# THE WELLCARE GROUP OF COMPANIES EDI TRANSACTION SET 837P X12 HEALTH CARE ENCOUNTERS PROFESSIONAL ASC X12N VERSION **5010A1** COMPANION GUIDE

## Inbound
## 837 Professional
## Encounters Submission

## Table of Contents

## Revision History

| Date | Rev # | Author | Description |
|---|---|---|---|
| 04/10/2012 | 1.01 Review | Craig Smitman | Encounters Review |
| 09/10/2013 | 1.02 Update | Craig Smitman | Updates after Encounters Review |
| 09/18/2013 | 1.03 Update | Craig Smitman | Updated the Paper Submission and added ICD-Mandate Dates |
| 10/04/2013 | 2.04 Update | Craig Smitman / GA Market | Updated the ICD-10 Verbiage to add Date of Service as part of the Mandate. |
| 02/26/2014 | 2.05 Update | Craig Smitman / Brittany McDermott | Fixed typo in the name convention. |
| 04/07/2014 | 2.06 Update | Craig Smitman / Joseph Yeckley | New ASO Payment Verbiage |
| 07/18/2014 | 2.07 Update | Craig Smitman / Alexei Sorokin | From Draft to Approved |
| 08/06/2014 | 2.08 Update | Craig Smitman / Tiffany Hilleary | Updated the ICD-10 Start Date and added New States for Windsor and removed EAS Logo. |
| 12/11/2014 | 2.10 Update | Craig Smitman | Updated Florida Transportation Rules. Removed Windsor from the guide |
| 08/30/2015 | 2.11 Update | Craig Smitman / Fran Meadows | Removed KY Requirements |
| 10/29/2015 | 2.12 Update | Craig Smitman | Updated the Guide with IA Requirements |
| 01/26/2016 | 2.13 Update | Craig Smitman | Updated what is required in the COB loops for Dual Members for Medicare / Medicaid payments. |
| 08/03/2016 | 2.14 Update | Craig Smitman | Update the Guide with NE Requirements<br>Removed the IA Requirements |
| 08/08/2016 | 2.15 Update | Craig Smitman / Edouard Desruisseaux / Tiffany Hilleary | Updated the WellCare Group of Companies, State Affiliation and Added Referring Provider State License and Spinal Manipulation Service Notes |
| 09/07/2016 | 2.16 Update | Craig Smitman / Edouard Desruisseaux | Made a change the NE in the Referring Provider State License Note. Changed NTE to REF. |

## Contact Roster

| Trading Partners and Providers: for questions, concerns or testing information, please email the following: | |
|---|---|
| **EDI Coordinator/Testing** | |
| **EDIAnalyst@wellcare.com** | Multi group supported email distribution |

## Introduction

The WellCare Group of Companies ("the Plan") used the standard format for Encounters Data reporting from Providers and Vendors. The Plan X12N 837 Professional Encounters "Companion Guide" is intended for use by the Plan's Providers and Trading Partners (TPs) in conjunction with HIPAA ANSI ASC X12N Technical Report Type 3 Electronic Transaction Standard (Version – TR3) and its related errata X222A1 Implementation Guide.

The Reference HIPAA TR3 for this Companion Guide is the ANSI ASC X12N 837P TR3 Version – 005010X222 and its related errata X222A1

- UAT 5010 X222A1 Start Date – 09/01/2011 for inbound Encounters
- Production 5010 X222A1 Start Date – 01/01/2012 for inbound Encounters
- Production 5010 X222A1 Mandate Date – 04/01/2012 for inbound Encounters

The Plan's Companion Guides have been written to assist those Providers and Vendors who will be implementing the X12 837 Healthcare Encounters Professional transactions but does not contradict, disagree, oppose, or otherwise modify the HIPAA Technical Report Type 3 (TR3) in a manner that will make its implementation by users to be out of compliance.

Using this Companion Guide does not mean that an Encounter will be paid. It does not imply payment policies of payers or the benefits that have been purchased by the employer or subscriber. This Companion Guide clarifies the HIPAA-designated standard usage and must be used in conjunction with the following document:

### The 837 Professional Healthcare Encounters TR3 Implementation Guides (IG)

To purchase the IG, contact Washington Publishing Company at **www.wpc-edi.com**.

This Companion Guide contains data clarifications derived from specific business rules that apply exclusively to Encounters processing for the Plan. Field requirements are located in the ASC X12N 837P (005010X222A1) TR3 Implementation Guide.

Submitters are advised that updates will be made to the Companion Guides on a continual basis to include new revisions to the web sites below. Submitters are encouraged to check our website periodically for updates to the Companion Guides.

## The WellCare Group of Companies (The Plan)


'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.

WellCare Health Insurance of Illinois, Inc.

WellCare Health Insurance of New York, Inc.

WellCare Health Plans of New Jersey, Inc.

WellCare of Nebraska, Inc.

WellCare of Louisiana, Inc.

WellCare of New York, Inc.

WellCare of Connecticut, Inc.

WellCare of Georgia, Inc.

Harmony Health Plan of Illinois, Inc.

Easy Choice California

WellCare of Texas, Inc.

Healthy Connections Prime

Missouri Care, Inc.

WellCare of South Carolina, Inc.

Easy Choice Health Plan

WellCare of Kentucky, Inc.

WellCare Health Plans of Kentucky, Inc.

WellCare of Ohio, Inc.

WellCare of Florida, Inc., operating in Florida as Staywell and Staywell Kids

## State Affiliations

This Guide covers further clarification to Providers and Trading Partners (TPs) on how to report claims to The Plan. The Plan provides services in the following states:

Arizona – Medicare
Arkansas - Medicare
California – Medicare/Medicaid
Connecticut – Medicare/Medicaid
Florida – Medicare/Medicaid
Georgia – Medicare/Medicaid
Hawaii – Medicare/Medicaid
Illinois – Medicare/Medicaid
Indiana – Medicare
Kentucky – Medicaid/Medicare
Louisiana – Medicare
Mississippi – Medicare
Missouri – Medicare/Medicaid
Nebraska – Medicaid
New York – Medicare/Medicaid
New Jersey – Medicare/Medicaid
Ohio – Medicare
South Carolina – Medicaid / Medicare
Texas – Medicaid
Tennessee – Medicare

# Front-End WEDI SNIP Validation

The Front-End System, utilizing EDIFECS Validation Engine, will be performing the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) Validation. Any Encounters that do not pass WEDI SNIP Validations will be rejected. Below are a few examples of the Health Plans SNIP level requirements:

## WEDI SNIP Level 1: EDI Syntax Integrity Validation

- Syntax errors also referred to as Integrity Testing, which is at the file level. This level will verify that valid EDI syntax for each type of transaction has been submitted. When these errors are received the entire file will be rejected back to the submitter. Errors can occur at the file level, batch level within a file, or individual Encounter level. It is therefore possible that an entire file or just part of a file could be rejected and sent back to the submitter when one of these errors is encountered.

  Examples of these errors include but are not limited to:
  - Invalid date or time
  - Invalid telephone number
  - The data element is too long (i.e., the Encounters form field expects a numerical figure 9 characters long but reads 10 or more characters)
  - Field 'Name' is required on the Reject Response Transaction (i.e., Field 'ID' is missing. It is required when Reject Response is "R")
  - A slash is not allowed as a value for dates (i.e., date of service is expected to be in a numerical format of CCYYMMDD. MM/DD/CCYY is incorrect.)

## WEDI SNIP Level 2: HIPAA Syntactical Requirement Validation

- This level is for HIPAA syntax errors. This level is also referred to as Requirement Testing. This level will verify that the transaction sets adhere to HIPAA Implementation guides.

  Examples of these errors include but are not limited to:
  - Social Security Number is not valid.
  - Procedure Date is required when ICD Code is reported.
  - Encounters number limit per transaction has been exceeded.
  - 'Name' is required when ID is not sent.
  - Revenue Code should not be used when it is already used as a Procedure Code.
  - NPI number is invalid for 'Name'.
  - State code is required for an auto accident.
  - Employer Identification Number (EIN) is invalid.
  - Missing/invalid Patient information. Member identification missing or invalid. Patient's city, state, or ZIP is missing or invalid.
  - Invalid character or data element. The data element size is invalid or has invalid character limits.
  - Missing NPI. WellCare requires NPI numbers on Encounters as of May 23, 2008 in accordance with HIPAA guidelines. An NPI must be a valid 10-digit number.
  - Legacy ID still on Encounters. Legacy numbers include Provider IDs, Medicaid and Medicare IDs, UPIN and State License numbers. All legacy numbers need to be removed from Encounters.

## WEDI SNIP Level 3: Balancing Validation

- This level is for balancing of the Encounter. This level will validate the transactions submitted for balanced field totals and financial balancing of Encounters.

  Examples of these errors include but are not limited to:
  - Total charge amount for services does not equal sum of lines charges.
  - Service line payment amount failed to balance against adjusted line amount.

## WEDI SNIP Level 4: Situational Requirements

- This level is for Situation Requirements/Testing. This level will test specific inter-segment situations as defined in the implementation guide, where if A occurs, then B must be populated.

  Examples of these errors include but are not limited to:
  - If the Encounter is for an auto accident, the accident date must be present.
  - Patient Reason for Visit is required on unscheduled outpatient visits.
  - Effective date of coverage is required when adding new coverage for a member.
  - Physical address of service location is required for all places of service billed.
  - Referral number is required when a referral is involved.
  - Subscriber Primary ID is required when Subscriber is the Patient.
  - Payer ID should match to the previously defined Primary Identifier of Other Payer.

## WEDI SNIP Level 5: External Code Set Validation

- This level not only validates the code sets, but also ensures the usage is appropriate for any particular transaction and appropriate with the coding guidelines that apply to the specific code set.

  Examples of these errors include but are not limited to:
  - Validated CPT code
  - ICD Codes
  - ZIP code
  - National Drug Code (NDC)
  - Taxonomy Code validation
  - State code
  - Point of Origin for Admission or Status Codes
  - Adjustment Reason Codes and their appropriate use within the transaction

## WEDI SNIP Level 7: Custom Health Plan Edits

- This level is intended for specific business requirements by the Health Plan that are not covered within the WEDI SNIP or the Implementation Guide.

## Paper Encounter Submission

For Optical Character Recognition (OCR) from paper to EDI, all paper Encounter submissions must meet the criteria below to be submitted as a "Clean EDI Claim" for The Plan EDI Gateway and Core Systems Adjudication.

- The Health Plan requires a "Clean EDI Encounter Claim" submission for all paper claims.
  - This means that the encounter must be in the nationally accepted HIPAA paper format along with the standard coding guidelines with no further information, adjustments, or alteration in order to be processed and paid by the Health Plan.

- Paper encounter must be submitted on the original "Red and White Claims" CMS-1500 Claim Forms or their successor with "drop out" red ink.
  - Beginning 04/01/2014, The Plan will only accept CMS-1500 claims forms on the 02/12 version.
  - The Plan will be following the same release schedule as outlined by CMS for the use of the new CMS-1500 claim form as defined in the June 27, 2013 MLN Connects Provider eNews on the **www.cms.gov** site.

- In addition to CMS mandating the use of Red Claims (Encounters), the Health Plan requires certain standards, since all paper Encounters are read through OCR software. This technology allows The Plan to process encounters with greater accuracy and speed.
  - All forms should be printed or typed in **large**, capitalized black font.
  - The font theme should be **Arial** with a point size of **10, 11,** or **12**.

- After OCR, all paper claims are subjected to WEDI SNIP Validation.

- The Health Plan will not accept the following:
  - Handwritten encounters
  - Faxed or altered claim forms
  - Black and white copied forms
  - Outdated CMS claim forms

# Electronic Submission

The Plan can only process one (1) ISA GS and IEA GE Segment per file sent. The Plan can process multiple ST & SE transactions of the same transaction type within the ISA GS and IEA GE Segments.

Professional Fee-for-Service Encounters submitted using the TS3 format **must** be in a separate file from all Encounter reporting.

When sending Institutional Encounters, the Plan expects the BHT06 to be:

- Encounters Identifier (BHT06) has to be set to "**RP**" (Reporting).
- FFS Identifier (BHT06) has to be set to "**CH**" (Chargeable). See the *FFS Companion Guides* for complete details on files and validation requirements.
- The Plan will not process "**31**" (Subrogation Demand) Encounters. These Encounters will be rejected.

## File Size Requirements

The following list outlines the file sizes by transaction type:

| Transaction Type | Testing Purposes | Production Purposes |
|---|---|---|
| 837 formats – Encounters | 50-100 Encounters | < 5000 Encounters per ST/SE.<br>10 ST/SE per file. |

## Submission Frequency

We process files 24 hours a day, 7 days a week, 365 days per year.

## Encounter File Upload for Direct Submitters

## Encounter File Test Process

The Plan will accept test files on a case-by-case basis. Notify the Testing Coordinator of your intent to test and to schedule accordingly.

***IF YOU DO NOT NOTIFY THE PLAN OF YOUR INTENT TO TEST, YOUR ENCOUNTER SUBMISSION MAY BE OVERLOOKED.***

## Encounter Testing

1. Create test files in the ANSI ASC X12N 837P format.

    - Files should include all types of provider Encounters.
    - Batch files by 837P type of Encounter and group by month.
    - Set Header Loops for Test:
        - Header ISA15 to "**T**"
        - Header BHT06 use "**RP**" in the Header for encounters

2. Name each batch file according to the File Naming Standards listed below:

    - Your company Identifier short name can be up to 5 Characters (Example: CMPNM)
    - 837TEST
    - Date test file is submitted to the Plan (CCYYMMDDHHMM)
    - Last byte equaling file type **P** = Professional Services
      **Example:** CMPNM _837TEST_200509011525**P**

3. Transmit your **TEST** files to The Plan's SFTP site: **https://edi.wellcare.com** or submit through your Clearinghouse.

4. Email a copy of the file Upload Response and your file name to the EDI Coordinator (See contact roster).

## Encounter Production

After the Provider or TPs are production ready, the Plan will accept ANSI ASC X12N 837P format and process batch files daily. Files must have the appropriate PRODUCTION identifiers as listed in the 837P Mapping Documents.

**Encounter Naming Standards*:*** The Plan uses the file name to help track each batch file from the drop-off site through the end processing into The Plan's data warehouse.

1. Encounter Header information for Production and Encounters IDs:

    - Set Header Loops for Production:
        - o Header ISA15 to "**P**"
        - o Header BHT06 must use "**RP**" in the Header for encounters

2. Name each batch file according to the File Naming Standards listed below:

    - Your company Identifier short name must be 5 Characters (Example: CMPNM)
    - 837PROD
    - Date production file is submitted to the Plan (CCYYMMDDHHMM)
    - Last byte equaling file type **P** = Professional Services
    - **Example**: CMPNM _837PROD_200509011525**P**

3. The Plan recommends the use of EDIFECS or CLAREDI for SNIP Levels 1 through 6 for integrity testing before uploading your production files.

4. Transmit your Production files to the Plan through the SFTP site or through your clearinghouse. For direct submitters, see *FTP Process* section.

5. After the file has passed through the Plan's Enterprise Systems validation process, (includes business edits), the electronic ANSI ASC X12N 999 (Functional Acknowledgement) outlining file acceptance/rejection will be posted to the SFTP site within 24 hours. See the 837 IG for additional information about the response coding and Attachment C in this Guide for examples.

6. If the file is unreadable, then trading partner will be notified by a third-party coordinator via email.

# FTP Process for Production, Encounters, and Test Files

## Secure File Transfer Protocol

MOVEit® is the Plan's preferred file transfer method of transferring electronic transactions over the Internet. It has the FTP option or online web interface.

Secure File Transfer Protocol (SFTP) is specifically designed to handle large files and sensitive data. The Plan uses Secure Sockets Layer (SSL) technology, the standard internet security, and SFTP ensures unreadable data transmissions over the internet without a proper digital certificate.

Registered users are assigned a secure mailbox where all reports are posted. Upon enrollment, they will receive a login and password.

In order to send files to the Plan, submitters need to have an FTP client that supports AUTH SSL encryption.

The AUTH command allows The Plan to specify the authentication mechanism name to be used for securing the FTP session. Sample FTP client examples are:

- WS_FTP PRO® (The commercial version supports automation and scripting). WS_FTP PRO® has instructions on how to connect to a WS_FTP Server using SSL.
- Core FTP Lite® (The free version supports manual transfers). Core FTP Lite® has instructions on how to connect to a WS_FTP Server. Also, The Plan can help you with setup.

# The Plan Specific Information

## Highlighted Business Rules

### Patient (Dependent):

The Plan will reject and will not pay any Encounters that indicate the patient is the dependent. These Loops consist of the following:

- Patient Hierarchical (2000C) Loop
- Patient Name (2010CA) Loop

All Newborn and Dependents must have Medicaid or Medicare ID as per the States and CMS requirements. The Members' IDs must be in the Subscriber Loops that consist of the following:

- Subscriber Hierarchical (2000B) Loop
- Subscriber Name (2010BA) Loop
- Payer Name (2010BB) Loop

### Provider/Vendor:

- The Taxonomy Code within the Billing Provider Hierarchical Level (2000A) Loop (PRV) Segment is required for all Encounters submissions. The Taxonomy reported on the Encounters must match the Billing Provider's specialty, which is maintained by the Workgroup for Electronic Data Interchange (WEDI).

- Providers who perform care or services must be identified within the Rendering Provider Loop (2310B), when the Rendering Provider is not the same in the Billing Provider Name (2010AA) Loop. If the Billing Provider (2010AA) and the Rendering Provider are the same, do not populate Loop 2310B. When using the 2310B Loop, the Plan requires that the Taxonomy Code is populated in the PRV Segment. The Taxonomy code must match the Rendering Provider's specialty, which is maintained by the Workgroup for Electronic Data Interchange (WEDI).

- The Plan requires the name and physical address where services were rendered in Service Facility Location Name in Loop 2310C, when the location of the health care service is different than the address within the Billing Provider Loop 2010AA. This loop must not contain a P.O. box in the Address (N3) Segment.

### Patient Control Number:

The Plan requires that the Patient Control Number in the Encounters Information (2300) Loop (CLM01) Segment be unique for each Encounter submitted.

### Subscriber Gender:

The Plan will reject any Encounter that has the Subscriber Gender Code in the Subscriber Demographic Information (2010BA) loop as "U" – Unknown. This element must be "F" – Female or "M" – Male.

### ICD-10 Mandate

As of Oct. 1, 2015, ICD-9 Diagnosis Codes cannot be used for services provided on or after this date. We will only accept ICD-10 Diagnosis Codes on all claims for Service Dates on or after Oct. 1, 2015, and we will reject any claims that have both ICD-9 and ICD-10 codes on the same claim after such date. Please refer to the CMS website for more information about ICD-10 diagnosis codes at **www.cms.gov**. Please see the NUCC guide for billing details. Please see 837 IG for EDI for correct qualifier to use with the ICD-10 diagnosis codes.

## Prior Authorizations and/or Referral Numbers

The Plan requires all submitters to send the Prior Authorizations and/or Referral Numbers when assigned by The Plan. The Plan will deny any services as "Not Covered" if the services require an authorization and/or referral.

## Valid National Provider Identifiers (NPI)

All submitters are required to use the National Provider Identification (NPI) numbers that are now required in the ANSI ASC X12N 837 as per the 837 Professional (TR3) Implementation Guide for all appropriate loops.

## Corrected Encounter Submission

### Replacement (Adjustment) Encounter or Void/Cancel Encounter

When submitting a "Corrected Encounter", use the appropriate Encounter Frequency Type Code in the CLM05-3 segment. Please indicate whether for Replacement (Adjustment) of prior Encounter "7" or a Void/Cancel of prior Encounter "8".

Also, per the Implementation Guide – when "7" or "8" is used as Encounter Frequency Type Code for Replacement or Void/Cancel of Prior Encounters Submission, the Encounter Level information in Loop 2300 and segment REF with an F8 qualifier must contain the WellCare Control Number (WCN). This can be found in our 277CA and 277U files. Please see 277CA/277U Companion Guides.

## Coordination of Benefits (COB) and Dual Member Adjudication Information – MOOP

All submitters that adjudicate Encounters for The Plan HMO or have COB information from other payers are required to send in all the Coordination of Benefits and Adjudication Loops as per the Coordination of Benefits 1.4.1 section within the 837 Professional (TR3) Implementation Guide.

Providers and Vendors must have the 837 Professional (TR3) Implementation Guide in conjunction with this Companion Guide to create the loops below correctly.

The required loops and segments that are needed to be sent for a compliant COB are as follows:

- Other Subscriber Information (2320) Loop
- Other Subscriber Name (2330A) Loop
- Line Adjudication Information (2430) Loop
    - For out-of-pocket amounts, use Loop ID 2430 220 Position 300 Data Element 782 for Patient Responsibility

  - This includes coinsurance, co-pays and deductibles – Please refer to Code Set 139 for the correct Encounters Adjustment Reason Code

- Dual Member specific requirement on Encounter submission from vendors:
  - 2330B payer loop – Dual Member submissions vendors have to report both 2320 COB payer loops (Medicaid and Medicare) even if the benefits are covered under either Medicaid or Medicare.
  - If the benefits are covered under Medicaid only then paid amount should be reported under Medicaid COB loop with Medicaid payer ID = 'WELLCAREMCD' and Medicare COB loop with zero paid amount under payer ID = 'WELLCAREMCR'.
  - If the benefits are covered under Medicare, then COB paid amount should be reported under Medicare COB loop with NM109 payer ID = 'WELLCAREMCR' and Medicaid COB loop with zero paid amount under payer ID = 'WELLCAREMCD'.
  - Payer IDs to be used in 2320 COB loop:
    - WELLCAREMCD – for Medicaid
    - WELLCAREMCR – for Medicare payer

**National Drug Code (NDC) – Medicaid Encounters Submission Only**

Per the 837 Professional (TR3) Implementation Guide, all submitters are required to supply the National Drug Code (NDC) for all HCPCS J-codes submitted on the Encounter(s). The NDC must be reported in Loop 2410 Segment LIN03. Also, per the Implementation Guide, the Drug Quantity and Price must be reported within the CTP segment. The Plan uses the First Data Bank (FDB) and CMS to validate the NDC codes for the source of truth.

## Transportation Vendors

All Transportation Vendors must now use the ambulance pick-up and drop-off location loops.

Please see the Transportation Notes for Florida, Georgia, Illinois and Nebraska below for more detail on how Transportation Information must be generated for these states.

- The physical address is required for the pick-up/drop-off location.
- Any P.O. box information within this segment will be rejected.
- Please use the default diagnostic codes for the following states:
  - FL – V700
  - OH – 7999
  - IL – 7999
  - MO – V609

## ASO Payments – Vendor Contract

For all Vendors that have an ASO Contract and expect ASO reimbursements in accordance with the terms and conditions of the contract must send "ASO" on the Line of the ASO service in the 2400 NTE Line Note Segment.

# Reporting States Notes:

## Illinois Notes:

### Transportation

Transportation Encounters, emergency and non-emergency, must report specific information about the trip in the NTE 2300 Loop. The State code, Vehicle License Number, Origin Time, and Destination Time must be reported in Loop 2300 Encounters Note, NTE02 element. The information contained in this field will apply to all service sections unless overridden in the 2400 Loop.

**NTE01:** Value "ADD"
**NTE02:** State or Province Code, Vehicle License Number, Origin Time, Destination Time
**Example:** NTE*ADD* IL,12345678,1155,1220 and must follow this format

Each field must be separated with a comma.

The length for each field is listed below:

| Length | Description |
|---|---|
| 2 | State or Province Code (Use Code source 22: States and Outlying Areas of the U.S. |
| 8 | Vehicle License Number |
| 4 | Origin Time<br>Time expressed in 24-hour clock time as follows: HHMM, where H = hours (00-23), M = minutes (00-59). |
| 4 | Destination Time<br>Time expressed in 24-hour clock time as follows: HHMM, where H = hours (00-23), M = minutes (00-59). |

NOTE: The State or Province Code, Origin Time and Destination Time fields **must** contain the length per field as listed above. Vehicle license number may vary from 1 to a maximum of 8 characters. If the license plate number is less than 8 characters, left justify and space fill.

**Transportation Modifiers – Emergency Transportation Encounters**
Place Codes for origin and destination will be reported using Procedure Modifiers, and they will be reported with each procedure code billed. The one-digit modifiers are combined to form a two-digit modifier that identifies the transportation provider's place of origin with the first digit, and the destination with the second digit.

| Modifier | Description |
|---|---|
| D | Diagnostic or therapeutic site, other than P or H when used as an origin code |
| E | Residential facility |
| H | Hospital |
| N | Skilled nursing facility |
| P | Physician's office |
| R | Residence |
| S | Scene of accident or acute event |
| X | Destination code only, intermediate stop at physician's office on the way to the hospital |

**Transportation Modifiers – Non-Emergency Transportation Encounters**
Place Codes for origin and destination will be reported using Procedure Modifiers, and they will be reported with each procedure code billed. The one-digit modifiers are combined to form a two-digit modifier that identifies the transportation provider's place of origin with the first digit, and the destination with the second digit.

Non-emergency transportation Encounters must contain HIPAA compliant modifiers. This will require the provider to **map the HFS proprietary codes to the HIPAA codes accepted by HFS** as shown below. The allowable values of these Modifiers for Illinois Medicaid are:

| HFS Proprietary Code | HIPAA Modifier Accepted by HFS | Description |
|---|---|---|
| E<br>F<br>G | D | Diagnostic or therapeutic site, other than P or H |
| B<br>C | H | Hospital |
| A | P | Physician's office |
| H<br>I<br>K | R | Residence |

For example, if the patient is transported from his home ("K") to a physician's office ("A"), the "K" will be changed to an "R" and the "A" changed to a "P", so the modifier reported on the 837P will be "RP".
**NOTE:** Continue to report HFS' proprietary codes ("KA" in this example) on **paper** Encounters.

**Taxonomy:**
The providers must report the billing provider taxonomy code in *PRV03 o*f the 2000A Loop. For HFS, the provider taxonomy code will be used to derive the Department's unique categories of service. For additional detail on Taxonomy codes, refer to Appendix 5 of Chapter 300 Provider Handbook for Electronic Processing.

## Florida State Notes

**Private Transportation:**
Private Transportation providers are currently required to submit start and stop time information on the Encounters. This offers a means to distinguish between services submitted for the same recipient on the same day. The X12N 837 Professional transaction does not provide the capability for providers to submit start and stop times. Private Transportation Encounters will use two modifiers instead of start and stop times.

The values are:

D Diagnostic or therapeutic site other than "P" or "H"

E Residential, domiciliary, custodial facility (nursing home, not a skilled nursing facility)

G Hospital-based dialysis facility (hospital or hospital-related)

H Hospital

I Site of transfer (for example, airport or helicopter pad) between types of ambulance

J Non-hospital-based dialysis facility

N Skilled nursing facility (SNF)

P Physician's office (includes HMO non-hospital facility, clinic, etc.)

R Residence

S Scene of accident or acute event

X Intermediate stop at physician's office in route to the hospital (includes HMO non-hospital facility, clinic, etc.)

**Note: Modifier X** can only be used as a designation code in the second modifier position.

The Origin and Destination codes will be billed together as a two-character modifier to provide combinations to uniquely identify services billed on the same day. If the provider needs to use the same procedure code and origin/destination modifier for the same recipient on the same day, a second modifier will be billed with the value of '76' (Repeat Procedure by Same Physician).

**Note about Round Trip:** A round trip means that the patient was picked up, taken somewhere, and returned to the same place they were picked up. There are only two legs to a round trip, going out and coming back. If you made a trip with three legs (going out, going somewhere else, coming back) that is not a round trip.

A. To bill a round trip if you bill for a base rate and mileage:
   (1) Round trips will need to supply a brief description for the purpose of the round trip in CR109, Loop 2300.

   (2) Ambulance pick-up and drop-off locations are required for all ambulance and nonemergency transportation claims. The pickup and drop-off locations will be sent in the following segments in Loop 2310E and 2310F: NM1, N3 and N4. Please see pages 7-8 and 7-11 of this companion guide for details of the segments.

   (3) Bill only one line for mileage (unless you have a known exception). The modifier for origin and destination should reflect the pick-up point and the stop point (e.g., Home to Doctor is a modifier of RP). Enter the total miles for the entire trip.

(4) If you bill a base rate, you will send that line item once. For wheelchair-van and stretcher van, submit total charges of two times your base rate on this line item.

B. To bill a round trip if you bill for a base rate only:

(1) Round trips will need to supply a brief description for the purpose of the round trip in CR109, Loop 2300.

(2) Ambulance pick-up and drop-off locations are required for all ambulance and nonemergency transportation claims. The pick-up and drop-off locations will be sent in the following segments in Loop 2310E and 2310F: NM1, N3 and N4. Please see pages 7-8 and 7-11 of this companion guide for details of the segments.

(3) Bill only one line item for base rate. The modifier for origin and destination should reflect the pick-up point and the stop point (e.g., Home to Doctor is a modifier of RP). For wheelchair-van and stretcher van, submit total charges of two times your base rate on this line item.

**Note about multi-leg trips:** For a trip that had multiple segments and is not a round trip as described above, each segment must be billed as a separate line item.

C. To bill a multi-leg trip if you bill for a base rate and mileage

(1) Ambulance pick-up and drop-off locations are required for all ambulance and on emergency transportation claims. The pick-up and drop-off locations will be sent in the following segments in Loop 2310E and 2310F: NM1, N3 and N4.

(2) Bill one line item for each segment of mileage. The modifier for origin and destination should reflect the start point and the stop point.

(3) Bill one line item for each segment of base rate. The modifier for origin and destination should reflect the start point and the stop point for that leg of the trip.

D. To bill a multi-leg trip if you bill for a base rate only:

(1) Ambulance pick-up and drop-off locations are required for all ambulance and nonemergency transportation claims. The pick-up and drop-off locations will be sent in the following segments in Loop 2310E and 2310F: NM1, N3 and N4. Please see pages 7-8 and 7-11 of this companion guide for details of the segments.

(2) Bill one line item for each segment of base rate. The modifier for origin and destination should reflect the start point and the stop point for that leg of the trip.

## Georgia Notes

## Transportation:

Ambulance Transport Reason Code:

In the CR104 Segment, the State of Georgia requires for Ambulance Claims:

**'A'** – Patient was transported to nearest facility for care of symptoms, complaints, or may be used to indicate that the patient was transferred to a residential facility
**'B'** – Patient was transported for the benefit of a preferred physician
**'C'** – Patient was transported for the nearness of family members
**'D'** – Patient was transported for the care of a specialist or for availability of specialized equipment
**'E'** – Patient Transferred to Rehabilitation Facility

In the CR105 Segment, the State of Georgia requires that an Ambulance Unit of Basis for Measurement Code has to be "DH" for Miles.

### Nebraska State Notes

**Providers Not Eligible for NPI (Atypical):**
Nebraska Medicaid defines a provider ineligible for an NPI as an atypical provider, such as: MHCP (Medically Handicapped Children's Program) clinics, MIPS (Medicaid in Public Schools), Personal Care Aides, Mental Health Personal Care Aides/Community Treatment Aides, Mental Health Home Health Care Aides and Non-Emergency Transportation providers and Community Support Workers.

**Vision services:**
When using V2799 to claim for frame front/chassis, temple, hinge, nose pad, or eyeglasses case replacement; enter description of replacement.
For Telehealth services, enter the site where the patient is receiving the Telehealth service.

**Referring Provider State License:**
The State License Number needs to be reported in the REF 2310A Loop.

- State license number must be the two-digit alphabetical state code abbreviation, followed by the state license number. For example, NE123456

## Designator Description

**M** – Mandatory: The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.

**R** – Required: At least one of the elements specified in the condition must be present.

**S** – Situational: If a segment or field is marked as "Situational", it is only sent if the data condition stated applies.

## Further Encounter Field Descriptions

Refer to the IG for the initial mapping information. The grid below further clarifies additional information The Plan requires.

| **Interchange Control Header:** | | | | | | |
|---|---|---|---|---|---|---|
| **Pos** | **Id** | **Segment Name** | **Req** | **Max Use** | **Repeat** | **Notes** |
| | **ISA06** | Interchange Sender ID | M | 1 | | For Direct submitters, use unique ID assigned by The Plan, e.g.: 123456 followed by spaces to complete the 15-digit element.<br><br>For Clearinghouse submitters, use ID as per the clearinghouse |
| | **ISA08** | Interchange Receiver ID | M | 1 | | For Direct submitters, use "**WELLCARE**"<br>**Note:** Please make sure the Receiver ID is **left-justified** with **trailing spaces** for a total of 15 characters. Do not use leading ZEROS.<br><br>For Clearinghouse submitters, use ID as per the clearinghouse |
| **Functional Group Header:** | | | | | | |
| | **GS02** | Senders Code | M | 1 | | For Direct submitters, use your existing Plan Submitter ID **or** the Trading Partner ID provided during the enrollment process.<br><br>For Clearinghouse submitters, use ID as per the clearinghouse |
| | **GS03** | Receivers Code | M | 1 | | For Direct submitters, use WellCare ID "**WELLCARE**"<br><br>For Clearinghouse submitters, use ID as per the clearinghouse |
| **Header:** | | | | | | |
| **Pos** | **Id** | **Segment Name** | **Req** | **Max Use** | **Repeat** | **Notes** |
| 0100 | **BHT06** | Encounters/Encounter Identifier | R | 1 | | Use value of "**CH**" – Chargeable ( ) or "**RP**" – Reporting (Encounters) Encounters<br><br>The Plan will reject any Encounters that have "**31**' – Subrogation Demand. |
| **LOOP ID - 1000A – Submitter Name** | | | | | **1** | |
| 0200 | **NM109** | Submitter Identifier | R | | | For Direct submitters, use "**ETIN**", i.e.,<br>The Plan Submitter ID or 6-digit Trading Partner ID assigned during the EDI enrollment process.<br><br>For Clearinghouse submitters, use ID as per the clearinghouse |
| **LOOP ID - 1000B – Receiver Name** | | | | | **1** | |
| 0200 | **NM103** | Receiver Name | R | 1 | | For Direct submitters, use value "**WELLCARE HEALTH PLANS, INC**"<br>(e.g., WellCare Health Plans of Georgia,<br>WellCare Health Plans of New York)<br><br>For Clearinghouse submitters, use ID as per the clearinghouse |

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| 0200 | **NM109** | Receiver Primary ID | R | 1 | | For Direct submitters, use the value of Payer ID<br><br>For Clearinghouse submitters, use ID as per the clearinghouse |

**Detail:**

| Pos | Id | Segment Name | Req | Max Use | Repeat | Notes |
|---|---|---|---|---|---|---|
| **LOOP ID - 2000A – Billing/Pay-To Provider Hierarchical Level** | | | | | **>1** | |
| 0030 | **PRV03** | Billing Provider Specialty Information | S | 1 | | **All States**<br>The correct Billing Provider Taxonomy Code **must** be sent. |
| **LOOP ID - 2010AA – Billing Provider Name** | | | | | **1** | |
| 0150 | **NM108** | Billing Provider Primary Type | R | 1 | | **All States**<br>All non-Atypical submitters **must** have value of "**XX**".<br><br>All Atypical submitters **must** not use this element. |
| 0150 | **NM109** | Billing Provider ID | R | 1 | | **All States**<br>All non-Atypical submitters **must** have NPI.<br><br>All Atypical submitters **must** not use this element. |
| 0350 | **REF01** | Billing Provider Tax Identification | R | 1 | | **All States**<br>All Atypical and non-Atypical submitters are required to use the value of "**EI**". |
| 0350 | **REF02** | Billing Provider Tax Identification | R | 1 | | **All States**<br>All submitters are required to send in their "**TAX ID**". |
| 0350 | **REF01** | Billing Provider UPIN/License Information | R | 2 | | **All States**<br>Only Atypical submitters may use this REF segment. |
| 0350 | **REF02** | Billing Provider UPIN/License Information | R | 2 | | **All States**<br>Only Atypical submitters may use this REF segment. |
| **LOOP ID - 2000B – Subscriber Hierarchical Level** | | | | | **>1** | |
| 0050 | **SBR01** | Payer Responsibility Sequence Number Code | R | 1 | | Use the value of "**P**" if the Plan is the primary payer. |
| 0050 | **SBR09** | Encounters Filing Indicator Code | | 1 | | Value equal to Medicaid or Medicare filing. |
| 0070 | **PAT09** | Pregnancy Indicator | S | 1 | | Use indicator of "**Y**" if subscriber is pregnant. |
| **LOOP ID - 2010BA – Subscriber Name** | | | | | **1** | |
| 0150 | **NM108** | Subscriber Primary Identification code Qualifier | S-R | 1 | | Use the value "**MI**". |
| 0150 | **NM109** | Subscriber Primary Identifier | S-R | 1 | | **All States**<br>Subscriber Medicaid/Medicare ID, The Plan ID |
| 0320 | **DMG03** | Subscriber Demographic Information | S-R | 1 | | **All States**<br>All submitters **must** send "**F**" – Female or "**M**" – Male only |
| **LOOP ID - 2010BB – Payer Name** | | | | | **1** | |
| 0150 | **NM108** | Identification code Qualifier | | | | Use value "**PI**". |
| 0150 | NM109 | Identification code | | | | Use value Payer ID. |

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| **LOOP ID - 2300 – Encounters information** | | | | | **100** | |
| 1300 | **CLM01** | Encounters Submitters Identifier | R | 1 | | **All States**<br>All submitters are required to send unique IDs for each Encounter sent. |
| 1300 | **CLM05-3** | Encounters Frequency Type Code | R | 1 | | **All States**<br>Use "**1**" on original Encounter(s) submission<br><br>Use "**7**" for Encounter(s) Replacement (Adjustment)<br><br>Use "**8**" for Encounter(s) void<br><br>For both "**7**" and "**8**", include the original **WellCare Claim Number (WCN)**, as indicated in Loop 2300 **REF02 (Original Reference Number**). |
| 1350 | **DTP** | Last Menstrual Period | S-R | 1 | | **All States**<br>All submitters **must** send this segment when the Pregnancy Indicator is in the PAT09 in the 2000B loop is set to "**Y**" – Yes. |
| 1800 | **REF02** | Prior Authorization Number | S-R | 1 | | **State Notes**<br>**GA, LA** submitters are required to submit the "**G1**" in the **REF01** and Auth Number in the **REF02**.<br><br>**HI** submitters are required to submit the "**G1**" in the **REF01**. Although this REF Segment can also be used for referral numbers, Med-QUEST is only concerned with PA numbers for services that were authorized by Med-QUEST. Use this segment when the PA is at the Encounter rather than the service line level.<br><br>**All States**<br>This is now a single segment for just the PA number.<br><br>All submitters are required to send this segment when The Plan has assigned a PA number. |
| 1800 | **REF02** | Referral Number | S-R | 1 | | **State Notes**<br>**GA, LA** submitters are required to submit the "**9F**" in the **REF01** and referral number in the **REF02**.<br><br>**All States**<br>This is now a single segment for just the referral number.<br><br>All Submitters are required to send this segment when the Plans has assigned a referral number |
| 1800 | **REF02** | Code qualifying the Reference Identification | S-R | 1 | | **State Note**<br>**HI** submitters must submit **"P4"** in the **REF01** when the Department of Human Services Social Services Division |

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| | | | | | | (DHS/SSD) is responsible for Medicaid Waiver Programs in Hawaii. SSD Encounters for Medicaid Waiver services are identified by a "W" in the Demonstration Project Identifier element. |
| 1800 | **REF02** | Original Reference Number (ICN/DCN) | S-R | 1 | | **All States**<br>All submitters must submit an "**F8**" in the **REF01** when **CLM05-3** (Encounters Submission Reason Code) = "**7**", or "**8**", the **Plan Trace Number** is assigned to a previously submitted Encounter(s) and required to be sent in the transaction. |
| 1900 | **NTE01** | Note Reference Code | S-R | 20 | | **All States**<br>For **MAS** procedure codes, use "**ADD**" in the **NTE01**<br><br>**State Note:**<br>**OH** Medicaid co-payments exclusions – Send in "**ADD**" in the **NTE01**<br><br>**IL** Must use "**ADD**" when the services require additional information to be reported. |
| 1900 | **NTE02** | Description | S-R | | | **All States**<br>For **MAS** procedure codes, see CMS documentation.<br><br>**State Notes**<br>**OH** When Medicaid co-payment exclusion applies, the 10-character code (see below) **must** be the first item in the **NTE02**. There **must** always be a single space between the word COPAY and the fourth character exclusion code.<br>• COPAY EMER (Emergency)<br>• COPAY HSPC (Hospice)<br>• COPAY PREG (Pregnancy)<br><br>**IL** For all Encounters that are special priced, include the appropriate required detail in this section.<br>For emergency and non-emergency transportation Encounters, this element will contain the State, Vehicle License Number, Origin Time, and Destination Time. See section on Transportation Encounters under the Payer Specific Business Rules and Limitations section for more detail. |
| 1950 | **CR104** | Ambulance Transport Reason Code | S-R | 1 | | **State Notes**<br>**FL** Enter the Ambulance Transport Reason Code.<br>**Note:** Refer to the 837 Professional Implementation Guide for the valid code values. |

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| | | | | | | **GA** Ambulance Transport Reason Codes<br>**'A'** – Patient was transported to nearest facility for care of symptoms, complaints, or both. May be used to indicate that the patient was transferred to a residential facility.<br>**'B'** – Patient was transported for the benefit of a preferred physician<br>**'C'** – Patient was transported for the nearness of family members<br>**'D'** – Patient was transported for the care of a specialist or for availability of specialized equipment<br>**'E'** – Patient Transferred to Rehabilitation Facility |
| 1950 | **CR105** | Ambulance Unit or Basis for Measurement Code | S-R | 1 | | **State Notes**<br>**FL** 'DH' – Miles<br>**GA** 'DH' – Miles |
| 1950 | **CR106** | Ambulance Transport Distance | S-R | 1 | | **State Notes**<br>**FL** Florida Medicaid will process only the whole number when units are entered with decimals.<br>**Example**: Units entered on the transaction 3.75 will be processed as 3 units.<br><br>**GA** Quantity<br><br>**IL** Transportation providers must report the number of "loaded" miles. |
| 2200 | **CR210** | Spinal Manipulation Service Information | S-R | 1 | | **State Note**<br>**NE** Report the treatment number(s) billed on this claim |
| 2200 | **CRC01** | Ambulance Certification – Code Category | S-R | 1 | | **All States**<br>'07' - Ambulance Certification<br>The CRC segment is required if CR1 is used. |
| 2200 | **CRC02** | Ambulance Certification – Certification Condition Code Applies Indicator | S-R | 1 | | **All States**<br>**'Y'** – Yes<br>'**N**' – No<br>CRC02 is a Certification Condition Code applies indicator. A "**Y**" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply. |
| 2200 | **CRC03** | Ambulance Certification – Condition Indicator | S-R | 1 | | **State Note**<br>**GA** '**01**' – Patient was admitted to a hospital<br>'**04**' – Patient was moved by stretcher<br>'**05**' – Patient was unconscious or in shock<br>'**06**' – Patient was transported in an emergency situation<br>'**07**' – Patient had to be physically restrained<br>'**08**' – Patient had visible hemorrhaging |

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| | | | | | | '**09**' – Ambulance service was medically necessary<br>'**12**' – Patient is confined to a bed or chair |
| 2200 | **CRC01** | EPSDT Referral – Code Category | S-R | 1 | | **State Notes**<br>**FL, GA**<br>'**ZZ**' – Mutually Defined<br><br>Enter this for Child Health Checkup Screening referral information. |
| 2200 | **CRC02** | EPSDT Referral – Certification Condition Indicator | S-R | 1 | | **State Notes**<br>**FL, GA** '**Y**' – Yes<br>'**N**' – No<br>For Child Health Checkup Screenings, enter "**Y**" if the patient is referred to another provider as a result of the screening.<br>Enter '**N**' if no referral is made.<br>If '**N**' is entered here, enter '**NU**' in 2300, CRC03 |
| 2200 | **CRC03** | EPSDT Referral – Condition Code | S-R | 1 | | **State Notes**<br>**FL, GA** Enter one of the following valid values. For Child Health Checkup Exam Result:<br>'**AV**' – Patient Refused Referral<br>'**NU**' – Not Used (Patient Not Referred)<br>'**S2**' – Under Treatment<br>'**ST**' – New Services Requested |
| **LOOP ID – 2310A – Referring Provider Name** | | | | | **1** | |
| 2500 | **NM108** | Referring Provider Name | S-R | 1 | | **All States**<br>All non-Atypical submitters **must** have value of "**XX**".<br><br>All Atypical submitters **must** not use this element |
| 2500 | **NM109** | Referring Provider ID | R | 1 | | **All States**<br>All non-Atypical submitters **must** have NPI.<br><br>All Atypical submitters **must** not use this element |
| 2710 | **REF01** | Referring Reference Identification Qualifier | S | 5 | | **All States**<br>Only Atypical submitters can use this segment<br><br>**State Note**<br>**NE** Medicaid will only process "**0B**" |
| 2710 | **REF02** | Referring Provider Secondary Identification | S | 5 | | **All States**<br>Only Atypical submitters can use this segment<br><br>**State Note**<br>**NE** State license number must be the two-digit alphabetical state code abbreviation, followed by the state license number: for example, NE123456 |
| **LOOP ID – 2310B – Rendering Provider Name** | | | | | **1** | |
| 2500 | **NM108** | Rendering Provider Name | S-R | 1 | | **All States**<br>All non-Atypical submitters **must** have value of "**XX**".<br><br>All Atypical submitters **must** not |

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| | | | | | | use this Element |
| 2500 | **NM109** | Rendering Provider ID | R | 1 | | **All States**<br>All non-Atypical submitters **must** have NPI.<br><br>All Atypical submitters **must** not use this element |
| 2550 | **PRV03** | Rendering Taxonomy Code | S-R | 1 | | **All States**<br>All Submitters **must** send the Rending Provider's Taxonomy Code as per the 837.<br><br>**State Notes**<br>**CT GA IN LA** submitters **must** send the Taxonomy Codes.<br><br>**MO** Submitters are required to send in the Taxonomy Codes if submitter has multiple MO HealthNet Legacy Provider IDs |
| 2710 | **REF01** | Rendering Reference Identification Qualifier | S | 3 | | **All States**<br>Only Atypical submitters can use this segment |
| 2710 | **REF02** | Rendering Provider Secondary Identification | S | 3 | | **All States**<br>Only Atypical submitters can use this segment |
| **LOOP ID – 2310C Service Facility Location** | | | | | **1** | |
| 2500 | **NM1** | Service Facility Location | S-R | 1 | | **All States**<br>All submitters **must** use this loop when the physical location where the service took place is different than the address in the Billing Provider Name (2010AA) Loop. |
| 2650 | **N301** | Service Facility Location Address | R | 1 | | **All States**<br>All submitters **must** send in physical address. The Plan will reject any Encounters that contain a P.O. box in this segment. |
| 2710 | **REF01** | Service Facility Location Secondary Identification Qualifier | S | 3 | | **All States**<br>Only Atypical submitters can use this segment. |
| 2710 | **REF02** | Service Facility Location Secondary Identification | S | 3 | | **All States**<br>Only Atypical submitters can use this segment. |
| **LOOP ID – 2310E Ambulance Pickup Location** | | | | | **1** | |
| 2500 | **NM1** | Ambulance Pickup Location | S-R | 1 | | **All States**<br>All Transportation submitters **must** use this loop. |
| 2650 | **N301** | Ambulance Pickup Location Address | R | 1 | | **All States**<br>All Transportation submitters **must** send in Physical Address. The Plan will reject any Encounters that contain a P.O. box in this segment.<br>**NOTE:** If the ambulance pickup location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, 'crossroad of State Road 34 and 45' or 'Exit near Mile marker 265 on Interstate 80'). |
| 2700 | **N4** | Ambulance Pickup Location | R | 1 | | **All States**<br>All Transportation submitters |

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| | | City, State ZIP Code | | | | **must** send this in. |
| **LOOP ID – 2310F - Ambulance Drop-Off Location** | | | | | **1** | |
| 2500 | **NM1** | Ambulance Drop-Off Location | S-R | 1 | | **All States**<br>All Transportation submitters **must** use this loop. |
| 2650 | **N301** | Ambulance Drop-Off Location Address | R | 1 | | **All States**<br>All Transportation submitters **must** send in physical address. The Plan will reject any Encounters that contain a P.O. box in this segment.<br>**NOTE:** If the ambulance pickup location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, 'crossroad of State Road 34 and 45' or 'Exit near Mile marker 265 on Interstate 80'.) |
| 2700 | **N4** | Ambulance Drop-Off Location City, State ZIP Code | R | 1 | | **All States**<br>All Transportation Submitters **must** send this in |
| **LOOP ID – 2320 – Other Subscriber Information** | | | | | **10** | |
| 2900 | **SBR01** | Payer Responsibility Sequence Number Code | R | 1 | | **All States**<br>All Vendor/Provider submitters that adjudicate Encounters for the Plan **must** make themselves the Primary "**P**".<br><br>In the SBR01 Element in the Subscriber Information (2000B) **must** be sent to the next available Payer Responsibility Number Code |
| 2950 | **CAS02** | Encounters Adjustment Reason | S | 5 | | **State Note**<br>**GA** Interest paid on the Encounters should be reported in a CAS segment. Please use Code "**225**" for interest payments.<br>**NOTE:** Do not report interest paid as a separate line item on the Encounter(s). |
| 3000 | **AMT02** | Coordination of Benefits (COB) Payer Paid Amount | S | 1 | | **All States**<br>All Vendor/Provider submitters that adjudicate Encounters for The Plan **must** send this segment.<br><br>This element **must** be the amount paid by the Vendor to the Provider. |
| **LOOP ID – 2330B Other Payer Name** | | | S | | **1** | |
| 2250 | **NM103** | Last Name or Organization Name | R | 1 | | **All States**<br>All Vendor/Provider submitters that adjudicate Encounters for The Plan **must** send this segment.<br><br>For a Medicaid Payment: WELLCAREMCD<br>For a Medicare Payment: WELLCAREMCR |
| 2250 | **NM109** | Identification Code | R | 1 | | **All States**<br>All Vendor/Provider submitters |

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| | | | | | | that adjudicate Encounters for The Plan **must** send this segment.<br><br>The Vendor/Provider submitters who are paying the Encounter(s) **must** use the IDs below:<br><br>For a Medicaid Payment: WELLCAREMCD<br>For a Medicare Payment: WELLCAREMCR<br><br>This will be used in the Line Adjudication Information (2430) Loop in the SVD01. |
| **LOOP ID – 2400 – Line Note** | | | | | **1** | |
| 4850 | **NTE02** | Line Note Text | S | 1 | | **State Notes**<br>**NE** For vision services: When using V2799 to claim for frame front/chassis, temple, hinge, nose pad, or eyeglasses case replacement, enter description of replacement.<br>For Telehealth services, enter the site where the patient is receiving the Telehealth service.<br><br>**IL** For all claims that are special priced, include the appropriate required detail in this section. For emergency and non-emergency transportation claims, this element will contain the State, Vehicle License Number, Origin Time, and Destination Time. See section on Transportation claims under the Payer Specific Business Rules and Limitations section for more detail. |
| **LOOP ID – 2420A – Rendering Provider Name** | | | | | **1** | |
| 5050 | **PRV03** | Taxonomy Code | S-R | 1 | | **State Notes**<br>**MO, IL** Submitters are required to send in the Taxonomy Codes if submitter has multiple MO HealthNet Legacy Provider IDs. |
| **LOOP ID – 2430 Line Adjudication Information** | | | | | **15** | |
| 5400 | **SVD01** | Identification Code | S-R | 1 | | **All States**<br>All Vendor/Provider submitters that adjudicate Encounters for The Plan **must** send this segment.<br><br>The Vendor/Provider submitters who are paying the Encounter(s) must use the IDs below:<br><br>For a Medicaid Payment: WELLCAREMCD<br>For a Medicare Payment: WELLCAREMCR<br><br>This will be the same as in the Other Payer Name (2330B) |

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| | | | | | | Identification Code in the NM109. |
| 5400 | **SVD02** | Monetary Amount | R | 1 | | **All States**<br>All Vendor/Provider submitters that adjudicate Encounters for the Plan **must** send this segment.<br><br>This is how much was paid by the Vendor/Provider after Check Run. |
| 5450 | **CAS02** | Encounters Adjustment Reason Code | R | 1 | | **All States**<br>All Vendor/Provider submitters that adjudicate Encounters for the Plan **must** send this segment.<br><br>This **must** be a HIPAA-compliant reason code. |
| 5450 | **CAS03** | Monetary Amount | R | 1 | | **All States**<br>All Vendor/Provider submitters that adjudicate Encounters for the Plan **must** send this segment.<br><br>This is the difference between what the Vendor/Provider paid and how much was billed. |
| 5500 | **DTP03** | Date Time Period | R | 1 | | **All States**<br>All Vendor/Provider submitters that adjudicate Encounters for the Plan **must** send this segment.<br><br>The Vendor/Provider **must** use the check date for the payment date. |

## Attachment A

## Glossary

| Term | Definition |
|---|---|
| **HIPAA** | In 1996, Congress passed into federal law the Health Insurance Portability and Accountability Act (HIPAA) in order to improve the efficiency and effectiveness of the entire health care system. The provisions of HIPAA, which apply to health plans, health care providers, and healthcare clearinghouses, cover many areas of concern including, preventing fraud, waste and abuse, preventing pre-existing condition exclusions in health care coverage, protecting patients' rights through privacy and security guidelines and mandating the use of a national standard for EDI transactions and code sets. |
| **SSL**<br>**(Secure Sockets Layer)** | SSL is a commonly used protocol for managing the security of a message transmission through the internet. SSL uses a program layer located between the HTTP and TCP layers. The "sockets" part of the term refers to the sockets method of passing data back and forth between a client and a server program in a network or between program layers in the same computer. SSL uses the public- and private-key encryption system from RSA, which also includes the use of a digital certificate. |
| **Secure FTP (SFTP)** | Secure FTP, as the name suggests, involves a number of optional security enhancements, such as encrypting the payload or including message digests to validate the integrity of the transported files to name two examples. Secure FTP uses Port 21 and other ports, including SSL. |
| **AUTH SSL** | AUTH SSL is the explicit means of implementing secure communications as defined in RFC 2228. AUTH SSL provides a secure means of transmitting files when used in conjunction with an FTP server and client that both support AUTH SSL. |
| **Required Segment** | A required segment is a segment mandated by HIPAA as mandatory for exchange between Trading Partners. |
| **Situational Segment** | A situational segment is a segment mandated by HIPAA as optional for exchange between Trading Partners. |
| **Required Data Element** | A mandatory data element is one that **must** be transmitted between Trading Partners with valid data. |
| **Situational Data Element** | A situational data element may be transmitted if data is available. If another data element in the same segment exists and follows the current element the character used for missing data should be entered. |
| **N/U (Not Used)** | An N/U (Not Used) data element is included in the shaded areas if the Implementation Guide is NOT USED according to the standard, and no attempt should be made to include these in transmission.. |
| **ATTENDING PROVIDER** | The primary individual provider who attended to the client/member during an inpatient hospital stay. This must be identified in 837I. |
| **BILLING PROVIDER** | The Billing Provider entity may be a health care provider, a billing service, or some other representative of the provider. |
| **IMPLEMENTATION GUIDE (IG)** | Instructions for developing the standard ANSI ASC X12N Health Care Encounters 837 transaction sets. The Implementation Guides are available from Washington Publishing Company. |

<table>
<tr><th>Term</th><th>Definition</th></tr>
<tr><td>PAY-TO PROVIDER</td><td>This entity may be a medical group, clinic, hospital, other institution, or the individual provider who rendered the service.</td></tr>
<tr><td>REFERRING PROVIDER</td><td>Identifies the individual provider who referred the client or prescribed ancillary services/items such as Lab, Radiology or Durable Medical Equipment (DME).</td></tr>
<tr><td>RENDERING PROVIDER</td><td>The primary individual provider who attended to the client/member. They must be identified in 837P.</td></tr>
<tr><td>TRADING PARTNERS (TPs)</td><td>Includes all of the following: payers, switch vendors, software vendors, providers, billing agents, clearinghouses</td></tr>
<tr><td>DATE FORMAT</td><td>All dates are 8-character dates in the format CCYYMMDD. The only date data element that varies from the above standard is the Interchange Date data element located in the ISA segment. The Interchange Date data element is a 6-character date in the YYMMDD format.</td></tr>
<tr><td>DELIMITERS</td><td>A delimiter is a character used to separate 2 data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction. The following characters are used as data delimiters for all transaction segments:
<table>
<tr><th>CHARACTER</th><th>PURPOSE</th></tr>
<tr><td>* Asterisk</td><td>Data Element Separator</td></tr>
<tr><td>: Colon</td><td>Sub-Element Separator</td></tr>
<tr><td>^ Caret</td><td>Repetition Separator</td></tr>
<tr><td>~ Tilde</td><td>Segment Terminator</td></tr>
</table>
</td></tr>
</table>

# Attachment B
## 999 Interpretations

The examples below show an accepted and a Rejected X12 N 999. On The Plan SFTP site in the respective *Provider Directory,* the X12N 999 files (when opened) will display as one complete string without carriage returns or line feeds. In the examples below, we added carriage returns at the end of each segment.

### Accepted 999

ISA~00~ ~00~ ~ZZ~123456789 ~ZZ~987654321 ~111211~2345~^~00501~000000001~0~P~+'
GS~FA~123456789~133052274~987654321~2345~1~X~005010X231A1'
ST~999~0001~005010X231A1'
AK1~HC~77123~005010X222A1'
AK2~837~0001~005010X222A1'
IK5~A'
AK9~A~1~1~1'
SE~6~0001'
GE~1~1'
IEA~1~000000001'

### Rejected 999

ISA~00~ ~00~ ~ZZ~123456789 ~ZZ~987654321 ~111227~1633~^~00501~000000001~0~P~+'
GS~FA~123456789~987654321~20111227~1633~1~X~005010X231A1'
ST~999~0001~005010X231A1'
AK1~HC~3264~005010X222A1'
AK2~837~000000060~005010X222A1'
IK3~SV5~32~2400~8'
CTX~CLM01+0116.0090738.01'
IK4~4~782~I9'
IK4~6~594~I9'
IK3~SV5~43~2400~8'
CTX~CLM01+0116.0090738.01'
IK4~4~782~I9'
IK4~6~594~I9'
IK5~R~I5'
AK9~R~1~1~0'
SE~14~0001'
GE~1~1'
IEA~1~000000001'

### Partial 999

ISA~00~ ~00~ ~ZZ~123456789 ~ZZ~987654321 ~111115~2119~^~00501~000000001~0~P~+'
GS~FA~123456789~RHCLM117~20111115~2119~1~X~005010X231A1'
ST~999~0001~005010X231A1'
AK1~HC~184462723~005010X222A1'
AK2~837~000000001~005010X222A1'
IK5~A'
AK2~837~000000002~005010X222A1'
IK5~A'
AK2~837~000000003~005010X222A1'
IK5~A'
AK2~837~000000004~005010X222A1'
IK5~A'
AK2~837~000000005~005010X222A1'
IK5~A'
AK2~837~000000006~005010X222A1'
IK5~A'
....
AK2~837~000000126~005010X222A1'
IK5~A'
AK2~837~000000127~005010X222A1'
IK5~A'
AK2~837~000000128~005010X222A1'

```
IK3~NM1~22~2310~8'
CTX~CLM01+001-375436/483311'
IK4~4~1036~I9'
IK3~NM1~40~2310~8'
CTX~CLM01+001-375436/483312'
IK4~4~1036~I9'
IK3~NM1~58~2310~8'
CTX~CLM01+001-375436/483313'
IK4~4~1036~I9'
IK3~NM1~76~2310~8'
CTX~CLM01+001-387563/483314'
IK4~4~1036~I9'
IK3~NM1~94~2310~8'
IK5~E~I5'
AK2~837~000000129~005010X222A1'
IK5~A'
AK2~837~000000130~005010X222A1'
IK5~A'
AK2~837~000000131~005010X222A1'
IK5~A'
...
AK2~837~000000277~005010X222A1'
IK5~A'
AK2~837~000000278~005010X222A1'
IK5~A'
AK2~837~000000279~005010X222A1'
IK3~NM1~46~2310~8'
CTX~CLM01+599440'
IK4~4~1036~I9'
IK3~NM1~72~2310~8'
CTX~CLM01+599450'
IK4~4~1036~I9'
IK5~E~I5'
AK2~837~000000280~005010X222A1'
IK5~A'
AK2~837~000000281~005010X222A1'
IK5~A'
AK2~837~000000282~005010X222A1'
IK5~A'
...
AK2~837~000000729~005010X222A1'
IK5~A'
AK2~837~000000730~005010X222A1'
IK5~A'
AK2~837~000000731~005010X222A1'
IK5~A'
AK9~P~731~731~730'
SE~1696~0001'
GE~1~1'
IEA~1~000000001'
```

# Attachment C
## COB Claim Examples

## 1 Payer COB Example

ISA*00* *00* *ZZ*SENDER *ZZ*WELLCARE *130111*1452*^*00501*000016700*1*T*:~
GS*HC* SENDER *WELLCARE*20130111*145200*16700*X*005010X222A1~
ST*837*0001*005010X222A1~
BHT*0019*00*1*20130111*1452*RP~
NM1*41*2* SENDER *****46* SENDER~
PER*IC* SENDER *EM* SENDER @ SENDER.COM~
NM1*40*2*WELLCARE HEALTH PLANS, INC*****46*WELLCARE~
HL*1**20*1~
PRV*BI*PXC*152W00000X~
NM1*85*2*HEATH CARE PROVIDER*****XX*9999999999~
N3*1201 13TH STREET~
N4*TAMPA*FL*342221234~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*421-001******MB~
NM1*IL*1*MEMBER LAST NAME*MEMBER FRIST NAME****MI*MEMBER ID~
N3*123 MAIN ST~
N4*TAMPA*FL*342229999~
DMG*D8*19720706*M~
NM1*PR*2*WELLCARE*****PI*SENDER~
N3*PO BOX 7777~
N4*PHOENIX*AZ*85011~
CLM*1 PAYER COB EXAMPLE*300***11:B:1*Y*A*Y*Y*P~
DTP*454*D8*20121101~
REF*D9*2012354M0007100~
HI*BK:3671~
SBR*S*18***14****MB~
AMT*D*100~
OI***Y*P**Y~
NM1*IL*1*MEMBER LAST NAME*MEMBER FRIST NAME****MI*MEMBER ID~
NM1*PR*2*SENDER*****PI*SENDER~
DTP*573*D8*20121219~
REF*F8*PP2012354M0007100~
LX*1~
SV1*HC:V2020*100*UN*1***1~
DTP*472*D8*20121101~
SVD*SENDER*50*HC:V2020**1~
CAS*CO*45*50~
DTP*573*D8*20121219~
LX*2~
SV1*HC:V2200*200*UN*1***1~
DTP*472*D8*20121101~
SVD*SENDER*50*HC:V2200**1~
CAS*CO*45*150~
DTP*573*D8*20121219~
SE*44*0001~
GE*1*16700~
IEA*1*000016700~

## Dual Member Payer COB Example

ISA*00* *00* *ZZ*SENDER *ZZ*WELLCARE *130111*1452*^*00501*000016700*1*T*:~
GS*HC*SENDER*WELLCARE*20130111*145200*16700*X*005010X222A1~
ST*837*0001*005010X222A1~
BHT*0019*00*1*20130111*1452*RP~
NM1*41*2*SENDER*****46*SENDER~
PER*IC*SENDER*EM*SENDER@SENDER.COM~
NM1*40*2*WELLCARE HEALTH PLANS, INC*****46*WELLCARE~
HL*1**20*1~
PRV*BI*PXC*152W00000X~
NM1*85*2*HEATH CARE PROVIDER*****XX*9999999999~
N3*1201 13TH STREET~
N4*TAMPA*FL*342221234~
REF*EI*999999999~
HL*2*1*22*0~
SBR*P*18*421-001******MB~
NM1*IL*1*MEMBER LAST NAME*MEMBER FRIST NAME****MI*MEMBER ID~
N3*123 MAIN ST~
N4*TAMPA*FL*342229999~
DMG*D8*19720706*M~
NM1*PR*2*WELLCARE*****PI*WELLCARE~
N3*PO BOX 7777~
N4*PHOENIX*AZ*85011~
CLM*2 PAYER COB EXAMPLE*300***11:B:1*Y*A*Y*Y*P~
DTP*454*D8*20121101~
REF*D9*2012354M0007100~
HI*BK:3671~
SBR*T*18***14****MB~
AMT*D*50~
OI***Y*P**Y~
NM1*IL*1*MEMBER LAST NAME*MEMBER FRIST NAME****MI*MEMBER ID PAYER 2~
NM1*PR*2*WELLCAREMCD*****PI* WELLCAREMCD~
DTP*573*D8*20121101~
REF*F8*PAYER 2 TRACE NUMBER~
SBR*S*18***14****MB~
AMT*D*100~
OI***Y*P**Y~
NM1*IL*1*MEMBER LAST NAME*MEMBER FRIST NAME****MI*MEMBER ID~
NM1*PR*2* WELLCAREMCR*****PI* WELLCAREMCR~
DTP*573*D8*20121219~
REF*F8*PP2012354M0007100~
LX*1~
SV1*HC:V2020*100*UN*1***1~
DTP*472*D8*20121101~
SVD* WELLCAREMCR*50*HC:V2020**1~
CAS*CO*45*50~
DTP*573*D8*20121219~
SVD* WELLCAREMCD*25*HC:V2020**1~
CAS*CO*45*75~
DTP*573*D8*20121101~
LX*2~
SV1*HC:V2200*200*UN*1***1~
DTP*472*D8*20121101~
SVD* WELLCAREMCR*50*HC:V2200**1~
CAS*CO*45*150~
DTP*573*D8*20121219~
SVD* WELLCAREMCD*25*HC:V2200**1~
CAS*CO*45*175~
DTP*573*D8*20121101~
SE*44*0001~
GE*1*16700~
IEA*1*000016700~

## The WellCare Group of Companies (The Plan)


'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.

WellCare Health Insurance of Illinois, Inc.

WellCare Health Insurance of New York, Inc.

WellCare Health Plans of New Jersey, Inc.

WellCare of Nebraska, Inc.

WellCare of Louisiana, Inc.

WellCare of New York, Inc.

WellCare of Connecticut, Inc.

WellCare of Georgia, Inc.

Harmony Health Plan of Illinois, Inc.

Easy Choice California

WellCare of Texas, Inc.

Healthy Connections Prime

Missouri Care, Inc.

WellCare of South Carolina, Inc.

Easy Choice Health Plan

WellCare of Kentucky, Inc.

WellCare Health Plans of Kentucky, Inc.

WellCare of Ohio, Inc.

WellCare of Florida, Inc., operating in Florida as Staywell and Staywell Kids