Service Code Service Code Modifier 50 The reverse is also true. Service Code Service Code Modifier RT	Matching Service Code Service Code Modifier RT Matching DOS Service Code Service Code Modifier 50 Matching DOS	Original Claim: DOS: 3/1/14 Service: 20610-50 EDGE Accepted New Claim: DOS: 3/1/14 Service: 20610-RT EDGE Rejected
Service Code Service Code Modifier LT The reverse is also true. Service Code No Service Code Modifier	Matching Service Code No Service Code Modifier Matching DOS Service Code Service Code Modifier LT Matching DOS	Original Claim: DOS: 1/28/14 Service: 20610-LT EDGE Accepted New Claim: DOS: 1/28/14 Service: 20610 EDGE Rejected

When the following elements are present on a stored active claim	…and the following elements are submitted on a new claim …	…the new claim is rejected
Service Code Service Code Modifier NU, RR, UE or blank	Matching Service Code Service Code Modifier NU, RR, UE or blank Matching DOS	Original Claim: E0240-RR 1/1/14 - 1/30/14 Accepted New Claim: E0240 1/16/14 Rejected - Rental claim on file New Claim: E0240-NU 1/20/14 Rejected - Rental claim on file New Claim: E0240-UE 2/2/14 Accepted - New DOS

The following values are the minimum set of elements used for matching encounters:

7.11.2.4   Duplicate Encounter Matching Elements – Professional (Marketplace Only)

Loop	Segment	Data Element
Control	ISA – Interchange Control Header	ISA06 - Interchange Sender ID
2310D – Rendering Provider Name	NM1 – Rendering Provider Name	NM109 - Rendering Provider Id
2400 – Service Line Number	DTP – Date – Service Date	DTP03 - Service Dates, where Date Time Qualifier (DTP01) is 472
	SV1 – Professional Service	SV101 - 02 - Procedure Code
		SV101 - [03-06] - Procedure Modifier
		SV105 - Place of Service Code

7.11.2.5   Duplicate Matching Elements- Institutional Outpatient BillTypeOnly- Encounters (Marketplace Only)

Loop	Segment	Data Element
2310D – Rendering Provider Name	NM1 – Rendering Provider	NM109 - Rendering Provider Id
2300 – Claim Information	CLM – Claim Information	CLM05 - 01 - Facility Type Code and Billclasscode

Loop	Segment	Data Element
2400 – Service Line Number	DTP – Date – Service Date	DTP03 - Service Dates, where Date Time Qualifier (DTP01) is 472
	SV2 – Institutional Service	SV201 - Service Line Revenue Code
		SV202 - 01 - Procedure Code
		SV202 - [03-06] – Procedure Modifier (Service Line Revenue Code)

7.11.3 Encounter Re-Submission Guidelines

Providers resubmitting encounters must be sure to enter the appropriate frequency code for the encounter that is being resubmitted to Molina Healthcare using a Frequency Code in Loop 2300 CLM05-3, along with the Original ICN or Payer Claim Control Number in Loop 2300 REF02.

Loop	Segment	Data Element	Comments
2300	CLM – Claim Information	CsLM01 -- Patient Control Number	Unique Claim Number in the billing submitter's patient management system. See **Encounter Re-Submission Examples**
	CLM – Claim Information	CLM05 -03 – Claim Frequency Code	Molina accepts the following: 1: Original/Admit Through Discharge Claim 7: Replacement of Prior Claim 8: Void/Cancel of a Prior Claim See **Encounter Re-Submission Examples**
	REF – Payer Claim Control Number	REF01 – Reference Identification Qualifier	Use "F8"

Loop	Segment	Data Element	Comments
	REF- Payer Claim Control Number	REF02 – Payer Claim Control Number or ICN	Not used for Claim Frequency Code = 1 Use last previously submitted CLM01 -- Patient Control Number (Claim Number) or ICN. A unique number assigned by the payer to identify a claim. The number is usually referred to as an Internal Control Number (ICN), Claim Control Number (CCN) or a Document Control Number (DCN) See **Encounter Re-Submission Examples**

7.11.3.1 *Frequency Code Table (Loop 2300 CLM05-3) - Encounters*

In most cases, Molina recommends that the below frequency codes 1, 7, or 8 are entered in Loop 2300 CLM05-3 as defined below:

Loop	Segment	Claim Frequency Code	Description	Definition
2300	CLM05-3	1	Original/Admit Through Discharge Claim	Provider utilizes code for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which it expects payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP.
2300	CLM05-3	7	Replacement of Prior Claim	Used to correct a previously submitted bill. The provider applies this code to the corrected or "new" bill. In cases where a vendor has to correct an encounter which was previously denied (rejected) by Molina, Molina recommends that vendors resubmit the encounter with a frequency code '7' (Adjustment) along with the original claim ICN or payer control # in 2300 REF02.

Loop	Segment	Claim Frequency Code	Description	Definition
2300	CLM05-3	8	Void/Cancel of a Prior Claim	The provider uses this code to cancel this bill which is an exact duplicate of a previously accepted (paid bill). In cases where the original encounter was accepted (paid), a provider can resubmit the exact same encounter using frequency code '8' (Void) to cancel the original. When using frequency code '8', providers must also include the original claim ICN or payer claim # in 2300 REF02. Note: If the original encounter was never accepted and was either rejected or denied, then providers should use Frequency Code 7 (Adjustment/Replacement) instead.

However, some states may require the use of other Frequency Codes (besides 1, 7, or 8). See the table below for the other allowed Frequency Codes which will be accepted by Molina Healthcare (exceptions may apply by state/contract).

7.11.3.2 _Other Encounter Frequency Codes Table (Loop 2300 CLM05-3)_

Note: In this table above, please notice the following exceptions as shown in red:

- California – The valid frequency codes allowed are 1, 2, 3, 4, 5, 7, 8, and 9
- Medicare– The valid frequency codes allowed are 1, 2, 3, 4, 5, 7, 8, and 9
- Florida –The only valid frequency codes allowed are 1,3 (hospice), 7, or 8
- Wisconsin – Interim billing (2, 3, and 4) is NOT permitted for inpatient hospital stays unless the provider's contract specifically

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Loop	Segment	Claim Frequency Code	Description	Definition

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2300	CLM05-3	0	Nonpayment/Zero Claims	Provider utilizes code when it does not anticipate payment from the payer for the bill, but is informing the payer about a period of non-payable confinement or termination of care. The "Through" date of this bill is the discharge date for this confinement, or termination of the plan of care.
2300	CLM05-3	2	Interim- First Claim	**CA and Medicare. WI will only accept for Inpatient stays if allowed by the Provider's Contract.** Used for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement / course of treatment. <u>If the frequency code is 2, the patient status must be 30 (Still a Patient or Expected to Return for Outpatient Services)</u>.
2300	CLM05-3	3	Interim- Continuing Claims	**CA, FL, and Medicare. WI will only accept for Inpatient stays if allowed by the Provider's Contract.** Used when a bill for which utilization is chargeable for the same confinement / course of treatment has already been submitted and further bills are expected to be submitted later. <u>If the frequency code is 3, the patient status must be 30 (Still a Patient or Expected to Return for Outpatient Services)</u>. California – Interim claims will be accepted for stays that exceed 29 days. Florida utilizes frequency code 3 to denote Hospice claims only. Medicare-allows the use of frequency code 3 for interim billing.
2300	CLM05-3	4	Interim - Last Claim	**CA and Medicare. WI will only accept for Inpatient stays if allowed by the Provider's Contract.** Used for a bill for which utilization is chargeable and which is the last in a series for this confinement or course of treatment. The "through" date of this bill is the discharge for this treatment. <u>If the frequency code is 4, the patient status code cannot be 30</u>.

2300	CLM05-3	5	Late Charge Only	**CA and Medicare Only.** Late charges should be added to the original claim and resubmitted utilizing frequency code 7.
		6		**DO NOT USE** – Frequency Code 6 is no longer valid and is therefore no longer utilized in claims processing.
2300	CLM05-3	9	Final Claim for a Home Health Episode	**CA and Medicare only.** This code indicates the home health bill should be processed as a debit or credit adjustment to the request for anticipated payment.

7.11.3.3 Encounter Re-Submission Examples

Example 1 - Unique Patient Control Number (CLM01)

- Each encounter should be unique
- Patient Control Number of Original encounter = C1
- Patient Control Number of First Reversal encounter = C1R1
- Patient Control Number of First Adjustment encounter = C1A1
- Patient Control Number of Subsequent Reversal encounter = C1R2
- Patient Control Number of Subsequent Adjustment encounter = C1A2

Example 2 - 5010 HIPAA Compliant Submission

- Submitter sends an Original Encounter to Molina
- Molina denies it back to the Submitter for some reason. Molina will load the encounter into our system as denied
- The Submitter then should send an Adjustment Encounter with Frequency Code 7 and REF*F8 filled with the Original Paid/Denied Encounter's Patient Control Number
- Molina would accept this as Adjustment Encounter

Example 3 - Submitting an Adjustment/Replacement Encounter

- Original encounters
  - Frequency Code = 1
  - Original Reference Number = (empty)
- First Adjustment encounters
  - Frequency Code = 7
  - Original Reference Number = Patient Control Number of Original Encounter
- Subsequent Adjustment encounters
  - Frequency Code = 7

o   Original Reference Number = Patient Control Number of previous Adjustment Encounter

- Example:
  o   **Original Encounter :** Patient Control Number = C1,   Frequency Code = 1
  o   **First Adjustment Encounter :** Patient Control Number = C1A1, Frequency Code = 7, Original Reference Number = C1
  o   **Subsequent Adjustment Encounter :** Patient Control Number = C1A2, Frequency Code = 7, Original Reference Number = C1A1

File	Patient Control Number (CLM01)	Claim Frequency Code (CLM05 - 03)	REF*F8 (REF02)	Notes
1	10	1		Original. Reference Identifier should not be sent for Frequency Code = 1
2	15	7	10	First Adjustment/Replacement
3	20	1		Original. Reference Identifier should not be sent for Frequency Code = 1
4	50	7	20	First Adjustment/Replacement
5	75	7	15	Subsequent Adjustment/ Replacement

Note: In cases where a vendor has to correct an encounter, which has been previously denied (rejected) by Molina, Molina recommends that vendors resubmit the encounter to Molina using frequency code '7' (Adjustment).

Example 4 - Submitting a Reversal Encounter and New Original Claim for Adjustment/Replacement

- Original encounters
    - Frequency Code= 1
    - Original Reference Number = (empty)
- Adjustment encounters
    - Frequency Code = 7
    - Original Reference Number = Patient Control Number of Original Encounter
- Reversal encounters
    - Frequency Code = 8
    - Original Reference Number = Patient Control Number of Adjustment Encounter that has to be reversed
- Example:
    - **Original Encounter :** Patient Control Number = C1,   Frequency Code = 1
    - **Adjustment Encounter :** Patient Control Number = C1A1, Frequency Code = 7, Original Reference Number = C1
    - **Reversal Encounter to VOID Adjustment :** Patient Control Number = C1R2, Frequency Code = 8, Original Reference Number = C1A1

File	Patient Control Number (CLM01)	Frequency Code (CLM05 - 03)	REF*F8 (REF02)	Notes
1	10	1	<empty>	Original. Reference Identifier should not be sent for Frequency Code = 1
2	16	8	10	Reversal
2	15	1		Original. Reference Identifier should not be sent for Frequency Code = 1
3	20	1		Original. Reference Identifier should not be sent for Frequency Code = 1
4	51	8	20	Reversal
4	50	1		Original. Reference Identifier should not be sent for Frequency Code = 1
5	76	8	15	Reversal of Subsequent original claim
5	75	1		Original. Reference Identifier should not be sent for Frequency Code = 1

Example 5 - Submitting a Reversal Encounter Only, No Adjustment/Replacement

- Original encounters
  - o Frequency Code = 1
  - o Original Reference Number = (empty)
- Reversal encounters
  - o Frequency Code = 8
  - o Original Reference Number = Patient Control Number of Original Encounter that has to be reversed
  - o Adjudication Date = the date that the encounter was reversed in the adjudication system.
  - o Paid Amount= the paid amount shown on the reversal should match the paid amount on the original encounter.
- Example:
  - o **Original Encounter :** Patient Control Number = 10 (C1),   Frequency Code = 1 , Adjudication Date= 1/1/2012, Paid Amount= $100.00
  - o **Reversal Encounter :** Patient Control Number = 15 (C1R1), Frequency Code = 8, Original Reference Number = 10 (C1), Adjudication Date=2/1/2012, Paid Amount= $100.00

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File	Patient Control Number (CLM01)	Frequency Code (CLM05 - 03)	REF*F8 (REF02)	Adjudication Date	Paid Amount	Notes
1	10	1		01/01/2012	100.00	Original. Reference Identifier should not be sent for Frequency Code = 1
2	15	8	10	02/01/2012	100.00	Reversal. Adjudication date the encounter was reversed.
3	20	1		01/01/2012	100.00	Original. Reference Identifier should not be sent for Frequency Code = 1
4	50	8	20	02/01/2012	100.00	Reversal

8.1.1   Vendor Denied Encounters – Texas, Ohio, New Mexico, Illinois, Wisconsin, & Utah Only

Molina Healthcare will now require vendors in the state of Texas, Ohio, New Mexico, Illinois, Wisconsin, and Utah to submit their vendor denied claims as Denied Encounters. Vendor Denied Encounters would be any claims that were denied payment by the Vendor to the provider for services rendered.

Note: In the future, Molina will accept Vendor Denied Encounters from ALL other States. However, with the exception of TX, NM, OH, IL, WI, and UT, other states' vendors should not submit Vendor Denied Encounters until they have been tested and approved to do so by Molina IT. The Molina Companion Guide will be updated as other states have been approved to begin submitting vendor denied encounters.

Molina Healthcare will acknowledge Professional, Dental, and Institutional submissions for vendor denied encounters. The ASC X12N 837 Version 5010 submission format is outlined below for claim and line level vendor denials. The inbound vendor denied encounters file will be submitted by following the existing inbound submission schedule. The file will contain only vendor denied encounters and the paid encounters will be excluded from the file (when possible).

Vendor denied encounter files that fail to meet the ANSI ASC X12N version 5010 for 837 Dental Institutional/ Professional HIPAA compliance standards will be rejected by Molina Healthcare and returned to the vendor via the 999 Functional Acknowledgment Report. The vendor shall make the necessary corrections and resubmit the file to Molina Healthcare.

The vendor denied encounters that fail to meet the claim format standards and rules as outlined by Molina Healthcare will be rejected by Molina Healthcare and returned to the vendor via the 277 Claims Acknowledgement report. The vendor shall make the necessary corrections and resubmit the file to Molina Healthcare.

8.1.1.1   Requirements for Vendor Denied Encounters

All vendor denied encounters file submissions - shall meet the following mandatory requirements:

1. Vendor should exclude duplicate denied encounters

2. Vendor should exclude encounters that are denied due to member eligibility issues (i.e. non-Molina Members should be excluded and members that were not eligible on the Date of Service should be excluded).

3. Vendor should submit encounters per Molina's re-submission guidelines.

4. Partial denials (mix of denied and paid service lines) should be included in the Paid Encounters file but not in the Denied encounters file.

5. Vendor can submit fully denied encounters, fully paid encounters, and partially paid encounters (mix of paid/denied service lines) in the same file or in separate files.

6. Vendor must enter Claim Adjustment Reason Code (CARC) "A1" in the first iteration of Loop 2320/2430 on all vendor denied encounters and/or vendor denied service lines; otherwise, the encounter or service line will be processed incorrectly as a normal Paid encounter.

8.1.1.2 File naming conventions for Vendor Denied Encounters

The two options below applies to Denied Encounters that are sent in a separate file from the paid encounters and denied encounters that are sent in the same file as the paid encounters. The vendor should carefully follow these instructions when deciding whether to submit the Paid and Denied encounters in the same file or separate files.

1. **Same Batch File Submission-**Denied Encounters or Denied Lines in the same batch as Paid Encounters or Paid Lines (in other words, there is a mixture of paid and denied service lines on a single encounter AND/OR, a mixture of fully paid and fully denied encounter files in the same batch file):

   Filename: **MH<st>_<vendorname>_<plantype>_<format>_yymmddhhmmss.txt**

   - <st> = state (e.g. TX)
   - <vendorname> = vendor name (e.g. ABC Health, etc.)
   - <plantype> = e.g. LTC – Long Term Care, MD – Medicaid, etc.
   - <format> = 837P, 837I or 837D

   Note: Some vendors may be unable to identify the Denied Encounters from the Paid or Partially Paid encounters and thus will include Paid, Partially Paid, and Denied Encounters in the same file; therefore, the presence of an A1 CARC code in the first iteration of the CAS segment is required and will distinguish the vendor denied encounters or vendor denied service lines from the true COB denied service encounter and service lines.

2. **Separate Batch File- Denied Encounters Only** (In other words, there are no paid service lines or partially paid encounters that appear in the batch file)

   Filename: **MH<st>_<vendorname>_<plantype>_Denied_<format>_yymmddhhmmss.txt**

   - <st> = state (e.g. TX)
   - <vendorname> = vendor name (e.g. ABC Health, etc.)
   - <plantype> = e.g. LTC – Long Term Care, MD – Medicaid, etc.
   - <format> = 837P, 837I or 837D

   Note: Notice that the above filename shows the word 'denied' to indicate that this is a fully denied encounter file (therefore; there should be no paid lines or paid encounters in this file).

Although the filename shows 'denied' for the fully Denied Encounters, vendors should not rely solely on this filename to indicate that the batch file of encounters is denied. Vendors should also ensure the presence of the A1 CARC code in the first iteration of the CAS segment for each denied encounter or denied service line for consistency.

8.1.1.3 CAS Adjustment Trio-Vendor Denied Encounters

A single CAS segment contains six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first non-zero adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05- CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

8.1.1.4 Claim Adjustment Reason Codes (CARC) -Vendor Denied Encounters

Molina accepts the Standard Claim Adjustment Reason Codes (CARC) as shown on the Washington Publishing Company (WPC) website at **www.wpc-edi.org**.

Note: The vendor must use the Claim Adjustment Reason Codes that were valid during the Date of Service billed. The WPC website keeps the list of Current, and Deactivated CARC codes that should be used depending on the date of service billed.

The submission of Claim Adjustment Reason Code (CARC) of "A1" in the first iteration of 2320/2430 will be required to identify all vendor denied encounters. If there are multiple CAS segments in the first iteration of 2320/2430, then an A1 CARC is needed for each CAS segment.

Examples of the use of the A1 CARC code are in the section **Examples of Vendor Denied Encounters**

    a.   Value of "A1" will allow Molina's system to determine partial line level denials (mix of paid and denied service lines) accurately.

    b.   If denied and paid are sent in the same file the process can determine which claims are paid/denied.

    c.   A1 CARC code is used to identify a denied line vs. a true COB scenario

    d.   For consistency, separate fully denied encounter files (where filename shows "denied") should contain A1 CARC code as well.

8.1.1.5 Claim Adjustment Group Codes-Vendor Denied Encounters

Claim Adjustment Group Code	Claim Adjustment Group Code Name
CO	Contractual Obligation
CR	Corrections and Reversal *Note: This value is not to be used with 005010 and up.*
OA	Other Adjustment
PI	Payer Initiated Reductions
PR	Patient Responsibility

8.1.1.6 Historical Vendor Denied Encounter Submissions

Vendor Denied Encounter Submissions (meaning any old denied encounters that were never submitted previously to Molina and still remain in a Denied disposition) need to be submitted to Molina as fully vendor denied encounters:

a. Vendor shall only submit historical encounters where the final disposition in their system shows that the encounter is still in a Denied status. If an encounter was already paid and submitted to Molina, the denial should not be sent again.

   i. If a partially denied encounter (i.e. an encounter with a mix of paid & denied service lines) has been previously submitted as a PAID encounter already to Molina, then do not re-submit it again.

8.1.1.7 Claim Level -Vendor Denied Encounters

Loop	Segment	Data Element	Comments
2320	CAS – Claim Level Adjustments	CAS01 – Claim Adjustment Group Code	The Claim Adjustment Group Code is required. **See WPC list of Claim Adjustment Group Codes.**
		CAS02 – Adjustment Reason Code	When encounter is Denied and there is a denied Claim Adjustment Reason Code (CARC), enter CARC code of 'A1' showing a zero dollar amount along with the CARC code containing the true denial reason. **See WPC list of Claim Adjustment Reason Codes.**
		CAS03 – Adjustment Amount	Required. Denied amount
		CAS04 – Adjustment Quantity	Required when number of service units has been adjusted. Represents the denied units.
	AMT – Coordination of Benefits (COB) Payer Paid Amount	AMT01 – Amount Qualifier Code	Use "D"
		AMT02 – Payer Paid Amount	Use "0"

8.1.1.8 Line Level -Vendor Denied Encounters

Loop	Segment	Data Element	Comments
2430	SVD – Line Adjudication Information SV3 – Line Adjudication Information	SVD02 – Service Line Paid Amount	Use "0"
	CAS – Line Adjustment	CAS01 – Claim Adjustment Group Code	**See WPC list of Claim Adjustment Group Codes.**
		CAS02 – Adjustment Reason Code	When encounter is Denied and there is a denied Claim Adjustment Reason Code (CARC), enter CARC code of 'A1' showing a zero dollar amount along with the CARC code containing the true denial reason. **See WPC list of Claim Adjustment Reason Codes.**
		CAS03 – Adjustment Amount	Required. Denied amount
		CAS04 – Adjustment Quantity	Required when number of service units has been adjusted. Represents the denied units.

8.1.1.9 Examples of Vendor Denied Encounters

Below are some samples of vendor denied encounters or vendor denied service lines.

Note: Vendor Denied encounters are only allowed for vendors in the state of Texas, Ohio, and New Mexico only. The Molina Companion Guide will be updated as new states have been approved to submit vendor denied encounters.

Fully Denied Example (Denied Original Encounter with All Service Lines Denied)

If paid and denied encounters will be submitted in the same file or in a separate file, the denied encounters are required to be submitted with the below data in the <u>first iteration</u> of Loops 2320 and 2430 and "A1" for the Claim Adjustment Reason Code (CARC), in addition to any other CARC's reported

Note: If the second iteration of 2320 and 2430 contains "A1" CARC, the encounter <u>will not</u> be considered as denied).

1. Claim Paid Amount (2320 AMT02) as Zero
2. Service Line Paid Amount (2430 SVD02) as Zero
3. Service Line Claim Adjustment Reason Code (2430 CAS02) as "A1" in all service lines
4. Service Line Charge Amount (2400 SV102) = Service Line Paid Amount (2430 SVD02) + Service Line Adjustment Amount (2430 CAS03)
5. Claim Charge Amount (2300 CLM02) = Claim Paid amount (2320 AMT02) + Sum of All Service Line Adjustment Amount (2430 CAS03)

```
CLM*1234567*214.56***22:B:1*N*A*Y*Y*P
HI*BK:47819*BF:7380*BF:7540
SBR*S*G8*******ZZ
AMT*D*0 -----------------------------------------------------------Claim Paid Amount is Zero
OI***Y***Y
NM1*IL*1*LNAME*SUBSCRIBE****MI*1234567890
N3*123 ANOTHER DR
N4*ANOTHER CITY*CA*900011234
NM1*PR*2*MOLINA SUBMITTER*****PI*MOLINASUBID
DTP*573*D8*20140122
LX*1
SV1*HC:30465*140.06*UN*2***1
DTP*472*D8*20130801
SVD*MOLINASUBID*0*HC:30465**1 ----------------------Service Line Paid Amount is Zero
CAS*CO*A1*0**B13*140.06 ---------------------Service Line CARC is "A1" along with other CARC codes
DTP*573*D8*20140122
LX*2
SV1*HC:88342:26*74.5*UN*2***1
DTP*472*D8*20130801
SVD*MOLINASUBID*0*HC:30465**1 ----------------------Service Line Paid Amount is Zero
CAS*CO*A1*0**B13*74.5 ------------------------Service Line CARC is "A1" along with other CARC codes
DTP*573*D8*20140122
```

Note: Although this example, uses Claim Adjustment Group Code-CO (Contractual Obligation), other appropriate Claim Adjustment Group Codes may be used as defined by **www.wpc-edi.com**. The Claim Adjustment Reason Codes (CARC) can also be found at **www.wpc-edi.com**.

Partial Denial Example (Mix of Paid and Denied Service Lines on Single or Separate Encounter)

If paid and denied encounters will be submitted in the same file or in a separate file, denied encounters are required to be submitted with the below in the <u>first iteration</u> of Loops 2320 and 2430 and "A1" for the Claim Adjustment Reason Code (CARC), in addition to any other CARC's reported. If the second iteration of 2320 and 2430 contains "A1" CARC, the encounter <u>will not</u> be considered as denied.

- Line Adjustment Claim Adjustment Reason Code use "A1" for Denied Service Lines (2430 CAS02)
- Line Item Charge Amount (2400 SV102) = Service Line Paid Amount (2430 SVD02) + Service Line Adjustment Amount (2430 CAS03)

```
CLM*1234567*214.56***22:B:1*N*A*Y*Y*P
HI*BK:47819*BF:7380*BF:7540
SBR*S*G8*******ZZ
AMT*D*200.56 -----------------------------------------------------------Claim Paid Amount is Non -zero
OI***Y***Y
NM1*IL*1*LNAME*SUBSCRIBE****MI*1234567890
N3*123 ANOTHER DR
N4*ANOTHER CITY*CA*900011234
NM1*PR*2*MOLINA SUBMITTER*****PI*MOLINASUBID
DTP*573*D8*20140122
LX*1
SV1*HC:30465*210.56*UN*2***1
DTP*472*D8*20130801
SVD*MOLINASUBID*200.56*HC:30465**1  -------------Service Line Paid Amount is Non-zero
CAS*CO*45*10 --------------------------------------------------Service Line CARC is not "A1"
DTP*573*D8*20140122
LX*2
SV1*HC:88342:26*4*UN*2***1
DTP*472*D8*20130801
SVD*MOLINASUBID*0*HC:30465**1  ----------------------Service Line Paid Amount is Zero
CAS*CO*A1*0**B13*4 ---------------------------------------Service Line CARC is "A1" along with other CARC codes
DTP*573*D8*2014012
```

Note: Although this example uses Claim Adjustment Group Code-CO (Contractual Obligation), other appropriate Claim Adjustment Group Codes may be used as defined by **www.wpc-edi.com**. The Claim Adjustment Reason Codes (CARC) can also be found at **www.wpc-edi.com**.

8.1.2   277CA Error Code List- Encounters Only

Category Code	Status Code	Entity Identifier	Reject Encounter	Molina Status Description	WPC - EDI Status Description (Standard)
A6	0		Y	Missing Spinal Manipulation Information for the service code	Cannot provide further status electronically.
A7	0		Y	Financial Arrangement Code Validation	Cannot provide further status electronically.
A7	0		Y	Care Type Code Validation	Cannot provide further status electronically.
A3	1		Y	MMP Medicaid Secondary Enrollment and Planid Found for NON-LTSS Duals	For more detailed information, see remittance advice.
A3	1		Y	Invalid Age for Dual Member	For more detailed information, see remittance advice.
A3	1		Y	Multiple Reversals received for same Parent encounter	For more detailed information, see remittance advice.
A3	26	QC	Y	Member Not Found	Entity not found. Note: This code requires use of an Entity Code.
A3	41	41	Y	Encounter Routed Claimline	Special handling required at payer site.
A3	41	41	Y	Encounter Routed Claim	Special handling required at payer site.
A3	54	41	Y	Claim is duplicate	Duplicate of a previously processed claim/line.
A3	54	41	Y	Claim Line is duplicate	Duplicate of a previously processed claim/line.
A3	54	41	Y	Claim is duplicate in the file	Duplicate of a previously processed claim/line.
A3	54		Y	Duplicate Transportation Line	Duplicate of a previously processed claim/line.
A3	72		Y	ICD Split bill Required	Claim contains split payment.
A7	96	77	Y	CPF Validation - Servicefacility	No agreement with entity. Note: This code requires use of an Entity Code.

Category Code	Status Code	Entity Identifier	Reject Encounter	Molina Status Description	WPC - EDI Status Description (Standard)
A3	97	QC	Y	No Enrollment Segment	Patient eligibility not found with entity. Note: This code requires use of an Entity Code.
A3	97	GB	Y	Member not found for newborn Parent Encounters as Adjustment or Reversal received	Patient eligibility not found with entity. Note: This code requires use of an Entity Code.
A3	125	87	Y	Invalid Pay To Provider Name	Entity's name. Note: This code requires use of an Entity Code.
A3	125	82	Y	Invalid Rendering Provider Name	Entity's name. Note: This code requires use of an Entity Code.
A3	125	71	Y	Missing/Incomplete/Invalid Attending Provider Name	Entity's name. Note: This code requires use of an Entity Code.
A3	126	85	Y	Invalid Billing Address Line	Entity's address. Note: This code requires use of an Entity Code.
A3	126	87	Y	Invalid Pay To Provider Address	Entity's address. Note: This code requires use of an Entity Code.
A3	126	77	Y	Invalid Service Facility Address	Entity's address. Note: This code requires use of an Entity Code.
A3	128	87	Y	Invalid Pay To Provider TaxID	Entity's tax id. Note: This code requires use of an Entity Code.
A7	145	82	Y	Invalid Rendering Taxonomy Code Length	Entity's specialty/taxonomy code. Note: This code requires use of an Entity Code.
A7	145	82	Y	Invalid Rendering Provider TaxonomyCode	Entity's specialty/taxonomy code. Note: This code requires use of an Entity Code.
A7	145	71	Y	Invalid Attending Taxonomy Code Length	Entity's specialty/taxonomy code. Note: This code requires use of an Entity Code.
A7	145	71	Y	Invalid Attending Provider TaxonomyCode	Entity's specialty/taxonomy code. Note: This code requires use of an Entity Code.
A7	178		Y	Invalid Claim Charge Amount	Submitted charges.
A7	178		Y	Negative Charge amount At Header level	Submitted charges.

Category Code	Status Code	Entity Identifier	Reject Encounter	Molina Status Description	WPC - EDI Status Description (Standard)
A7	183	QC	Y	Invalid Patient Paid Amount	Amount entity has paid. Note: This code requires use of an Entity Code.
A3	187	41	Y	Claim Level - DOSFROM is out of range (1994 - 2050)	Date(s) of service.
A3	187	41	Y	Claim Level - DOSFROM is greater than received and/or run date	Date(s) of service.
A3	187	41	Y	Claim Level - DOSFROM is greater than DOSTO	Date(s) of service.
A3	187	41	Y	Different DOSFROM at the Header and Line level (Min)	Date(s) of service.
A3	187	41	Y	DOSFROM is Invalid	Date(s) of service.
A3	187	41	Y	Claim Level - DOSTO is out of range (1994 - 2050)	Date(s) of service.
A3	187	41	Y	Claim Level - DOSTO is greater than received and/or run date	Date(s) of service.
A3	187	41	Y	Claim Level - DOSTO is less than DOSFROM	Date(s) of service.
A3	187	41	Y	Different DOSTO at the Header and Line level (Max)	Date(s) of service.
A3	187	41	Y	DOSTO is Invalid	Date(s) of service.
A3	187	41	Y	Line Level - DOSFROM is out of range (1994 - 2050)	Date(s) of service.
A3	187	41	Y	Line Level - DOSFROM is greater than received and/or run date	Date(s) of service.
A3	187	41	Y	Line Level - DOSFROM is greater than DOSTO	Date(s) of service.
A3	187	41	Y	Line Level - Invalid or Missing DOSFROM	Date(s) of service.
A3	187	41	Y	Line Level - DOSTO is out of range (1994 - 2050)	Date(s) of service.

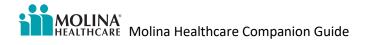| Category Code	Status Code	Entity Identifier	Reject Encounter	Molina Status Description	WPC - EDI Status Description (Standard)
A3	187	41	Y	Line Level - DOSTO is greater than received and/or run date	Date(s) of service.
A3	187	41	Y	Line Level - DOSTO is less than DOSFROM	Date(s) of service.
A3	187	41	Y	Line Level - Invalid or Missing DOSTO	Date(s) of service.
A3	188		Y	ICD10 – Anesthesia claims with invalid DOS End date	Statement from-through dates.
A3	189	41	Y	Admit date is out of range (1994 - 2050)	Facility admission date
A3	189	41	Y	Admit date is greater than the first DOSFROM	Facility admission date
A3	189	41	Y	Admit date is greater than received and/or run date	Facility admission date
A3	189	41	Y	Admit date is required	Facility admission date
A6	189		Y	Facility Admission Date is Missing	Facility admission date
A7	189		Y	Facility Admission Date is Future Date	Facility admission date
A3	190	41	Y	Validate Discharge for Prof	Facility discharge date
A3	218	41	Y	NDC Indicator not found	NDC number.
A3	228		Y	Invalid Bill Type	Type of bill for UB claim
A7	228		Y	Invalid Billtype 33	Type of bill for UB claim
A3	230	41	Y	Invalid Admit Hour (0 - 23)	Hospital admission hour.
A3	231	41	Y	Admit type required for 11x bill type	Hospital admission type.
A3	233	41	Y	Invalid Discharge Hour (0 - 23)	Hospital discharge hour.
A3	234	41	Y	Discharge status is required for inpatient and SNF claims	Patient discharge status.
A3	247	41	Y	Claim does not have any service lines	Line information.
A3	247	41	Y	Claim has more than 50 claimlines	Line information.

Category Code	Status Code	Entity Identifier	Reject Encounter	Molina Status Description	WPC - EDI Status Description (Standard)
A3	247	41	Y	Negative charge on claim line	Line information.
A3	249	41	Y	Place of Service is Invalid	Place of service.
A7	249		Y	Invalid Transportation Place of Service	Place of service.
A3	254	41	Y	Primary ICD-9/10 diagnostic code is invalid/missing	Principal diagnosis code.
A3	254		Y	Invalid primary diagnosis code for ICD9 starts with E or ICD10 which start with V,X,W,Y	Principal diagnosis code.
A3	255	41	Y	Invalid ICD-9/10 diagnosis code	Diagnosis code.
A3	255	41	Y	ICD-9/10 diagnosis code is not valid on DOS	Diagnosis code.
A3	255		Y	Encounters with DOD/DOS on or after 10/01/2015 are not having ICD10 Proc Codes	Diagnosis code.
A3	255		Y	Encounters with DOD/DOS before 10/01/2015 are not having ICD9 Diag Codes	Diagnosis code.
A3	255		Y	Encounters with DOD/DOS before 10/01/2015 are not having ICD9 Proc Codes	Diagnosis code.
A3	255		Y	Encounters are having both ICD9 and ICD10 Diag Codes	Diagnosis code.
A3	255		Y	Encounters are having both ICD9 and ICD10 Proc Codes	Diagnosis code.
A3	255		Y	Encounters with DOD/DOS on or after 10/01/2015 are not having ICD10 Diag Codes	Diagnosis code.
A3	255		Y	Invalid ECI code for ICD9 not starts with E or ICD10 not starts with V,X,W,Y	Diagnosis code.

Category Code	Status Code	Entity Identifier	Reject Encounter	Molina Status Description	WPC - EDI Status Description (Standard)
A3	400	41	Y	Amount billed at claim level does not equal Sum of amounts at line level	Claim is out of balance
A3	402	41	Y	Amount billed at claim level is Negative	Amount must be greater than zero. Note: At least one other status code is required to identify which amount element is in error.
A3	453	41	Y	Invalid modifier code on Date of Service	Procedure Code Modifier(s) for Service(s) Rendered
A3	453	41	Y	Invalid U Modifier	Procedure Code Modifier(s) for Service(s) Rendered
A7	453		Y	Invalid Anesthesia Modifier Measurement Code	Procedure Code Modifier(s) for Service(s) Rendered
A7	453		Y	Invalid Modifier Code for Medicare	Procedure Code Modifier(s) for Service(s) Rendered
A6	453		Y	Missing Transportation Modifier	Procedure Code Modifier(s) for Service(s) Rendered
A7	453		Y	Invalid Transportation Modifier	Procedure Code Modifier(s) for Service(s) Rendered
A6	453		Y	Missing Second Descriptor for Transportation Modifier	Procedure Code Modifier(s) for Service(s) Rendered
A7	453		Y	Invalid Second Descriptor for Transportation Modifier	Procedure Code Modifier(s) for Service(s) Rendered
A3	454	41	Y	Invalid CPT/HCPCS code	Procedure code for services rendered.
A3	454	41	Y	Invalid Service Code on DOS	Procedure code for services rendered.
A3	454	41	Y	Procedure Code not found or not valid on date of service	Procedure code for services rendered.
A6	454		Y	ProcedureCode required for RevenueCode is missing	Procedure code for services rendered.
A3	455	41	Y	Revenue Code not found	Revenue code for services rendered.
A3	455	41	Y	Revenue code not valid on date of service	Revenue code for services rendered.

Category Code	Status Code	Entity Identifier	Reject Encounter	Molina Status Description	WPC - EDI Status Description (Standard)
A3	455	41	Y	Revenue code is required when POS is InPatient	Revenue code for services rendered.
A3	460	41	Y	Invalid Condition Code	NUBC Condition Code(s)
A3	460	41	Y	Condition Code not valid on DOS	NUBC Condition Code(s)
A3	475		Y	Patient age is greater than 18 for Pediatric Dental MarketPlace Program	Procedure code not valid for patient age
A3	476	41	Y	Procedure Quantity is Zero	Missing or invalid units of service
A7	476		Y	Invalid Service Units Value	Missing or invalid units of service
A3	477	41	Y	Invalid Diagnosis Pointer	Diagnosis code pointer is missing or invalid
A3	492	41	Y	Procedure Date is out of range (1994 - 2050)	Other Procedure Date
A3	492	41	Y	Procedure Date is greater than received and/or run date	Other Procedure Date
A3	492	41	Y	Procedure Date is greater than DOSTO	Other Procedure Date
A7	507		Y	Invalid HCPCS Code for Medicare	HCPCS
A7	514	82	Y	Invalid Rendering Provider Middle Name	Entity's Middle Name Note: This code requires use of an Entity Code.
A7	514	DN	Y	Invalid Referring Provider Middle Name	Entity's Middle Name Note: This code requires use of an Entity Code.
A7	514	71	Y	Invalid Attending Provider Middle Name	Entity's Middle Name Note: This code requires use of an Entity Code.
A3	521		Y	CAS Segment not received for Encounter Service lines Denied by Vendor	Adjustment Reason Code

Category Code	Status Code	Entity Identifier	Reject Encounter	Molina Status Description	WPC - EDI Status Description (Standard)
A3	521		Y	Missing or Invalid CARC Codes on DOS	Adjustment Reason Code
A3	521		Y	Missing or Invalid CARC Codes on DOS at Line level	Adjustment Reason Code
A3	535		Y	Invalid ClaimReferno for Freqcode 1	Claim Frequency Code
A3	535		Y	Missing ClaimReferno for Freqcode 7	Claim Frequency Code
A3	535		Y	Missing ClaimReferno for Freqcode 8	Claim Frequency Code
A3	535		Y	Missing Parent for Freqcode 7	Claim Frequency Code
A3	535		Y	Missing Parent for Freqcode 8	Claim Frequency Code
A3	554	41	Y	Paid date is out of range (1994 - 2050)	Date Claim Paid
A3	554	41	Y	Paid date is greater than received and/or run date	Date Claim Paid
A3	554		Y	Paid date received lesser than DOS OR Paid date greater than Processed date at header level	Date Claim Paid
A3	554		Y	Paid date received lesser than DOS OR Paid date greater than Processed date at line level	Date Claim Paid
A3	560	85	Y	Invalid API	Entity's Additional/Secondary Identifier. Note: This code requires use of an Entity Code.
A3	562		Y	NPI Check Digit Validation Failed	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562		Y	Length of NPI is Invalid	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.

Category Code	Status Code	Entity Identifier	Reject Encounter	Molina Status Description	WPC - EDI Status Description (Standard)
A3	562		Y	First Digit of NPI is Invalid	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562	85	Y	Missing Billing/Pay-to Provider NPI	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562	82	Y	Missing Rendering Provider NPI	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562	85	Y	Validate NPI Existence for Billing	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562	82	Y	Validate NPI Existence for Rendering	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562	85	Y	NPI in File does not match with NPI in System	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562	82	Y	RENDERING PROVIDER NPI NOT MATCHED WITH MPF	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562	87	Y	PAYTO PROVIDER NPI NOT MATCHED WITH MPF	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562	87	Y	Invalid Pay To Provider NPI	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562	82	Y	Invalid Rendering Provider NPI	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562	71	Y	Missing/Incomplete/Invalid Attending Provider NPI	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562	85	Y	Missing Both NPI and API	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.

Category Code	Status Code	Entity Identifier	Reject Encounter	Molina Status Description	WPC - EDI Status Description (Standard)
A3	562	87	Y	CPF Validation - PaytoProvider	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562	82	Y	CPF Validation - RenderingProvider	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562		Y	Missing Both NPI and API for Rendering	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A6	562	71	Y	Missing Both NPI and API for Attending	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562	DN	Y	Invalid Referring Provider NPI	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	562	DK	Y	Invalid Ordering Provider NPI	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A7	562		Y	Service Facility is not present for POS<>11	Entity's National Provider Identifier (NPI). Note: This code requires use of an Entity Code.
A3	564	41	Y	Invalid EPSDT Condition Code	EPSDT Indicator
A7	583		Y	Negative Charge amount in Line level	Line Item Charge Amount
A3	610	41	Y	Invalid patient status for bill type	Patient Discharge Facility Type Code
A7	643		Y	Invalid ServiceLine Paid Amount	Service Line Paid Amount
A7	643		Y	Negative paid amount in Line level	Service Line Paid Amount
A7	644		Y	Invalid ServiceLine Charge Amount	Service Line Rate
A3	666	41	Y	Service code is missing or invalid	Surgical Procedure Code

Category Code	Status Code	Entity Identifier	Reject Encounter	Molina Status Description	WPC - EDI Status Description (Standard)
A7	673		Y	Patient Reason for Visit Code is Missing/Invalid for required RevenueCode	Patient Reason for Visit
A3	693		Y	Claim Paid Amount Is Negative	Amount must be greater than or equal to zero. Note: At least one other status code is required to identify which amount element is in error.
A3	694	41	Y	Amount billed at claim level is Zero	Amount must not be equal to zero. Note: At least one other status code is required to identify which amount element is in error.
A3	694	41	Y	All Claim lines came with the zero paid amount and a denied reason	Amount must not be equal to zero. Note: At least one other status code is required to identify which amount element is in error.
A3	694	41	Y	Claim line came with the zero paid amount and a denied reason	Amount must not be equal to zero. Note: At least one other status code is required to identify which amount element is in error.
A3	718		Y	Claim Aged more than 365 days for newborn	Claim/service not submitted within the required timeframe (timely filing).
A7	719		Y	Invalid Occurrence Code for required Patient Status Code	NUBC Occurrence Code(s)
A7	719		Y	Invalid Occurrence Code	NUBC Occurrence Code(s)
A7	719		Y	Invalid Occurrence Code for bill type (81/82)	NUBC Occurrence Code(s)
A3	721	41	Y	Occurrence Code not found	NUBC Occurrence Span Code(s)
A7	721		Y	Invalid Occurrence Span Code	NUBC Occurrence Span Code(s)

Category Code	Status Code	Entity Identifier	Reject Encounter	Molina Status Description	WPC - EDI Status Description (Standard)
A3	722	41	Y	Occurrence Start Date must not be greater than current date	NUBC Occurrence Span Code Date(s)
A3	722	41	Y	Occurrence Start Date must not be greater than Occurrence End Date	NUBC Occurrence Span Code Date(s)
A3	722	41	Y	Occurrence Start Date is missing	NUBC Occurrence Span Code Date(s)
A3	722	41	Y	Occurrence End Date is missing	NUBC Occurrence Span Code Date(s)
A3	725	41	Y	Value Code not found	NUBC Value Code(s)
A3	726	41	Y	Validate Value Amount based on Value Code in the File	NUBC Value Code Amount(s)
A6	727		Y	Missing Date of Accident	Accident date
A7	727		Y	Accidentdate received greater than DOS OR Accidentdate greater than Processed date at header level	Accident date
A6	728		Y	Missing Accident State	Accident state
A7	728		Y	Invalid Accident State	Accident state
A3	732	41	Y	Not able to identify Vendor Paid or Denied Encounter as PaidAmt and AdjreasonCode submitted are inconsistent	Information submitted inconsistent with billing guidelines. Note: At least one other status code is required to identify the inconsistent information.
A3	732	41	Y	Paid amount Greater than Zero for Encounter Denied by Vendor	Information submitted inconsistent with billing guidelines. Note: At least one other status code is required to identify the inconsistent information.
A6	740		Y	Missing Transportation DropOff State/ ZipCode	Drop-Off Location

Category Code	Status Code	Entity Identifier	Reject Encounter	Molina Status Description	WPC - EDI Status Description (Standard)
A7	740		Y	Invalid Transportation DropOff State/ ZipCode	Drop-Off Location
A3	751	41	Y	AMB01 - Missing/incomplete/invalid pick-up information	Ambulance Pick-up State or Province Code
A3	751	41	Y	AMB01 - Missing/incomplete/invalid drop-off information	Ambulance Pick-up State or Province Code
A7	751		Y	Invalid Transportation PickUp State/ ZipCode	Ambulance Pick-up State or Province Code
A6	751		Y	Missing Transportation PickUp State/ ZipCode	Ambulance Pick-up State or Province Code
A7	755	82	Y	Invalid API For Rendering Provider	Entity's primary identifier. Note: This code requires the use of an Entity Code.
A3	159		Y	PatientStatusCode must have Occurrence Code 55 (Date of Death) that is more than or equal to Claim DOS (Thru Date)	Entity's date of death. Usage: This code requires use of an Entity Code.
A3	159		Y	PatientStatus code must have Occurrence Code 55 (Date of Death) on header level	Entity's date of death. Usage: This code requires use of an Entity Code.v
A3	88		Y	Encounters are not eligible for submission on or after 1/1/2020	Entity not eligible for benefits for submitted dates of service. Usage: This code requires use of an Entity Code.
A3	54		Y	Overlapping DOS Not allowed For InPatient Adjuent claims	Duplicate of a previously processed claim/line.

Category Code	Status Code	Entity Identifier	Reject Encounter	Molina Status Description	WPC - EDI Status Description (Standard)
A3	54		Y	Exact Duplicate – Adjustment Claim	Duplicate of a previously processed claim/line.
A7	453		Y	Inclusive services not allowed on same date as previously billed	Procedure Code Modifier(s) for Service(s) Rendered
A7	453		Y	Inclusive services not allowed on same date (at line)	Procedure Code Modifier(s) for Service(s) Rendered

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8.1.4 277CA Excel Field Mapping/Sample 277CA File - Encounters

- **277CA Excel Field Mapping Document** – maps fields in 277CA EDI files to custom Molina 277CA Excel File as illustrated below.

Summary Tab

Molina Excel Format		277CA Implementation Guide Information					
Excel Data Element	Comments	Loop	Loop Name	Seg Id	Segment Name	Element	Data Element
Interchange Sender ID		Control	Control Segments	ISA	Interchange Control Header	ISA06	Interchange Sender ID
Interchange Receiver ID		Control	Control Segments	ISA	Interchange Control Header	ISA08	Interchange Receiver ID
837 Receipt Date	Date the 837 was received	2200A	Transmission Receipt Control Identifier	DTP	Information Source Receipt Date	DTP03	Information Source Receipt Date
837 Process Date	Date the 837 was processed	2200A	Transmission Receipt Control Identifier	DTP	Information Source Process Date	DTP03	Information Source Process Date
Information Source Name		2100A	Information Source Name	NM1	Information Source Name	NM103	Information Source Name
Receiver Last or Organization Name		2100B	Information Receiver Name	NM1	Information Receiver Name	NM103	Information Receiver Last or Organization Name
Receiver First Name	Will be blank if organization	2100B	Information Receiver Name	NM1	Information Receiver Name	NM104	Information Receiver First Name
Receiver Middle Name		2100B	Information Receiver Name	NM1	Information Receiver Name	NM105	Information Receiver Middle Name
Receiver Primary ID	Electronic Transmitter Identification Number (ETIN)	2100B	Information Receiver Name	NM1	Information Receiver Name	NM109	Information Receiver Primary Identifier
Claim Transaction Batch Number	Value submitted in BHT03 data element from the 837	2200B	Information Receiver Application Trace Identifier	TRN	Information Receiver Application Trace Identifier	TRN02	Claim Transaction Batch Number
File Total Claims Submitted Amount	Total submitted charge amount across all Billing Providers received	2200B	Information Receiver Application Trace Identifier	STC	Information Receiver Status Information	STC04	Total Submitted Charges for Unit Work
File Total Claims Accepted Amount	Total dollar amount of claims accepted across all Billing Providers received in the file	2200B	Information Receiver Application Trace Identifier	AMT	Total Accepted Amount	AMT02	Total Accepted Amount
File Total Claims Rejected Amount	Total dollar amount of claims rejected across all Billing Providers received in the file	2200B	Information Receiver Application Trace Identifier	AMT	Total Rejected Amount	AMT02	Total Rejected Amount
File Total Claims Submitted Quantity	Total number of claims rejected across all Billing Providers received						
File Total Claims Accepted Quantity	Total number of claims accepted across all Billing Providers received	2200B	Information Receiver Application Trace Identifier	QTY	Total Accepted Quantity	QTY02	Total Accepted Quantity
File Total Claims Rejected Quantity	Total number of claims rejected across all Billing Providers received	2200B	Information Receiver Application Trace Identifier	QTY	Total Rejected Quantity	QTY02	Total Rejected Quantity

Details Tab

Molina Excel Format		277CA Implementation Guide Information			
Excel Data Element	Comments	Seg Id	Segment Name	Elem ent Id	Data Element
Billing Prov Last or Organization Name		NM1	Billing Provider Name	NM103	Provider Last or Organization Name
Billing Prov First Name	Blank if Organization	NM1	Billing Provider Name	NM104	Provider First Name
Billing Prov Middle Name		NM1	Billing Provider Name	NM105	Provider Middle Name
Billing Prov ID Type	FI - Federal Taxpayer's Identification Number XX - Centers for Medicare and Medicaid Services National Provider Identifier	NM1	Billing Provider Name	NM108	Identification Code Qualifier
Billing Prov ID		NM1	Billing Provider ID	NM109	Billing Provider Identifier
Billing Prov Secondary ID Qualifier	0B - State License Number 1G - Provider UPIN Number G2 - Provider Commercial Number LU - Location Number SY - Social Security Number TJ - Federal Taxpayer's Identification Number	REF	Provider Secondary Identifier	REF01	Reference Identification Qualifier
Billing Prov Secondary ID		REF	Provider Secondary Identifier	REF02	Reference Identification
Billing Prov Total Claims Submitted Quantity	Total number of accepted and rejected claims for the Billing Provider				
Billing Prov Total Claims Accepted Quantity	Total number of claims accepted for the Billing Provider	QTY	Total Accepted Quantity	QTY02	Total Accepted Quantity
Billing Prov Total Claims Rejected Quantity	Total number of claims rejected for the Billing Provider	QTY	Total Rejected Quantity	QTY02	Total Rejected Quantity
Billing Prov Total Claims Submitted Amount	Total dollar amount of accepted and rejected claims for the Billing Provider				
Billing Prov Total Claims Accepted Amount	Total dollar amount of claims accepted for the Billing Provider	AMT	Total Accepted Amount	QTY02	Total Accepted Amount
Billing Prov Total Claims Rejected Amount	Total dollar amount of claims rejected for the Billing Provider	AMT	Total Rejected Amount	QTY02	Total Rejected Amount
Patient Last Name		NM1	Patient Name	NM103	Patient Last Name
Patient First Name		NM2	Patient Name	NM104	Patient First Name
Patient Middle Name		NM3	Patient Name	NM105	Patient Middle Name or Initial
Patient Name Suffix		NM4	Patient Name	NM107	Patient Name Suffix
Patient ID Number		NM5	Patient Name	NM109	Patient Identification Number
Patient Control Number	Patient control number submitted in the CLM01 of the 837	TRN	Claim Status Tracking Number	TRN02	Patient Control Number
Payer Claim Control Number	Molina's Claim Id	REF	Payer Claim Control Number	REF02	Payer Claim Control Number
Clearinghouse Trace Number		REF	Claim Identifier Number For Clearinghouse and Other Transmission Intermediaries	REF02	Clearinghouse Trace Number
Bill Type ID	Institutional Claims when Institutional Type of Bill was received on the claim. Reference Identification Qualifier = BLT See 837 Institutional Implementation Guide for definition of Institutional Bill Type components. Concatenate the 837I CLM05-1 (Facility Type Code) and CLM05-3 (Claim Frequency Code) values. Code Source = 236 - Uniform Billing Claim Form Bill Type, Code Source 235 - Claim Frequency Type Code respectively.	REF	Institutional Bill Type Identification	REF02	Bill Type Identifier
Service Start Date (Header)		DTP	Claim Level Service Date	DTP03	Claim Service Period
Service End Date (Header)	Same as Start Date if single date		Claim Level Service Date	DTP04	Claim Service Period
Procedure Code		SVC	Service Line Information	SVC01 -	Procedure Code
Procedure Modifier 1		SVC	Service Line Information	SVC01 -	Procedure Modifier
Procedure Modifier 2		SVC	Service Line Information	SVC01 -	Procedure Modifier
Procedure Modifier 3		SVC	Service Line Information	SVC01 -	Procedure Modifier
Procedure Modifier 4		SVC	Service Line Information	SVC01 -	Procedure Modifier
Service Line Charge Amount	Zero is acceptable	SVC	Service Line Information	SVC02	Line Item Charge Amount
Revenue Code		SVC	Service Line Information	SVC04	Revenue Code
Service Unit		SVC	Service Line Information	SVC07	Original Units of Service Count
Service Line Number		REF	Service Line Item Identification	REF02	Line Item Control Number
Service Start Date (Line)		DTP	Service Line Date	DTP03	Service Line Date
Service End Date (Line)		DTP	Service Line Date	DTP03	Service Line Date
Status Type*	Billing Prov - Billing Level Status Claim Header - Claim Header Level Status Service Line - Service Line Level Status				
Claim Status Category Code*	CODE SOURCE 507: Health Care Claim Status Category Code. See Molina Companion Guide for applicable codes.	STC	Claim Level Status Information	STC01 - 1	Health Care Claim Status Category Code
Claim Status Code*	CODE SOURCE 508: Health Care Claim Status Code. See Molina Companion Guide for applicable codes.	STC	Claim Level Status Information	STC01 - 2	Health Care Claim Status Code
Entity ID Code*	See Molina Companion Guide for applicable codes.	STC	Claim Level Status Information	STC01-	Entity Identifier Code
Status Date*	Claim Header Level Only	STC	Claim Level Status Information	STC02	Status Information Effective Date
Status Action Code*	U - Reject WQ - Accept	STC	Claim Level Status Information	STC03	Status Information Action Code

Claim Charge Amount*	Sum of the charges (CLM02) submitted from original claim. If an original claim is split, report the original claim total here. Note that this amount may be reported in two or more claims.	STC	Claim Level Status Information	STC04	Total Claim Charge Amount
Status Message*	Free form message text. Provides additional information related to status information	STC	Service Line Status Information	STC12	Free Form Message Text
* multiple rows per claim may be returned					

- **277CA Sample Excel File** – sample file with mocked data

Summary Tab

Interchange Sender ID	MHXX12345
Interchange Receiver ID	VNXX98765
837 Receipt Date	20140425
837 Process Date	20140425
Information Source Name	Molina Healthcare
Receiver Last or Organization Name	Vendor XX
Receiver First Name	
Receiver Middle Name	
Receiver Primary ID	12345RCV
Claim Transaction Batch Number	000000012
File Total Claims Submitted Amount	25421.29
File Total Claims Accepted Amount	8944.66
File Total Claims Rejected Amount	16476.63
File Total Claims Submitted Quantity	36
File Total Claims Accepted Quantity	16
File Total Claims Rejected Quantity	20

Details Tab

Billing Prov First Name	Billing Prov ID Type	Billing Prov ID	Billing Prov	Billing Prov	Billing Prov Total Claims	Billing Prov Total Claim	Billing Prov Total Claims	Patient Last Name	Patient First Name	Patient Middle Name	Patient Name Suffix	Patient ID Number	Patient Control Number	Payer Claim Control Number	Clearinghouse Trace Number	Bill Type ID	Service Start Date (Header)	Service End Date (Header)	Procedure Code	Procedure Modifier 1
	XX	1000000000	0	8	10039.00	0.00	10039.00	PatLast1	PatFirst 1			PatID 1	Control1	Claim1	10000000		20131130	20131130		
	XX	1000000000	0	8	10039.00	0.00	10039.00	PatLast2	PatFirst 2	M2		PatID 2	Control2	Claim2	10000001		20130531	20130531		
	XX	1000000000	0	8	10039.00	0.00	10039.00	PatLast3	PatFirst 3			PatID 3	Control3	Claim3	10000002		20130328	20130328		
	XX	1000000000	0	8	10039.00	0.00	10039.00	PatLast4	PatFirst 4			PatID 4	Control4	Claim4	10000003		20130919	20130919		
	XX	1000000000	0	8	10039.00	0.00	10039.00	PatLast5	PatFirst 5			PatID 5	Control5	Claim5	10000004		20131201	20131201		
	XX	1000000000	0	8	10039.00	0.00	10039.00	PatLast6	PatFirst 6	M6		PatID 6	Control6	Claim6	10000005		20130814	20130814		
	XX	1000000000	0	8	10039.00	0.00	10039.00	PatLast7	PatFirst 7			PatID 7	Control7	Claim7	10000006		20130901	20130901		
	XX	1000000000	0	8	10039.00	0.00	10039.00	PatLast8	PatFirst 8			PatID 8	Control8	Claim8	10000007		20130412	20130412		
	XX	2222222222	1	0	486.00	486.00	0.00	PatLast9	PatFirst 9			PatID 9	Control9	Claim9	10000008		20140310	20140310		
	XX	3333333333	0	1	790.50	0.00	790.50	PatLast10	PatFirst 10			PatID10	Control10	Claim10	10000009		20131119	20131119		
	XX	4444444444	0	3	564.00	0.00	564.00	PatLast11	PatFirst 11			PatID 11	Control11	Claim11	10000010		20131126	20131126		
	XX	4444444444	0	3	564.00	0.00	564.00	PatLast11	PatFirst 11			PatID 11	Control12	Claim12	10000011		20131221	20131221		
	XX	4444444444	0	3	564.00	0.00	564.00	PatLast11	PatFirst 11			PatID 11	Control13	Claim13	10000012		20131229	20131229		
	XX	5555555555	1	0	6429.00	6429.00	0.00	PatLast12	PatFirst 12			PatID 12	Control14	Claim14	10000013		20130520	20130617		
	XX	6666666666	0	3	1022.00	0.00	1022.00	PatLast13	PatFirst 13			PatID 13	Control15	Claim15	10000014		20140205	20140205		
	XX	6666666666	0	3	1022.00	0.00	1022.00	PatLast13	PatFirst 13			PatID 13	Control16	Claim16	10000015		20140205	20140205		
	XX	6666666666	0	3	1022.00	0.00	1022.00	PatLast14	PatFirst 14			PatID 14	Control17	Claim17	10000016		20140212	20140219		
	XX	6666666666	0	3	1022.00	0.00	1022.00	PatLast15	PatFirst 15			PatID 15	Control18	Claim18	10000017		20140209	20140209		
	XX	7777777777	0	3	3072.03	0.00	3072.03	PatLast16	PatFirst 16	M16		PatID 16	Control19	Claim19	10000018		20131119	20131119		
	XX	7777777777	0	3	3072.03	0.00	3072.03	PatLast17	PatFirst 17	M17		PatID 17	Control20	Claim20	10000019		20140227	20140227		
	XX	7777777777	0	3	3072.03	0.00	3072.03	PatLast17	PatFirst 17	M17		PatID 17	Control21	Claim21	10000020		20140304	20140304		
	XX	8888888888	0	1	861.50	0.00	861.50	PatLast18	PatFirst 18			PatID 18	Control22	Claim22	10000021		20130824	20130824		
	XX	9999999999	1	0	205.00	205.00	0.00	PatLast19	PatFirst 19	M19		PatID 19	Control23	Claim23	10000022		20130124	20130124		
	XX	1010101010	1	0	689.50	689.50	0.00	PatLast20	PatFirst 20	M20		PatID 20	Control24	Claim24	10000023		20140215	20140215		
	XX	1111111111	1	1	387.60	260.00	127.60	PatLast21	PatFirst 21			PatID 21	Control25	Claim25	10000024		20130821	20130821	A4216	
	XX	1111111111	1	1	387.60	260.00	127.60	PatLast21	PatFirst 21			PatID 21	Control26	Claim26	10000025		20130821	20130821		
	XX	1212121212	6	0	477.95	477.95	0.00	PatLast22	PatFirst 22			PatID 22	Control27	Claim27	10000026		20140128	20140128		
	XX	1212121212	6	0	477.95	477.95	0.00	PatLast22	PatFirst 22			PatID 22	Control28	Claim28	10000027		20140228	20140228		
	XX	1212121212	6	0	477.95	477.95	0.00	PatLast23	PatFirst 23			PatID 23	Control29	Claim29	10000028		20140112	20140112		
	XX	1212121212	6	0	477.95	477.95	0.00	PatLast24	PatFirst 24	M24		PatID 24	Control30	Claim30	10000029		20140221	20140221		
	XX	1212121212	6	0	477.95	477.95	0.00	PatLast25	PatFirst 25	M25		PatID 25	Control31	Claim31	10000030		20140128	20140128		
	XX	1212121212	6	0	477.95	477.95	0.00	PatLast25	PatFirst 25	M25		PatID 25	Control32	Claim32	10000031		20140228	20140228		
	XX	1992793269	5	0	397.21	397.21	0.00	PatLast26	PatFirst 26			PatID 26	Control33	Claim33	10000032		20131029	20131029		
	XX	1992793269	5	0	397.21	397.21	0.00	PatLast27	PatFirst 27	M27		PatID 27	Control34	Claim34	10000033		20131030	20131030		
	XX	1992793269	5	0	397.21	397.21	0.00	PatLast28	PatFirst 28	M28		PatID 28	Control35	Claim35	10000034		20130811	20130811		
	XX	1992793269	5	0	397.21	397.21	0.00	PatLast28	PatFirst 28	M28		PatID 28	Control36	Claim36	10000035		20130917	20130917		
	XX	1992793269	5	0	397.21	397.21	0.00	PatLast29	PatFirst 29	M29		PatID 29	Control37	Claim37	10000036		20140316	20140316		

8.1.5 Medicare Provider Type/Taxonomy Code Crosswalk- Encounters Only

The Medicare Provider Type/Specialty (Taxonomy Code) Crosswalk lists the standard loading for Medicare provider type, specialty taxonomy code, specialty, Medicare ID and contract name. If the table doesn't reflect a contract for a particular specialty it is either due to the fact that a more specific specialty needs to be assigned or a specific contract has not yet been configured.

8.1.6 Medicare HCPCS Modifier Exclusion Code List- Encounters Only

These HCPCS modifiers are excluded (not allowed) by Medicare for Encounters.

AZ	HK	HY	SN	TL	U5
FB	HL	HA	SQ	TM	U6
GZ	HM	PA	SS	TN	U7
H9	HN	PB	ST	TP	U8
HA	HO	PC	SU	TQ	U9
HB	HP	SA	SV	TR	UA
HC	HQ	SB	SY	TT	UB
HD	HR	SD	TD	TU	UC
HE	HS	SE	TE	TV	UD
HF	HT	SH	TF	TW	UF
HG	HU	SI	TG	U1	UG
HH	HV	SK	TH	U2	Uh
HI	HW	SL	TJ	U3	UJ
HJ	HX	SM	TK	U4	UK

8.1.7 Medicare HCPCS Code Exclusion List- Encounters Only

This is the listing of excluded Medicare HCPCS code for use on Medicare Encounters.

A0021	A4250	A6540	E0459	G0255	H0010	H0040	H2019	J8499	S0032
A0080	A4264	A6541	E0481	G0282	H0011	H0041	H2020	J8515	S0034
A0090	A4266	A6544	E0571	G0295	H0012	H0042	H2021	J8565	S0039
A0100	A4267	A6549	E0625	G0428	H0013	H0043	H2022	J9001	S0040
A0110	A4268	A9152	E0637	G9013	H0014	H0044	H2023	J9002	S0073
A0120	A4269	A9153	E0638	G9014	H0015	H0045	H2024	K0740	S0074
A0130	A4466	A9180	E0641	G9016	H0016	H0046	H2025	L2861	S0077
A0140	A4490	A9270	E0642	G9050	H0017	H0047	H2026	L3891	S0078
A0160	A4495	A9272	E0936	G9051	H0018	H0048	H2027	L8685	S0080
A0170	A4500	A9273	E0970	G9052	H0019	H0049	H2028	L8686	S0081
A0180	A4510	A9274	E1085	G9053	H0020	H0050	H2029	L8687	S0088
A0190	A4520	A9275	E1086	G9054	H0021	H1000	H2030	L8688	S0090
A0200	A4554	A9279	E1089	G9055	H0022	H1001	H2031	M0075	S0091
A0210	A4555	A9300	E1090	G9056	H0023	H1002	H2032	M0076	S0092
A0225	A4566	B4100	E1130	G9057	H0024	H1003	H2033	M0100	S0093
A0380	A4570	E0203	E1140	G9058	H0025	H1004	H2034	M0300	S0104
A0382	A4575	E0231	E1250	G9059	H0026	H1005	H2035	M0301	S0106
A0384	A4580	E0232	E1260	G9060	H0027	H1010	H2036	P2031	S0108
A0390	A4590	E0240	E1285	G9061	H0028	H1011	H2037	P7001	S0109
A0392	A4627	E0241	E1290	G9062	H0029	H2000	J1680	Q0144	S0117
A0394	A4670	E0242	E1300	G9147	H0030	H2001	J1825	Q3026	S0119
A0396	A6000	E0243	E1358	H0001	H0031	H2010	J1826	Q3028	S0122
A0398	A6530	E0244	E2230	H0002	H0032	H2011	J3487	S0012	S0126
A0420	A6533	E0245	E8000	H0003	H0033	H2012	J3488	S0014	S0128
A0422	A6534	E0270	E8001	H0004	H0034	H2013	J3520	S0017	S0132
A0424	A6535	E0273	E8002	H0005	H0035	H2014	J3535	S0020	S0136
A0888	A6536	E0274	G0122	H0006	H0036	H2015	J3570	S0021	S0137
A0998	A6537	E0315	G0219	H0007	H0037	H2016	J7184	S0023	S0138
A4210	A6538	E0446	G0235	H0008	H0038	H2017	J7306	S0028	S0139
S0142	S0196	S0342	S0625	S2112	S2350	S3722	S3855	S4035	S5121
S0145	S0197	S0353	S0630	S2115	S2351	S3800	S3860	S4037	S5125
S0146	S0199	S0354	S0800	S2117	S2360	S3818	S3861	S4040	S5126
S0148	S0201	S0390	S0810	S2118	S2361	S3819	S3862	S4042	S5130
S0155	S0207	S0395	S0812	S2120	S2400	S3820	S3865	S4981	S5131
S0156	S0208	S0400	S1001	S2140	S2401	S3822	S3866	S4989	S5135
S0157	S0209	S0500	S1002	S2142	S2402	S3823	S3870	S4990	S5136
S0160	S0215	S0504	S1015	S2150	S2403	S3828	S3890	S4991	S5140
S0161	S0220	S0506	S1016	S2152	S2404	S3829	S3900	S4993	S5141
S0164	S0221	S0508	S1030	S2202	S2405	S3830	S3902	S4995	S5145
S0166	S0250	S0510	S1031	S2205	S2409	S3831	S3904	S5000	S5146
S0169	S0255	S0512	S1040	S2206	S2411	S3833	S3905	S5001	S5150
S0170	S0257	S0514	S1090	S2207	S2900	S3834	S4005	S5010	S5151
S0171	S0260	S0515	S2053	S2208	S3000	S3835	S4011	S5011	S5160
S0172	S0265	S0516	S2054	S2209	S3005	S3837	S4013	S5012	S5161
S0174	S0270	S0518	S2055	S2225	S3600	S3840	S4014	S5013	S5162
S0175	S0271	S0580	S2060	S2230	S3601	S3841	S4015	S5014	S5165
S0176	S0272	S0581	S2061	S2235	S3620	S3842	S4016	S5035	S5170
S0177	S0273	S0590	S2065	S2260	S3625	S3843	S4017	S5036	S5175
S0178	S0274	S0592	S2066	S2265	S3626	S3844	S4018	S5100	S5180
S0179	S0280	S0595	S2067	S2266	S3628	S3845	S4020	S5101	S5181
S0181	S0281	S0596	S2068	S2267	S3630	S3846	S4021	S5102	S5185
S0182	S0302	S0601	S2070	S2270	S3645	S3847	S4022	S5105	S5190
S0183	S0310	S0610	S2079	S2300	S3650	S3848	S4023	S5108	S5199
S0187	S0315	S0612	S2080	S2325	S3652	S3849	S4025	S5109	S5497
S0189	S0316	S0613	S2083	S2340	S3655	S3850	S4026	S5110	S5498
S0190	S0317	S0618	S2095	S2341	S3708	S3851	S4027	S5111	S5501

S0191	S0320	S0620	S2102	S2342	S3711	S3852	S4028	S5115	S5502
S0194	S0340	S0621	S2103	S2344	S3713	S3853	S4030	S5116	S5517
S5520	S8121	S8940	S9129	S9347	S9437	S9497	S9992	T1028	T2026
S5521	S8130	S8948	S9131	S9348	S9438	S9500	S9994	T1029	T2027
S5522	S8131	S8950	S9140	S9349	S9439	S9501	S9996	T1030	T2028
S5523	S8185	S8990	S9141	S9351	S9441	S9502	S9999	T1031	T2029
S5550	S8186	S8999	S9145	S9353	S9442	S9503	T1000	T1502	T2030
S5551	S8189	S9001	S9150	S9355	S9443	S9504	T1001	T1503	T2031
S5552	S8210	S9007	S9152	S9357	S9444	S9529	T1002	T1505	T2032
S5553	S8262	S9015	S9208	S9359	S9445	S9537	T1003	T1999	T2033
S5560	S8265	S9024	S9209	S9361	S9446	S9538	T1004	T2001	T2034
S5561	S8270	S9025	S9211	S9363	S9447	S9542	T1005	T2002	T2035
S5565	S8301	S9034	S9212	S9364	S9449	S9558	T1006	T2003	T2036
S5566	S8415	S9055	S9213	S9365	S9451	S9559	T1007	T2004	T2037
S5570	S8420	S9056	S9214	S9366	S9452	S9560	T1009	T2005	T2038
S5571	S8421	S9061	S9325	S9367	S9453	S9562	T1010	T2007	T2039
S8030	S8422	S9075	S9326	S9368	S9454	S9590	T1012	T2010	T2040
S8035	S8423	S9083	S9327	S9370	S9455	S9810	T1013	T2011	T2041
S8037	S8424	S9088	S9328	S9372	S9460	S9900	T1014	T2012	T2042
S8040	S8425	S9090	S9329	S9373	S9465	S9960	T1015	T2013	T2043
S8042	S8426	S9097	S9330	S9374	S9470	S9961	T1016	T2014	T2044
S8049	S8427	S9098	S9331	S9375	S9472	S9970	T1017	T2015	T2045
S8055	S8428	S9109	S9335	S9376	S9473	S9975	T1018	T2016	T2046
S8080	S8429	S9110	S9336	S9377	S9474	S9976	T1019	T2017	T2048
S8085	S8430	S9117	S9338	S9379	S9475	S9977	T1020	T2018	T2049
S8092	S8431	S9122	S9339	S9381	S9476	S9981	T1021	T2019	T2101
S8096	S8450	S9123	S9340	S9401	S9480	S9982	T1022	T2020	T4521
S8097	S8451	S9124	S9341	S9430	S9482	S9986	T1023	T2021	T4522
S8100	S8452	S9125	S9342	S9433	S9484	S9988	T1024	T2022	T4523
S8101	S8460	S9126	S9343	S9434	S9485	S9989	T1025	T2023	T4524
S8110	S8490	S9127	S9345	S9435	S9490	S9990	T1026	T2024	T4525
S8120	S8930	S9128	S9346	S9436	S9494	S9991	T1027	T2025	T4526
T4532	T4533	T4534	T4535	T4536	T4537	T4538	T4539	T4540	T4541
T4542	T4543	T4544	T5001	T5999	V2025	V2702	V5008		

8.1.8 Medicare Revenue Code Listing- Encounters Only

List of valid Medicare Revenue Codes that are allowed by Medicare.

Revenue Code
278
302
304
310
311
312
314
319
320
321
322
323
324
329
333
340
341
342
349
370
371
372
374
379
450
451
456
459
460
469
480
481
482
483
510
511
512
513
514
515

516
517
519
530
636
730
731
732
739
740
741
771
880
881
900
901
903
909
914
915
916
917
918
920
922
924
940
943

8.1.1 Wisconsin Atypical Service Code Exclusion List- Encounters Only

The below table lists the Wisconsin Atypical service code exclusion codes below:

Service Code	Service Code	Service Code	Service Code	Service Code
T1019	99509	A4310	A4311	A4312
A4314	A4315	A4320	A4322	A4326
A4328	A4331	A4333	A4338	A4340
A4344	A4349	A4351	A4352	A4357
A4358	A4402	A5112	A5120	T4521
T4522	T4523	T4529	T4531	T4532
T4536	99499	G9002	A0090	A0120
A0130	A0170	S0209	S0215	T2001
T2003	T2005	T2049		

8.1.2 Molina Paid Amounts Examples-Encounters Only

Vendor Only

```
NM1*85*1*BILL LAST*BILL FIRST****XX*1012131415~
N3*121314 SOME STREET~
N4*SOME CITY*CA*900001234~
REF*EI*987654321~
HL*2*1*22*0~
SBR*P*18**INS NAME*****HM~
NM1*IL*1*LNAME*SUBSCRIBE****MI*1234567890~
N3*123 ANOTHER DR~
N4*ANOTHER CITY*CA*900011234~
DMG*D8*19900202*F~
NM1*PR*2*MOLINA SUBMITTER*****PI*MOLINASUBID~
CLM*1234567000765*140.06***22:B:1*N*A*Y*Y*P~
HI*BK:47819*BF:7380*BF:7540~
SBR*S*G8*******ZZ~
AMT*D*140.06~
OI***Y***Y~
NM1*IL*1*LNAME*SUBSCRIBE****MI*1234567890~
N3*123 ANOTHER DR~
N4*ANOTHER CITY*CA*900011234~
NM1*PR*2*MOLINA SUBMITTER*****PI*MOLINASUBID~
DTP*573*D8*20140122~
LX*1~
SV1*HC:30465*140.06*UN*1*22**1~
DTP*472*D8*20130801~
SVD*MOLINASUBID*140.06*HC:30465**1~
DTP*573*D8*20140122~
```

Vendor and Other Insurance

```
NM1*85*1*BILL LAST*BILL FIRST****XX*1012131415~
N3*121314 SOME STREET~
N4*SOME CITY*CA*900001234~
REF*EI*987654321~
HL*2*1*22*0~
SBR*P*18**INS NAME*****HM~
NM1*IL*1*LNAME*SUBSCRIBE****MI*1234567890~
N3*123 ANOTHER DR~
N4*ANOTHER CITY*CA*900011234~
DMG*D8*19900202*F~
NM1*PR*2*MOLINA SUBMITTER*****PI*MOLINASUBID~
CLM*1234567000765*214.56***22:B:1*N*A*Y*Y*P~
HI*BK:47819*BF:7380*BF:7540~
SBR*S*G8*******ZZ~
AMT*D*140.06~
OI***Y***Y~
NM1*IL*1*LNAME*SUBSCRIBE****MI*1234567890~
N3*123 ANOTHER DR~
N4*ANOTHER CITY*CA*900011234~
NM1*PR*2*MOLINA SUBMITTER*****PI*MOLINASUBID~
DTP*573*D8*20140122~
SBR*T*18*ABC1234567890******HM~
AMT*D*74.5~
OI***Y***Y~
NM1*IL*1*LNAME*SUBSCRIBE****MI*1234567890~
N3*121314 SOME STREET~
N4*SOME CITY*CA*900001234~
NM1*PR*2*PAYER Y*****PI*PAYERYID~
DTP*573*D8*20140122~
LX*1~
SV1*HC:30465*140.06*UN*2***1~
DTP*472*D8*20130801~
SVD*MOLINASUBID*120.06*HC:30465**1~
CAS*CO*45*20~
DTP*573*D8*20140122~
SVD*PAYERYID*20*HC:88342:26**1~
CAS*CO*45*120.06~
DTP*573*D8*20140112~
LX*2~
SV1*HC:88342:26*74.5*UN*2***1~
DTP*472*D8*20130801~
SVD*MOLINASUBID*20*HC:30465**1~
CAS*CO*45*54.5~
DTP*573*D8*20140122~
SVD*PAYERYID*54.5*HC:88342:26**1~
CAS*CO*45*20~
DTP*573*D8*20140112~
```

8.1.3 Example IL Transportation 837P Encounter

Below is an example of an IL 837P Transportation Encounter. The highlighted fields show the necessary IL Transportation 837P requirements.

```
HL*377*360*22*0~
PRV*BI*PXC*343900000X~
SBR*P*18*BPL00000000168******MC~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*123456789~
N3*111 TEST AVE~
N4*BLOOMINGTON*IL*61701~
DMG*D8*19561212*M~
NM1*PR*2*ILLINOIS MEDICAID*****PI*37-1320188~
N3*1 W OLD STATE CAPITOL PLZ~
N4*SPRINGFIELD*IL*62701~
CLM*12345678901*224.5***41:B:1*Y*A*Y*Y*P~
DTP*050*D8*20170101~
AMT*F5*224.5~
NTE*ADD*TR,IL,27056LY,0945,1027;~
CR1****A*DH*9~
HI*BK:7999~
NM1*PW*2~
N3*202 W LOCUST ST~
N4*BLOOMINGTON*IL*61701~
NM1*45*2~
N3*1302 FRANKLIN AVE~
N4*NORMAL*IL*61761~
LX*1~
SV1*HC:A0120:RD*224.5*UN*1***1********0~
DTP*472*D8*20140527~
DTP*573*D8*20170102~
REF*6R*14356936527001~
HCP*02*224.5~
```

9 ASCX12 835 Remittance Advice

CONTROL SEGMENTS/ENVELOPE REQUIREMENTS

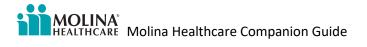| Loop	Segment	Data Element	Comments
	ISA – Interchange Control Header	ISA01 -- Authorization Information Qualifier	"00"
		ISA02 – Authorization Information	Space Fill
		ISA03 – Security Information Qualifier	"00"
		ISA04 – Security Information	Space Fill
		ISA05 – Interchange ID Qualifier	"ZZ"
		ISA06 – Interchange Sender ID	See **Molina Sender ID's by State**
		ISA07 – Interchange ID Qualifier	"ZZ"
		ISA08 – Interchange Receiver ID	The Sender ID is assigned by Molina for direct submitters. Please contact Molina if you have not obtained your Submitter Trading Partner ID. All others -- contact your Clearinghouse for this information.
		ISA11 Repetition Separator	Use '^'
		ISA12 -- Interchange Control Version Number	"00501"
		ISA13 – Interchange Control Number	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.
		ISA14 – Acknowledgment Requested	Recommended value -- "0" Molina does not support the transmission of TA1, regardless of the value submitted.
		ISA16- Repetition Separator	Use ':'
	GS Functional Group Header	GS02 -- Application Sender's Code	See **Molina Sender ID's by State**
		GS03 -- Application Receiver's Code	The Sender ID is assigned by Molina for direct submitters. Please contact

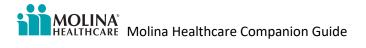| Loop	Segment	Data Element	Comments
			Molina if you have not obtained your Submitter Trading Partner ID. All others -- contact your Clearinghouse for this information.

10 ASCX12 834 BENEFIT ENROLLMENT

CONTROL SEGMENTS/ENVELOPES REQUIREMENTS - 834

Loop	Segment	Data Element	Comments
	ISA – Interchange Control Header	ISA01 -- Authorization Information Qualifier	"00"
		ISA02 – Authorization Information	Space Fill
		ISA03 – Security Information Qualifier	"00"
		ISA04 – Security Information	Space Fill
		ISA05 – Interchange ID Qualifier	"ZZ"
		ISA06 – Interchange Sender ID	See **Molina Sender ID's by State**
		ISA07 – Interchange ID Qualifier	"ZZ"
		ISA08 – Interchange Receiver ID	The Sender ID is assigned by Molina for direct submitters. Please contact Molina if you have not obtained your Submitter Trading Partner ID. All others -- contact your Clearinghouse for this information.
		ISA11 Repetition Separator	Use '>'
		ISA12 -- Interchange Control Version Number	"00501"
		ISA13 – Interchange Control Number	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.
		ISA14 – Acknowledgment Requested	Recommended value -- "0" Molina does not support the transmission of TA1, regardless of the value submitted.
		ISA16 Repetition Separator	Use '^'
	GS Functional Group Header	GS02 -- Application Sender's Code	See **Molina Sender ID's by State**

Loop	Segment	Data Element	Comments
		GS03 -- Application Receiver's Code	The Sender ID is assigned by Molina for direct submitters. Please contact Molina if you have not obtained your Submitter Trading Partner ID. All others -- contact your Clearinghouse for this information.
		BGN 06 – Beginning Segment	Blank space is sent. We have blanked out this value to comply with the 5010 HIPAA compliance.
2310	NM1	08 – Identification Code Qualifier	The provider name is passed in NM103, NM104, and NM105. If the provider name is not available, then the NPI is sent in NM108 and NM109. We have modified this to adhere to the 5010 HIPAA compliance.
	INS	08 (Employment Status code)	Pass the value "AC" We have modified this to adhere to the 5010 HIPAA compliance.
1000B	N1	04	"000000000" We have modified this to adhere to the 5010 HIPAA compliance.
1000C	N1	04	"000000000" We have modified this to adhere to the 5010 HIPAA compliance.
2000	DTP		The member level dates are not sent. The health coverage dates are passed in the loop 2300 DTP. We have modified this to adhere to the 5010 HIPAA compliance.

Loop	Segment	Data Element	Comments
2100C	N3,N4		2100C address fields will be populated only if they are different from 2100A address fields. We have modified this to adhere to the 5010 HIPAA compliance.
2100A	N3,N4		2100C address fields will be populated only if they are different from 2100A address fields. We have modified this to adhere to the 5010 HIPAA compliance.
2300	DTP		The member level dates are not sent. The health coverage dates are passed in the loop 2300 DTP. We have modified this to adhere to the 5010 HIPAA compliance.
All	N4	03 (Postal Code)	The zip code will be either 5 or 9. It is handled in the SP to display valid zip codes. We have modified this to adhere to the 5010 HIPAA compliance.

834-RESTRICTIONS/LIMITATIONS

- **File Size:** *NA.*
- **Character Set:** *Molina supports the Basic Character Set/Extended Character set in the file.*
- **Acknowledgement:** *NA*
- **Attachment:** *Molina Healthcare does not support attachments at this time.*
- **Functional Group Header and Trailer:** *Only "1" GS Functional Group Header and GE Functional Group Trailer can be accepted per file.*

11 ASCX12 277CA HEALTHCARE CLAIM ACKNOWLEDGMENT

CONTROL SEGMENTS/ENVELOPES REQUIREMENTS (277CA)

Loop	Segment	Data Element	Comments
	ISA – Interchange Control Header	ISA01 -- Authorization Information Qualifier	"00"
		ISA02 – Authorization Information	Space Fill
		ISA03 – Security Information Qualifier	"00"
		ISA04 – Security Information	Space Fill
		ISA05 – Interchange ID Qualifier	"ZZ"
		ISA06 – Interchange Sender ID	See **Molina Sender ID's by State**
		ISA07 – Interchange ID Qualifier	"ZZ"
		ISA08 – Interchange Receiver ID	The Sender ID is assigned by Molina for direct submitters. Please contact Molina if you have not obtained your Submitter Trading Partner ID. All others -- contact your Clearinghouse for this information.
		ISA11 -- Interchange Control Standards Identifier Repetition Separator	Use '^'
		ISA12 -- Interchange Control Version Number	"00501"
		ISA13 – Interchange Control Number	This Number must be unique and 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.
		ISA14 – Acknowledgment Requested	Recommended value -- "0" Molina does not support the transmission of TA1, regardless of the value submitted.
	GS -- Functional Group Header	GS02 -- Application Sender's Code	**Molina Sender ID's by State**

Loop	Segment	Data Element	Comments
		GS03 -- Application Receiver's Code	The Sender ID is assigned by Molina for direct submitters. Please contact Molina if you have not obtained your Submitter Trading Partner ID.

All others -- contact your Clearinghouse for this information. |

11.1 277CA Special Information – Encounters Only

1. 277CA will be generated for each HIPAA compliant 837 file received
2. Multiple 277CA files may be generated per 837 file received
   - Daily process will generate a 277CA file for each received 837 file which contains encounters that are in finalized status (not pend status)
   - Weekly process will generate a 277CA file for each received 837 file which contains encounters that were in pend status during daily process and have now been finalized
3. Encounters for newborn members that are not identified in Molina system will not be reported in 277CA file. The total quantities and amounts will exclude these encounters.
4. Billing Provider Level
   - Only Billing Provider errors will be reported at Billing Provider Level
   - Patient Segments are not suppressed when Billing Provider errors occur
5. Billing provider/Claim/Service Line errors will be reported at Claim level
6. Reconciliation can be performed using the Claim Level (Recommendation)
7. Service Line information will only be reported for denied service lines

11.1.1 277CA Error Codes List –Encounters Only

See **277CA Error Code List- For Encounters Only**

11.2 277CA Claim Status Category Codes

Claim Category codes indicate the general category of the status (accepted, rejected, additional information requested, etc.) which is then further detailed in the Claim Status Codes.

Please check below link for complete set:
http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/

Molina 277CA Claim Status Category Codes	
Category Code	**Description**
A1	Acknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.
A2	Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system

Molina 277CA Claim Status Category Codes	
Category Code	Description
A3	Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system
A6	Acknowledgement/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected.
A7	Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected.

12 ASCX12 999 IMPLEMENTATION ACKNOWLEDGEMENT

CONTROL SEGMENTS/ENVELOPES REQUIREMENTS

Loop	Segment	Data Element	Comments
	ISA – Interchange Control Header	ISA01 -- Authorization Information Qualifier	"00"
		ISA02 – Authorization Information	Space Fill
		ISA03 – Security Information Qualifier	"00"
		ISA04 – Security Information	Space Fill
		ISA05 – Interchange ID Qualifier	"ZZ"
		ISA06 – Interchange Sender ID	See **Molina Sender ID's by State**
		ISA07 – Interchange ID Qualifier	"ZZ"
		ISA08 – Interchange Receiver ID	The Sender ID is assigned by Molina for direct submitters. Please contact Molina if you have not obtained your Submitter Trading Partner ID. All others -- contact your Clearinghouse for this information.
		ISA11 -- Interchange Control Standards Identifier Repetition Separator	Use '^'
		ISA12 -- Interchange Control Version Number	"00501"
		ISA13 – Interchange Control Number	This Number must be unique and 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.
		ISA14 – Acknowledgment Requested	Recommended value -- "0" Molina does not support the transmission of TA1, regardless of the value submitted.
	GS -- Functional Group Header	GS02 -- Application Sender's Code	See **Molina Sender ID's by State**

Loop	Segment	Data Element	Comments
		GS03 -- Application Receiver's Code	The Sender ID is assigned by Molina for direct submitters. Please contact Molina if you have not obtained your Submitter Trading Partner ID. All others -- contact your Clearinghouse for this information.

13 Frequently Asked Questions

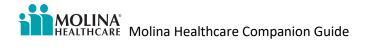For a list of our most frequently asked questions, please visit the FAQ Page on the Molina Healthcare website.

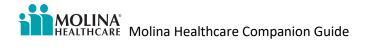## 14 Appendix

14.1 OAC Rule: http://codes.ohio.gov/oac/5160-15-23v1

15 Companion Guide Change Summary

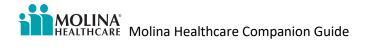This table shows the list of revisions and changes made to the Companion Guide.

Document Version #	Author-Dept.	Date of Change	Change Description
1.23	Naren Hoskere MHI IT Encounters	03/30/2021	**Addition** ➢ For IL only "L" = Pharmacy (7.8.1)
1.22	Cognizant – MHI IT Encounters	02/19/2020	**Additions** ➢ Duplicate Encounter Validation (Marketplace Only & All State Except IL ,PR) (7.11.2) **Updates** ➢ Updated 277CA Error Codes – Section 8.1.2
1.21	Fred Boyle – MHI IT Encounters		**Additions** ➢ **Out of Network Exception to TX MPF Validation (7.1.3).** ➢ **Financial Arrangement Code (7.9).**
1.20	Fred Boyle – MHI IT Encounters	3/28/2019	**Additions** ➢ Transportation requirements for All-states. (7.8.1). ➢ MS and ID requirements. ➢ FL CPT Code for public transportation used. (7.8.3). **Updates** ➢ Transportation requirements for IL and OH modified for their edits (7.8.2).
1.19	Fred Boyle – MHI IT Encounters	8/15/2018	**Updates** ➢ Retained CA Duplicate Logic as was shown in version 1.16. This effected section 7.11.1 and its sub-sections. ➢ Additional page formatting.
1.18	Fred Boyle – MHI IT Encounters	6/1/2018	**Additions** ➢ State of New York o Section 7.1.2 – Added requirement for PACDR 837D. REF*F8 will be reported in 2330B loop. Not available in 2300 loop, o Section 5.3 – Molina receiver Id for NY. o Section 5.4 – Molina sender Id for NY. **Updates** ➢ Updated 277CA Error Codes – Section 11.1.1 ➢ General page formatting.
1.17	Fred Boyle- MHI IT Encounters	12/15/2017	*Additions* ➢ *Added logic for COB Encounters with rules and sample 5010 record. Section 7.4 added – sections renumbered going forward.* ➢ *Added clarification for DTP*050 (repricer) segment Section 7.1 added – sections renumbered going forward.* ➢ *Duplicate logic for Dental Encounters – All States. Added criteria to determine duplicate encounter – section 7.11.1.3* ➢ *Added Idaho Receiver Ids in section 5.3.* *Updates* ➢ *Ohio transportation logic. Section 7.8 modified.* ➢ *Section 7.5 DTP Element updated to read Claim Check or Remittance Date.*
1.16	Jarica Smith-MHI IT Encounters	8/1/17	*Additions* ➢ *Added Duplicate logic for the state of CA Encounters.* ➢ *Added WI to the list of states that Molina will accept Vendor Denied Encounters.* *Updates* ➢ *Updated the Medicare encounters revenue Code list to include all Revenue Codes allowed by CMS- Medicare.* ➢ *Updated IL-Transportation Encounters that Molina will reject when SV1*UN field is greater than 1 and two sets of location modifiers was*

Document Version #	Author-Dept.	Date of Change	Change Description
1.15	Jarica Smith-MHI IT Encounters	4/19/17	*not submitted.* ➢ *Medicare encounters verbiage updated to ensure that if any valid Medicare Revenue code as shown in the Medicare Revenue code list is billed, then a Medicare HCPCS code is also required to be billed.* ➢ *Corrected the Medicare Encounters Modifier List to show those excluded (not allowed) by Medicare.* ➢ *Updated Encounter Duplicate logic for CMS Medicare and Dual Members.*
1.14	Jarica Smith-MHI IT Encounters	11/1/2016	*Additions* ➢ *IL Transportation-Added "I" as a valid 2 digit proc code modifier.* ➢ *IL Transportation-Added note that IL does not accept "II", "RR", "SS", and "XX" as valid 2 digit proc code modifier combinations.* ➢ *Added IL and UT as approved states for Vendor Denied Encounters.* ➢ *Added 277CA Excel Mapping/Sample 277CA File.* *Updates* ➢ *Removed 'S' as procedure code modifier for Non-Emergency Transportation Encounters and added 'G' and 'J'.* ➢ *Removed 2 taxonomies listed from loop 2000A PRV for IL Transportation Encounters.* ➢ *Updated 277CA Encounters Error Code List.* ➢ *Updated IL Transportation Encounters-Updated NTE segment that the Origin Time and Destination Time must be different and should not match.* ➢ *Updated the IL Transportation Providers Encounter 837P Example.* ➢ *Updated Medicare Provider- Encounters Special Requirements section hyperlinks.* ➢ *Updated Molina Companion Guide Table of Contents, version number, revision date, and headers throughout the document.*
1.13	Jarica Smith-MHI IT Encounters	07/19/2016	*Additions* ➢ *IL Transportation Providers-Added 2400 SV105-Place of Service Code must be 41, 42, or 99 (Situational if information is different than Place of Service carried in 2300 CLM05-1)* ➢ *Added Frequency Code Guidelines to include a Frequency Code Table under Encounter Resubmission.* ➢ *Removed Patient Control Number (Patient Account Number) from Encounter Duplicate Check Validation requirement* *Updates* ➢ *Updated 277 CA Error Code List to the most recent error codes list.* Additions ➢ IL Transportation Encounters-Added Facility Location Pickup Address 2310E or 2420G (Situational) which is required for IL Transportation (including a valid US 2 digit state code, city [up to 30 characters], and zip code with 5 or 9 numerics). ➢ IL Transportation Encounters -Added Facility Location Drop Off Address in Loop 2310F or 2420H (Situational) which is required for IL Transportation providers (including a valid US 2 digit state code, city [up to 30 characters], and zip code with 5 or 9 numerics). ➢ IL Transportation Encounters -Added 2 digit Procedure Code Modifier as required for IL Transportation Providers in Loop 2400 SV101-3

Document Version #	Author-Dept.	Date of Change	Change Description
1.12	Jarica Smith-MHI IT Encounters	05/27/2016	through SV101-6. ➤ IL Transportation Encounters -Added IL Transportation Provider Example using a hyperlink. ➤ IL Transportation Encounters: Added 2300 HI segment to ensure valid ICD9 or ICD10 transportation diagnosis codes are entered (listed default ICD-9 and ICD10 codes if there is no known Diagnosis). ➤ IL Transportation Encounters: Added CR105-CR106 for mileage at Header and/or Line Level (If different than header level) ➤ IL-Transportation Encounters -Added 2000A PRV03 to require the Taxonomy Code and listed the acceptable taxonomies for transportation. *Updates* ➤ Updated the Medicare Provider Specialty Code (Taxonomy) Crosswalk using the latest link as a hyperlink within the document instead of a table. ➤ Duplicate Encounter Validation - changed historical check for original from 27 months to 36 months ➤ Updated Table of Contents, Headings, and Section numbers to reflect latest changes.
1.11	Jarica Smith-MHI IT Encounters	10/23/2015	*Additions* ➤ Added Preface, Introduction, Getting Started, Connectivity/Testing/, Other Important Links, and FAQ section per the CAQH Core Master Provider Template. *Updates* ➤ Corrected typo in 837 Encounters requirements for the Billing Provider N3 segment to reflect 2010AA instead of 2010AB Loop. ➤ Corrected IL Transportation Encounter Edits SV105-Place of service codes as 41, 42, 99. ➤ Updated IL Transportation Encounter Edits to include requirements for 2 character valid US state code, state license #, and valid Origin and Destination Time in 24 hr valid format HHMM. ➤ Updated the Molina Companion Guide font and formatting using the CAQH Core Master Companion Guide Template. ➤ Updated section numbers & table of contents ➤ Corrected section Submitting a Reversal Encounter Only to include the Original Paid Date and Original Paid Amount ➤ Corrected Vendor Denied Examples to include element delimiter for CAS04. ➤ Revised 277 Error code lists to include latest updates ➤ Moved Companion Guide change summary to the end of the document. *Additions* ➤ *Added 277CA Errror codes list to include:* ➤ Invalid Ordering Provider NPI ➤ Invalid Referring Provider NPI ➤ Patient age is greater than 18 for Pediatric Dental MarketPlace Program *Updates* ➤ Table of Contents updated for the Molina Companion Guide & section numbers have been updated from previous version. ➤ 3.1.6 Header Level Paid Amounts and Other Insurance–Loop 2330A and 2330B ➤ 3.1.9 Transportation Providers-IL *Additions*

Document Version #	Author-Dept.	Date of Change	Change Description

1.10	Nicole Dotson-MHI IT Encounters	04/29/2015	➢ 3.1.8.1 Atypical Provider-California, Florida, Illinois, Michigan, New Mexico, Ohio, South Carolina, Texas, Utah, Medicare- Billing Provider Loop 2010A updated
			➢ 3.1.8.2 Atypical Provider-California, Florida, Illinois, Michigan, New Mexico, Ohio, South Carolina, Texas, Utah, Medicare-Rendering Provider Loop 2310B updated
			➢ 3.1.8.3 for Atypical Attending Provider –All States including Medicare
			➢ 8.5- 277 Claims Acknowledgement - Error Codes List
			➢ 3.2. Vendor Denied Encounters Information (TX/NM)
			➢ 8.2 Examples of Vendor Denied Encounters
			➢ 3.1.3 Medicare Special Requirements-837 Professional
			➢ 3.1.4 Medicare Special Requirements-837 Institutional
			
			Updates
			➢ 1.1 Versions Supported – Add 277CA and 999
			➢ 1.2 Contact Information - Add contact information for Encounters 277CA and 999
			➢ 1.7 Restrictions/Limitations - Update 837 Maximum file volume and ISA Usage indicator
			Additions
			➢ 1.3 Molina Receiver Ids - Consolidated repeated receiver id information in single location
			➢ 1.4 Molina Sender Ids - Consolidated repeated sender id information in single location
			➢ 3.1.1 Billing Provider Information
			➢ 3.1.2 Encounter Re-Submission Information for submission of reversals and adjustments
			➢ 3.1.5 Attending Provider Information
			➢ 3.1.6 Header Level Paid Amounts and Other Insurance
			➢ 3.1.7 Line Level Paid Amounts and Other Insurance
			➢ 3.1.8 Atypical Provider - California, Florida, Illinois, Michigan, New Mexico, Ohio, South Carolina, Texas, Utah, Medicare
			➢ 3.1.8.1 Atypical Provider - Washington
			➢ 3.1.8.2 Atypical Provider - Wisconsin
			➢ 3.1.9 Transportation – Illinois only - Illinois transportation NTE segment formatting
			➢ 3.1.10 Spinal Manipulation - Medicare only
			➢ 3.1.12 Duplicate Encounter Validation - Elements utilized in duplicate check
			➢ 6. ASCX12 277 Health Care Claim Acknowledgement - Add section and all sub-sections for encounters 277CA Control Segments, Envelope requirements and Encounter Error Codes
			➢ 7. ASCX12 999 Implementation Acknowledgement for Health Care Insurance - Add section and all sub-sections for encounters 999 Control Segments and Envelope requirements
			➢ 8. Additional Information
			    o 8.1 Add Encounter Re-submission Examples
			    o 8.3 Add Wisconsin Atypical Service Code Exclusion List
			    o 8.4 Add Molina Paid Amount Examples