

**FMMIS Batch Institutional Health
Care Claim and Encounter Claim
837I Companion Guide
004010 X096A1**

Version 1.3

March 1, 2008

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1 INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid and all other health insurance payers in the United States comply with the EDI standards for health care as established by the Secretary of Health Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N implementation guides. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Additional information on the *Final Rule for Standards for Electronic Transactions* can be found at <http://aspe.hhs.gov/admnsimp/final/txfin00.htm>. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

1.1 Purpose

The 837 Institutional transaction is used to submit health care claims and encounter data to a payer for payment. This transaction is the only acceptable format for electronic institutional claim submissions to the Agency for Health Care Administration (AHCA). The intent is to expedite the goal of achieving a totally electronic data interchange environment for health care encounter/claims processing, payment, corrections, and reversals. This transaction will support the submission of institutional claims and institutional encounters. The 837 Institutional transaction is the electronic correspondent to the paper UB04 claim forms; therefore, any claim types or encounter data submitted on the UB04 forms correlate to the 837 Institutional transaction, if data is submitted electronically.

All required segments within the 837 Institutional Transaction Set must always be sent by the submitted and received by the payer. Optional information will be sent when it is necessary for processing. Segments that are conditional are only sent when special criteria are met. Although required segments in the incoming transaction may not be used during claims processing, some of these data elements will be returned in other transaction such as the Unsolicited Claim Status (277 Transaction Set) and the Remittance Advice (835 Transaction Set).

1.2 Special Considerations for 837 Institutional Transaction

1. Subscriber, Insured: Recipient in the Florida Medicaid Eligibility Verification System:

The Florida Medicaid Eligibility Verification System does not allow for dependents to be enrolled under a primary subscriber, rather all enrollees/recipients are primary subscribers within each program or MCO (Managed Care Organization).

2. Provider Identification: Florida Medicaid ID or NPI:

The implementation date for National Provider Identifier (NPI) was May 23, 2007. The Agency for Health Care Administration has implemented the contingency plan for NPI and will continue to use the Florida Medicaid Provider Number until May 23, 2008.

Prior to May 23, 2008, if the Medicaid Provider Number is received in the 2010AA Billing Provider loop within the REF segment where REF01 equals 1D and the 2010AA NM1 segment where NM108 equals XX is not received, the claim will process correctly. If applicable the REF02, where REF01=1D can also be used within the 2010AB Pay-to-Provider, 2310A Attending Provider, 2310B Operating Provider, 2310C Other Provider, and/or 2310E Service Facility Provider loops.

Beginning May 23, 2008 for all health care providers, the Provider NPI, Taxonomy Code and Zip Code + 4 postal code must be received in the appropriate loops. The NPI will be sent in the NM109, where NM108 equals XX. The Taxonomy Code will be sent in the PRV03 and the Zip Code + 4 postal code will be sent in the N403 and N404.

For all non-healthcare providers where an NPI is not assigned, the claim must contain the Medicaid Provider Number within the appropriate loops within the REF segment where REF01 equals 1D.

Note: This information overrides the information documented in Section 3 for NM1 and REF segment provider number identification information.

3. Logical File Structure:

There can be only one interchange (ISE/IEA) per logical file. The interchange can contain multiple functional groups (GS/GE) however; the functional groups must be the same type.

4. Submitter:

Submissions by non-approved trading partners will be rejected.

5. Claims and Encounters:

Claims and encounters must be submitted in separate ISA/IEA envelopes.

6. Response/997 Functional Acknowledgement:

A response transaction will be returned to the trading partner that is present within the ISA06 data element.

The Agency for Health Care Administration will provide a 997 Functional Acknowledgment for all transactions that are received.

You will receive this acknowledgment within 48 hours unless there are unforeseen technical difficulties. If the transaction submitted was translated without errors for a request type transaction, i.e. 270 or 276, you will receive the appropriate response transaction generated from the request. If the transaction submitted was a claim transaction, i.e., 837, you will receive either the 835 or the unsolicited 277.

Note: The 835 and unsolicited are only provided weekly.

7. When NM108 = 24 or REF01=EI:

If the NM108 equals 24 (Employer Identification Number (EIN)) or the REF01 equals EI (EIN) within any loop, the value in the corresponding NM109 or REF02 must be in the format of XX-XXXXXXX.

Note: This format include the hyphen (-).

8. Claims Allowed per Transaction (ST/SE envelope):

The HIPAA implementation guide states on the CLM (Claim Information) segment that the developers recommend that trading partners limit the size of the transaction (ST/SE) envelope to a maximum of 5,000 CLM segments.

The Agency for Health Care Administration does not have a maximum for the number of claims per transaction (ST/SE envelope).

9. Document Level:

The Agency for Health Care Administration processes files at the claim level. It is possible based on where the error(s) occur within the hierarchical structure that some claims may pass compliance and others will fail compliance. Those claims that pass compliance will be processed within the Florida Medicaid Management Information System (FMMIS). Those claims that fail compliance will be reported on the 997.

10. Dependent Loop:

For the Agency for Health Care Administration, the subscriber is always the same as the patient (dependent). Claims containing data in the Patient Hierarchical Level (2000C loop) may not process correctly.

11. Compliance Checking:

Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. In addition to Level 4, Level 7 patient (dependent) level will occur if 2000C patient loop is received. All other levels will be validated within the FMMIS.

12. Identification of TPL:

Non-Medicare Payer (TPL) Paid Amount – The non-Medicare Paid Amount is the sum of the Payer Prior Payment Amounts (AMT01=C4) obtained from 2320 Loop(s) (Other Subscriber Information) per claim, where the payer is NOT Medicare (SBR09 (Claim Filing Indicator) does NOT equal MA (Medicare Part A), MB (Medicare Part B), 16 (HMO Medicare Risk), HM (HMO) or MC (Medicaid)).

Note: The 2320 loop can repeat multiple times per claim.

13. Processing for the 2300-HI Segment for the “Principal Procedure Information”:

The Agency for Health Care Administration will only use the value sent in the HI01-2, where HI01-1 equals BR in the Principal Procedure Information HI segment. If the value of BP is sent within the HI01-1, the value received in the HI01-2 will not be used for processing the claim.

Note: HIPAA allows the BP and/or BR qualifier values at the claim level within the HIxx-1 composite element, the HCPCS procedure code value would then be placed in the HIxx-2 composite element. For institutional claims, the Agency for Health Care Administration only

allows the HCPCS procedure code at the detail level within the 2400-SV202-2, where 2400-SV202-1 = “HC”. If the HCPCS procedure code is received within the HI segment, the claim will not fail compliance. However, the claim will not process correctly within the adjudication system.

14. Processing the 2300 HI Segment for the “Other Procedure Information”:

The Agency for Health Care Administration will only use the value sent in the HI01-2, where HI01-1 equals BQ in the Principal Procedure Information HI segment. If the value of BO is sent within the HI01-1, the value received in the HI01-2 will not be used for processing the claim.

Note: HIPAA allows the BQ and/or BO qualifier values at the claim level within the HIxx-1 composite element, the HCPCS procedure code value would then be placed in the HIxx-2 composite element. For institutional claims, the Agency for Health Care Administration only allows the HCPCS procedure code at the detail level within the 2400-SV202-2, where 2400-SV202-1 = “HC.” If the HCPCS procedure code is received within the HI segment, the claim will not fail compliance. However, the claim will not process correctly within the adjudication system.

15. National Drug Code (NDC):

The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. In order for the Agency for Health Care Administration to fully realize the drug rebate savings for claims billed, an NDC Code for the billed drug is required effective 01-01-2007.

2 TRANSMISSION AND DATA RETRIEVAL METHODS

EDS supports several types of data transport depending upon the trading partner’s need. Providers and their representatives can submit and receive data via: Web portal, Remote Access Server (RAS), and Value Added Network (VAN)/Switch Vendors for interactive transactions.

1. Web portal: Transaction files are uploaded/downloaded in the Trade Files menu on the secure Web portal.
2. Remote Access Server (RAS): This option is available to trading partners who do not have an existing Internet connection. The RAS server typically supports those who need a dial-up option. Once the RAS connection is established, transaction files are uploaded/downloaded in the Trade Files menu on the secure Web portal.
3. Value Added Networks (VANs) or Switch Vendors: VANs or Switch Vendors typically support interactive transactions through a dedicated connection to the fiscal agent. VANs sign a contract with the State and have unique, VAN specific communication arrangements with the fiscal agent. A list of approved vendors is listed on the fiscal agent Web site.

Detailed information to assist with EDI related processes are available on the Provider Public Web site at: <http://www.mymedicaid-florida.com>.

Information available includes:

1. Remote Access Server connectivity instructions for submitters without an existing Internet connection;
2. Trading Partner Testing Procedures (Ramp Manager) for all new trading partners, or trading partners adding a new transaction; and
3. Web Upload/Download instructions for submitters uploading/downloading via the secure Web portal.

File/System Specifications

EDI will only accept Windows\PC\DOS formatted files.

EDI will allow upload and download of zipped or compressed files.

Note: Only one X12 transaction file is permitted in each “zipped” file.

EDI does not require any specific file extensions. This includes acceptance of files without an extension.

The Web portal is designed to support the following Internet browsers:

1. Internet Explorer, version 6 or later;
2. Firefox, version 1.5 or later; and
3. Opera, version 8.5 or later.

3 Transmission Responses

For every transaction received, there is an expected response. The available responses are an Interchange Acknowledgement (TA1), a Functional Acknowledgement (997), and an Unsolicited Claim Status (277U).

Once a transaction is received, it will go through a ‘front end’ compliance check called a TA1. The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Once the transaction has passed the ‘front end’ compliance check it then goes through a syntax compliance edit. This edit is to verify the compliance within the ANSI X12 syntax according to the HIPAA Implementation Guides. The transaction will receive a Functional Acknowledgement (997) to provide feedback on the transaction. The 997 functional acknowledgement contains accepted or rejected information. If the transaction contains any syntactical errors, the segments and elements in which the error occurred will be reported in a rejected acknowledgement. If the transaction contains no syntactical errors, a positive 997 response will be generated and the transaction is passed on for processing.

4 EDI SUPPORT

The EDS EDI Unit is available to support trading partners and providers that exchange transactions electronically. Support functions include:

1. Enrollment processing for trading partners requesting to submit transactions electronically;
2. Installation assistance and submission support for Provider Electronic Solutions (PES) software;
3. Provide assistance to billing agents, clearinghouses and software vendors;
4. Identifying and troubleshooting technical issues;
5. Data Exchange help;

EDI staff is available Monday through Friday 8:00 a.m. to 5:00 p.m., EST by choosing option 3 when dialing:

1. Inside Florida: 1-800-289-7799;
2. Outside Florida: 1-800-955-7799; and
3. Local calls from Tallahassee area: 850-xxx-xxxx.

5 CONTROL SEGMENT DEFINITIONS FOR FLORIDA MEDICAID 837 INSTITUTIONAL TRANSACTION

X12N EDI Control Segments
ISA – Interchange Control Header Segment
IEA – Interchange Control Trailer Segment
GS – Functional Group Header Segment
GE – Functional Group Trailer Segment
ST – Transaction Set Header
SE – Transaction Set Trailer
TA1 – Interchange Acknowledgement

5.1 ISA - Interchange Control Header Segment

Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

837 Institutional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.3	N/A	ISA	ISA01 - Authorization Information Qualifier	'00' – No Authorization Information Present
B.3	N/A	ISA	ISA02 - Authorization Information	[space fill]
B.4	N/A	ISA	ISA03 - Security Information Qualifier	'00' – No Security Information Present
B.4	N/A	ISA	ISA04 - Security Information	[space fill]
B.4	N/A	ISA	ISA05 - Interchange ID Qualifier	'ZZ' – Mutually Defined
B.4	N/A	ISA	ISA06 - Interchange Sender ID	Trading Partner Supplied by Florida Medicaid, left justified space filled.
B.4	N/A	ISA	ISA07 - Interchange ID Qualifier	'ZZ' – Mutually Defined
B.5	N/A	ISA	ISA08 - Interchange Receiver ID	'77027' left justified and space filled. Florida Medicaid Sender ID
B.5	N/A	ISA	ISA09 - Interchange Date	The date format is YYMMDD.
B.5	N/A	ISA	ISA10 - Interchange Time	The time format is HHMM.
B.5	N/A	ISA	ISA11 - Interchange Control Standards Identifier	'U' – Interchange Control Standards Identifier
B.5	N/A	ISA	ISA12 - Interchange Control Version Number	'00401' – Control Version Number
B.5	N/A	ISA	ISA13 - Interchange Control Number	Interchange Unique Control Number – Must be identical to the interchange trailer IEA02.
B.6	N/A	ISA	ISA14 - Acknowledgment Request	'0' – No Acknowledgement Requested '1' – Acknowledgement

837 Institutional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
				Requested
B.6	N/A	ISA	ISA15 - Usage Indicator	'T' - Test Data 'P' - Production Data
B.6	N/A	ISA	ISA16 - Component Element Separator	'.' – Component Element Separator

5.2 IEA - Interchange Control Trailer

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

837 Institutional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.7	N/A	IEA	IEA01 - Number of included Functional Groups	Number of included Functional Groups
B.7	N/A	IEA	IEA02 - Interchange Control Number	Must be identical to the value in ISA13

5.3 GS – Functional Group Header

Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

837 Institutional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.8	N/A	GS	GS01 - Functional ID Code	'HC' – Health Care Claim (837)

837 Institutional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.8	N/A	GS	GS02 - Application Sender's Code	Trading Partner Supplied by Florida Medicaid, left justified, do not space fill.
B.8	N/A	GS	GS03 - Application Receiver's Code	'77027' left justified do not space fill. Florida Medicaid Receiver ID
B.8	N/A	GS	GS04 - Date	The date format is CCYYMMDD
B.8	N/A	GS	GS05 - Time	The time format is HHMM
B.9	N/A	GS	GS06 - Group Control Number	Group Control Number
B.9	N/A	GS	GS07 - Responsible Agency Code	'X' – Responsible Agency Code
B.9	N/A	GS	GS08 - Version/ Release/ Industry ID Code	'004010X096A1' – Version / Release / Industry Identifier Code

5.4 GE – Functional Group Trailer

Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

837 institutional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.10	N/A	GE	GE01 – Number of Transaction Sets Included	Number of included Transaction Sets
B.10	N/A	GE	GE02 – Group Control Number	Must be identical to the value in GS06

5.5 ST – Transaction Set Header

Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

837 Institutional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
56	N/A	ST	ST01 – Transaction Set Identifier Code	'837' – Health Care Claim
56	N/A	ST	ST02 – Transaction Set Control Number	Transaction Control Number

5.6 SE – Transaction Set Trailer

Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

837 Institutional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
503	N/A	SE	SE01 – Number of Included Segments	Total number of segments included in Transaction Set including ST and SE.
503	N/A	SE	SE02 – Transaction Set Control Number	Must be identical to the value in ST02.

5.7 TA1 – Interchange Acknowledgement

The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

837 Institutional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
B.11	N/A	TA1	TA101 - Interchange Control Number	Interchange control number of the original interchange received (ISA/IEA)
B.11	N/A	TA1	TA102 - Interchange Date	The date format is YYMMDD. Date within the original interchange received (ISA/IEA)
B.11	N/A	TA1	TA103 - Interchange Time	The time format is HHMM. Time within the original interchange received (ISA/IEA)
B.12	N/A	TA1	TA104 - Interchange Acknowledgement Code	'A' – Transmitted interchange control structure header/trailer received without errors. 'E' – Transmitted interchange control structure header/trailer received and accepted, errors are noted. 'R' – Transmitted interchange control structure header/trailer rejected due to errors.
B.12- B.13	N/A	TA1	TA105 - Interchange Note Code	See the 837I Implementation Guide for valid values.

5.8 Valid Delimiters

The following delimiters must be used for the 837I for Florida Medicaid otherwise the transaction may not process correctly.

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	~	126	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

6 COMPANION GUIDE FOR THE 837I TRANSACTION

This section specifies X12 837I fields for which Florida Medicaid has specific requirements.

837 Institutional Health Care Claim and Encounter Claims				
Page	Loop	Segment	Data Element	Comments
Header				
58	N/A	BHT	BHT02 - Transaction Set Purpose Code	'00' – Original
59	N/A	BHT	BHT06 - Transaction Type Code	'CH' – Chargeable (Use with Institutional Health Care Claim) 'RP' – Reporting (Use with Institutional Health Care Encounter)
Submitter Name				
63	1000A	NM1	NM109 - Identification Code	Florida EDI Trading Partner ID
Receiver Name				
68	1000B	NM1	NM103 – Name Last or Organization Name	'STATE OF FLORIDA MEDICAID'
68	1000B	NM1	NM109 - Identification Code	'77027' - Florida Medicaid Payer ID

Billing Provider Name				
71	2000A	PRV	PRV01 - Provider Code	'BI' – Billing Provider 'PT' – Pay-to-Provider
72	2000A	PRV	PRV02 - Reference Identification Qualifier	'ZZ' – Health Care Provider Taxonomy
72	2000A	PRV	PRV03 - Provider Specialty Code	Provider Taxonomy Code
77	2010AA	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
78	2010AA	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
81	2010AA	N4	N403 - Zip Code	Billing Provider Zip Code + 4 postal code (excluding punctuation and blanks)
83-84	2010AA	REF	REF01 - Reference Identification Qualifier	'EI' – EIN or 'SY' – SSN Healthcare providers must send NPI in the associated NM109 and the REF01='1D' should not be used. 'EI' or 'SY' must be used when NM108='XX'. Non-healthcare providers must send this REF segment where REF01='1D'. NM108 must equal '24' or '34' when REF01='1D'.

84	2010AA	REF	REF02 - Reference Identification	If REF01='EI' (EIN) If REF01='SY' (SSN) If REF01='1D' (Florida Medicaid Provider ID) See comments on associated REF01
Pay-to-Provider Name Used if Different than the Billing Provider				
92	2010AB	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
93	2010AB	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
114	2010AB	N4	N403 - Zip Code	Billing Provider Zip Code + 4 postal code (excluding punctuation and blanks)
97-98	2010AB	REF	REF01 - Reference Identification Qualifier	'EI' – EIN or 'SY' – SSN Healthcare providers must send NPI in the associated NM109 and the REF01='1D' should not be used. 'EI' or 'SY' must be used when NM108='XX'. Non-healthcare providers must send this REF segment where REF01='1D'. NM108 must equal '24' or '34' when REF01='1D'.

98	2010AB	REF	REF02 - Reference Identification	If REF01='EI' (EIN) If REF01='SY' (SSN) If REF01='1D' (Florida Medicaid Provider ID) See comments on associated REF01
Subscriber Level				
Note: For Florida Medicaid, the insured and the patient are always the same person. Use this HL segment to identify the recipient and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop may not process correctly.				
100	2000B	HL	HL04 - Hierarchical Child Code	'0' – No Subordinate HL Segment in this Hierarchical Structure
102	2000B	SBR	SBR01 - Payer Responsibility Sequence Number Code	Enter the appropriate standard code. The X12N 837I does not support the use of the Financial Class Code that is currently billed on Hospital claims. Claim Filing Indicators and the Payer Responsibility Sequence, which indicates the relationship each payer has to Medicaid and other payers on each claim will replace the data supplied by the Financial Class Code. See section 7 for a crosswalk of Financial Class Codes to the Claim Filing Indicator/Payer Responsibility Sequence.
104-105	2000B	SBR	SBR09 - Claim Filing Indicator Code	See Comment on 2000B-SBR01.
Subscriber Name				
109	2010BA	NM1	NM102 - Entity Type Qualifier	'1' – Person
110	2010BA	NM1	NM108 - Identification	'MI' – Member

			Code Qualifier	Identification Number
110	2010BA	NM1	NM109 - Identification Code	Florida Recipient 10-digit Medicaid ID
Payer Name				
127	2010BC	NM1	NM103 - Name Last or Organization Name	'STATE OF FLORIDA MEDICAID'
127	2010BC	NM1	NM108 - Identification Code Qualifier	'PI' – Payer Identification
128	2010BC	NM1	NM109 - Identification Code	'77027' - Florida Medicaid Payer ID
Claim Information				
158	2300	CLM	CLM01 - Claim Submitter's Identifier	Patient Control Number Value received will be returned on the '835' Remittance Advice
159	2300	CLM	CLM0-1 - Facility Type Code	Value received is the 1 st two positions of the Type of Bill (TOB).
159-160	2300	CLM	CLM05-3 - Claim Frequency Type Code	Value received is the 3 rd position of the Type of Bill (TOB). Frequency Code also indicates whether the current claim is an original claim, a void, or an adjustment. Valid values are as follows: 1 = Original Claim 7 = Adjustment (Replacement of Paid Claim) 8 = Void (Credit only). The ICN to credit should be placed in the REF02 where REF01='F8'. Providers must use the most recently paid ICN

				when voiding or adjusting. Consult your appropriate Reimbursement Handbook for additional guidelines for filing voids and adjustments.
165	2300	DTP	DTP01 - Date/Time Qualifier	'096' – Discharge
165	2300	DTP	DTP02 – Date Time Period Format Qualifier	'TM' – Time (HHMM)
166	2300	DTP	DTP03 - Date Time Period	Discharge Hour Bill the Discharge Hour on all claims involving final services rendered. When a Discharge Hour is submitted, the Discharge Date will be populated with the Statement Last Date of Service. This field only applies for nursing home patients discharged prior to the end of the month.
167	2300	DTP	DTP01 - Date/Time Qualifier	'434' – Statement Covers Period Dates
167	2300	DTP	DTP02 - Date Time Period Qualifier	'RD8' – Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
168	2300	DTP	DTP03 - Date Time Period	Statement Covers Period (From-Through) For Nursing Facilities: The X12N 837I does not support the use of the Nursing Home Discharge Date currently billed on Nursing Home claims. The Nursing Home Discharge Date will be derived using the Discharge Hour and the

				<p>Statement Date Time Period. The Discharge Hour will be used in conjunction with the last date in the range of dates to determine the Nursing Home Discharge Date.</p> <p>For patients who are discharged during the month, providers must submit the day the patient left the nursing home as the Last Date of Service. The Discharge Date will be populated with the Last Date of Service.</p>
172	2300	CL1	CL103 – Patient Status Code	<p>The X12N 837I does not support the use of the Nursing Home Termination Codes currently billed on Nursing Home claims. The Termination Code will be derived from the Patient Status Code.</p> <p>See Section 7 - Program Specific Required Information for Florida Medicaid Claims Processing.</p>
176-177	2300	CN1	CN101 – Contract Type Code	<p>The X12N 837I does not support the use of the Level of Care as it is currently billed on Nursing Home claims. Enter Contract Type '02' (Per Diem) in the Contract Type Code field and the Florida Level of Care value in the Reference Identification field. See the <i>Florida Medicaid Provider Reimbursement Handbook</i> for the valid</p>

				values for the Level of Care.
177	2300	CN1	CN102 – Contract Amount	Nursing Home per diem amount (Contract Amount)
177	2300	CN1	CN104 – Contract Code	Level of Care value (Contract Code)
191	2300	REF	REF01 – Reference Identification Qualifier	‘F8’ – Original Reference Number
192	2300	REF	REF02 – Reference Identification	Enter the 13-digit ICN or 17-digit TCN assigned to the original claim submission. (ICN/TCN to be credit/voided).
198	2300	REF	REF01 – Reference Identification Qualifier	‘G1’ – Prior Authorization Number ‘9F’ – Referral Number
199	2300	REF	REF02 – Reference Identification	Enter MediPass Referral Number if ‘9F’ value is used. Enter the 10-digit Prior Authorization Number. Enter this number only if the services rendered required and received Prior Authorization from AHCA or a Peer Review Organization such as KePRO or First Mental Health. This number must be entered with the qualifier ‘G1’ (Prior Authorization Number).
204	2300	K3	K301 - Fixed Format Information	MCO Receipt Date – Format CCYYMMDD Required for MCO Encounters

Note: For those HI Segments Page 232 thru Page 299 within the 837I Implementation Guide that can repeat multiple times and allow up to 12 occurrences of information within each segment will be captured and stored within the MMIS.

267-279	2300	HI	HI01-1 through HI12-1 - Code List Qualifier Code	'BH' – Occurrence
267-279	2300	HI	HI01-2 through HI12-2 - Occurrence Code	See Section 7 for a list of current Florida-specific Occurrence Codes to replacement codes and their description.
306-307	2300	QTY	QTY01 - Quantity Qualifier	'CA' – Covered Days 'NA' – Number of Non-Covered Days
Attending Physician Name				
Note: Required for Inpatient Services				
323	2310A	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
323	2310A	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
324	2310A	PRV	PRV01 - Provider Code	'AT' – Attending
325	2310A	PRV	PRV03 - Provider Specialty Code	Attending Provider Taxonomy Code Used for claims submitted with NPI
326-327	2310A	REF	REF01 - Reference Identification Qualifier	'0B' – State License Number '1D' – Medicaid Provider Number

				<p>Beginning on May 23, 2008, Healthcare providers must begin sending NPI in the associated NM109 data element and the REF01='1D' should not be used.</p> <p>Non-healthcare providers may send this REF segment where REF01='1D'.</p>
327	2310A	REF	REF02 - Reference Identification	<p>If REF01='0B' (State License Number)</p> <p>If REF01='1D' (Florida Medicaid Provider ID)</p> <p>Enter the Florida Department of Professional Regulation (DPR) medical license number for the attending physician (the physician primarily responsible for the care of the patient) or the medical license number of the resident physician. Enter the license information in the following format: ME9999999. This number must be entered with the qualifier '0B' (State License Number).</p> <p>Note: This is not required for nursing homes.</p>
Other Provider Name				
337	2310C	NM1	NM108 - Identification Code Qualifier	<p>'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers</p> <p>'24' – Employer's</p>

				<p>Identification Number OR '34' – Social Security Number for non-healthcare provider</p>
337	2310C	NM1	NM109 - Identification Code	<p>If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)</p>
340-341	2310C	REF	REF01 - Reference Identification Qualifier	<p>'0B' – State License Number '1D' – Medicaid Provider Number Beginning on May 23, 2008, Healthcare providers must begin sending NPI in the associated NM109 data element and the REF01=1D should not be used. Non-healthcare providers may send this REF segment where REF01='1D'</p>
341	2310C	REF	REF02 - Reference Identification	<p>If REF01='0B' (State License Number) If REF01='1D' (Florida Medicaid Provider ID) Enter the Performing Provider License Number using qualifier '0B' (State License Number), except when the claim requires MediPass authorization. When MediPass authorization is required, use Loop 2300, REF02 with Loop 2300, REF01 qualifier '9F', (Referral Number). Note: This is not required</p>

				for nursing homes.
Service Facility Name				
350	2310E	NM1	NM108 - Identification Code Qualifier	<p>‘XX’ – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers</p> <p>‘24’ – Employer’s Identification Number</p> <p>OR</p> <p>‘34’ – Social Security Number for non-healthcare provider</p>
350	2310E	NM1	NM109 - Identification Code	<p>If NM108=‘XX’ (NPI)</p> <p>If NM108=‘24’ (EIN)</p> <p>If NM108=‘34’ (SSN)</p>
356	2310E	N4	N403 – Zip Code	Service Facility Provider Zip Code + 4 postal code (excluding punctuation and blanks)
357-358	2310E	REF	REF01 - Reference Identification Qualifier	<p>‘1D’ – Medicaid Provider Number</p> <p>Beginning on May 23, 2008, Healthcare providers must begin sending NPI in the associated NM109 data element and the REF01=1D should not be used.</p> <p>Non-healthcare providers may send this REF segment where REF01=‘1D’.</p>
358	2310E	REF	REF02 - Reference Identification	<p>If REF01=‘1D’ or ‘1J’ (Florida Medicaid Provider ID)</p> <p>See comments on associated REF01</p>

Other Subscriber Information				
360	2320	SBR	SBR01 - Payer Responsibility Sequence Number Code	<p>Enter the appropriate standard code.</p> <p>The X12N 837I does not support the use of the Financial Class Code that is currently billed on Hospital claims. Claim Filing Indicators and the Payer Responsibility Sequence, which indicates the relationship each payer has to Medicaid and other payers on each claim will replace the data supplied by the Financial Class Code.</p> <p>See Section 7 for a crosswalk of Financial Class Codes to the Claim Filing Indicator/Payer Responsibility Sequence.</p>
363-364	2320	SBR	SBR09 - Claim Filing Indicator Code	See Comment on 2320-SBR01
367-370	2320	CAS	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 – Adjustment Reason Code	<p>For Inpatient:</p> <p>'1' – Deductible</p> <p>'2' – Coinsurance</p> <p>'66' – Blood Deductible</p> <p>Other external code source values from code source 139 are allowed.</p>
367-370	2320	CAS	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18 – Adjustment Amount	<p>If Adjustment Group Code (CAS01)=PR and Adjustment Reason Code value is:</p> <p>'1' enter the Medicare Deductible Amount.</p> <p>'2' enter the Medicare Coinsurance Amount.</p> <p>'66' enter the Medicare Blood Deductible.</p>

371	2320	AMT	AMT01 - Amount Qualifier Code	'C4' – Payer Amount Paid
371	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Amount Paid (TPL or MCO) Used for Fee-for-Service and Encounters
372	2320	AMT	AMT01 - Amount Qualifier Code	'B6' – Payer Allowed Amount
372	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Allowed Amount Paid (TPL or MCO) Used for Fee-for-Service and Encounters
Other Payer Name				
411	2330B	NM1	NM109 – Identification Code	This number must be identical to at least once occurrence of the 2430-SVD01 to identify the other payer. Florida Medicaid captures third party payment amount(s) from the service line(s) in 2430-SVD02 for Outpatient Claims. Note: The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail.
415	2330B	DTP	DTP01 - Date/Time Qualifier	'573' - Other Payer or MCO Claim Adjudication Date
415	2330B	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)
415	2330B	DTP	DTP03 – Date Time Period	TPL or MCO Adjudication Date (CCYYMMDD)

Service Line Number				
444	2400	LX	LX01 – Line Counter	Florida Medicaid will accept up to the HIPAA allowed 999 detail lines per claim.
446-447	2400	SV2	SV201 – Service Line Revenue Code	Nursing home submitters must enter a revenue code. Enter Revenue Code '0101' and the per diem amount if no home days or hospital days need to be reported. Enter Revenue Code '0185' for days spent in hospital or Service Line Revenue Code '0182' for days spent at home.(Nursing Home only)
446-447	2400	SV2	SV202-1 - Product/Service ID Qualifier	'HC' – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
449	2400	SV2	SV205 – Service Unit Count	Enter the number of days spent in hospital or at home. Florida Medicaid will process only the whole number when units are entered with decimals. Example: Units entered on the transaction 3.75 will be processed as 3 units.
Drug Identification				
October 2002 Addenda 37	2410	LIN	LIN02 – Service ID Qualifier	Enter 'N4' for National Drug Code.
October 2002	2410	LIN	LIN03 – Drug Identification	Enter National Drug Code

Addenda 37				(NDC)
October 2002 Addenda 39	2410	CTP	CTP03 – Unit Price	Drug Unit Price
October 2002 Addenda 39	2410	CTP	CTP04 – Quantity	National Drug Unit Count
October 2002 Addenda 39	2410	CTP	CTP05-1 – Unit or Basis for Measurement Code	Please refer to 837I, October 2002 Addenda for valid code values
Line Adjudication Information				
491	2430	SVD	SVD01 – Identification Code	This number should match one occurrence of the 2330B-NM109 identifying Other Payer
491	2430	SVD	SVD02 – Service Line Paid Amount	If Outpatient, the total Third Party Payment Amount will be calculated by adding the service line Third Party Payment Amounts. This will also be used for Crossover detail paid amount.
496-500	2430	CAS	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 – Adjustment Reason Code	For Outpatient: '1' enter the Medicare Deductible Amount '2' enter the Medicare Coinsurance Amount '66' enter the Medicare Blood Deductible Other external code source values from code source 139 are allowed.
496-501	2430	CAS	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18 –	If Adjustment Group Code (CAS01)=PR and

			Adjustment Amount	Adjustment Reason Code value is: '1' enter the Medicare Deductible Amount '2' enter the Medicare Coinsurance Amount '66' enter the Medicare Blood Deductible
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7 PROGRAM SPECIFIC REQUIRED INFORMATION FOR FLORIDA MEDICAID INSTITUTIONAL CLAIMS PROCESSING

Financial Class Codes Crosswalk

Financial Class Code	Description	Claim Filing Indicator / Payer Responsibility Sequence		
		1 st (Primary)	2 nd (Secondary)	3 rd (Tertiary)
100	Medicaid as sole payer	MC	09	09
210	Medicaid with one or more TPL	CO	MC	09
510	Medicare Part B or Part A with Medicaid	MB or MA	MC	09
180	Hospice with No Patient Responsibility	MC	ZZ	09
910	Medicare Part B with Medicaid	MB	MC	09

Current Florida-Specific Occurrence Codes to Replacement Codes Crosswalk

Current Code	Replacement Code	Description
50	Not Used	Newborn - Mother not on Medicaid
51	42	Newborn - Mother on Medicaid
54	73	Medically Needy First Date of Eligibility

Nursing Home Termination Codes to X12N 837I Patient Status Codes

FMMIS Nursing Home Termination Code	X12N 837I Patient Status Code
0 Per Diem	31 Still patient, State defined
1 Hospital	02 Transferred to hospital
2 Return home	01 Discharged
3 Death	20 Patient died CSP
4 Transfer to facility	03 Transferred to SNF
5 Medicaid termination or other	99 Unknown
Spaces	Values other than above

Crosswalk of Currently Used Revenue Codes to Equivalent Standard Codes

Current Revenue Code	Description	Standard Revenue Code
0273	Burn Pressure Garment	0273 is acceptable for use when billed with diagnosis codes 940.0 through 949.5.
0274	Cochlear Implant Handling	0278 – Other Implants
0278	Norplant Subdermal Contraceptive	0278 – Other Implants
0279	Other Supplies/Devices	0279 is acceptable for use when billed with diagnosis codes 940.0 through 949.5.
0452	Emergency Medical Screening	0451