

THE WELLCARE GROUP OF COMPANIES
EDI TRANSACTION SET
837I X12N HEALTH CARE
ENCOUNTER INSTITUTIONAL
ASC X12N VERSION **5010A2**
COMPANION GUIDE

**Inbound
837 Institutional
Encounters Submission**

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Revision History

Date	Rev #	Author	Description
04/06/2012	1.00	Craig Smitman	Encounters Review
05/04/2013	1.01	Craig Smitman	Updates made after IL Encounters Review
09/16/2013	1.03	Craig Smitman	Updates made after the Encounters team Review
09/18/2013	1.04	Craig Smitman	Added ICD-10 Mandate Business Rule and updated the Paper Claim Submission verbiage
10/04/2013	2.05 Update	Craig Smitman / GA Market	Updated the ICD-10 Verbiage to add Date of Service as part of the Mandate.
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.
08/30/2015	2.09 Update	Craig Smitman / Fran Meadows	Removed KY Requirements
10/29/2015	2.10 Update	Craig Smitman	Updated the Guide with IA Requirements
01/26/2016	2.11 Update	Craig Smitman	Updated what is required in the COB loops for Dual Members for Medicare / Medicaid payments.
08/03/2016	2.12 Update	Craig Smitman	Removed the IA Requirements Added NE Requirements Removed the Windsor Logo
08/15/2016	2.13 Update	Craig Smitman / Edouard Desruisseaux / Tiffany Hilleary	Updated the WellCare Group of Companies, State Affiliation and Added Patient Status Code note Updated the Paper Claim Submission Added IL Value Code for Birth Wight Requirement

Contact Roster

Trading Partners and Providers ; Questions, Concerns, 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 Trading Partners (TPs). WellCare X12N 837 Institutional Encounter ‘Companion Guide’ is intended for use by The Plan’s Providers and TPs in conjunction with HIPAA ANSI ASC X12N Technical Report Type 3 Electronic Transaction Standard (Version – TR3) and its related errata X223A2 Implementation Guide.

The Reference HIPAA TR3 for this Companion Guide is the ANSI ASC X12N 837I TR3 Version – 005010X223 and its related errata X223A2

- UAT 5010 X223A2 Start Date – 09/01/2011 for inbound Encounters
- Production 5010 X223A2 Start Date – 01/01/2012 for inbound Encounters
- Production 5010 X223A2 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 837I Healthcare Encounter Institutional 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 Institutional Healthcare TR3 Implementation Guides (IG)

To purchase the IG, contact the 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 837I (005010X223A2) 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.

Easy Choice California

WellCare Health Insurance of New York, Inc.

WellCare of Texas, Inc.

WellCare Health Plans of New Jersey, Inc.

Healthy Connections Prime

WellCare of Nebraska, Inc.

Missouri Care, Inc.

WellCare of Louisiana, Inc.

WellCare of South Carolina, Inc.

WellCare of New York, Inc.

Easy Choice Health Plan

WellCare of Connecticut, Inc.

WellCare of Kentucky, Inc.

WellCare of Georgia, Inc.

WellCare Health Plans of Kentucky, Inc.

Harmony Health Plan of Illinois, 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 on how to report Encounters 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 Encounter 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 and MM/DD/CCYY is entered improperly)

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 Codes are reported.
- Encounter 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 Encounter. 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 Box 15 (UB-04)
 - 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 and the Implementation Guide.

Paper Claim Submission:

For Optical Character Recognition (OCR) from Paper to EDI, all Paper claims 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 Claim” submission for all paper claims.
 - This means that the claims 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 claims must be submitted on the original “Red and White Claims” UB-04 Claim Forms or their successor with “drop out” red ink.
- In addition to CMS mandating the use of Red Claims, the Health Plan requires certain standards, since all Paper claims are read through OCR software. This technology allows the Health Plan to process claims 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 claims
 - 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 Segments per file sent. The Plan can process multiple ST & SE transactions of the same transaction type with in the ISA GS and IEA GE Segments

Institutional Encounters submitted using the TS3 format must be in a separate file from all FFS reporting.

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

- Encounters Identifier has to be set to **“RP” (Reporting)**.
- FFS Identifier 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
837I Format	50-100 Encounters	< 5000 Encounters per ST/SE. 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 837I format.
 - Files should include all types of provider Encounters.
 - Batch files by 837I 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 must be 5 characters (Example: CMPNM)
 - 837TEST
 - Date test file is submitted to The Plan (CCYYMMDDHHMM)
 - Last byte equaling file type I = Institutional Services

Example: CMPNM_837TEST_200509011525I
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 837I format and process batch files daily. Files must have the appropriate PRODUCTION identifiers as listed in the 837I 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:
 - Header ISA15 to "P"
 - 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 must be 5 characters (Example: CMPNM)
 - 837PROD
 - Date production file is submitted to The Plan (CCYYMMDDHHMM)
 - Last byte equaling file type I = Institutional Services
 - **Example:** CMPNM_837PROD_200509011525I
3. The Plan recommends the use of EDIFECS or CLAREDI for SNIP Levels 1 through 5 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 that 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 Billing Provider Name in Loop 2010AA must be a Billing agent, the Provider or Vendor that will receive the Payment in the 835 transaction for Encounters.
- The Taxonomy Code within the Billing Provider Hierarchical Level (2000A) Loop (PRV) Segment is required for all Encounter submissions. The Taxonomy reported on the Encounter must match the Billing Provider's specialty, which is maintained by the Workgroup for Electronic Data Interchange (WEDI).
- The Attending Provider who has overall responsibility for the patient's medical care and treatment reported in this Encounter must be identified for all Inpatient Encounter submissions. When using the Attending Provider Loop (2310A), The Plan requires that the Taxonomy Code be populated in the PRV Segment. The Taxonomy code must match the Attending 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 2310E only if it is different than Billing Address in the 2010AA loop. 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 Encounter Information (2300) Loop (CLM01) Segment be unique for each Encounter submitted and cannot repeat at any time.

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.

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.

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 CMS website for more information about ICD-10 Diagnosis Codes 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.

Valid National Provider Identifiers (NPI)

All Submitters are required to use the National Provider Identification (NPI) numbers that is now required in the ANSI ASC X12N 837 as per the 837 Institutional (TR3) Implementation Guide for all appropriate Loops, with the exception of atypical providers. Atypical providers must pre-register with The Plan before submitting claims to avoid NPI rejections. Atypical providers are classified as non-health care providers such as taxi drivers, carpenters, and personal care providers.

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 Encounter Submission, the Encounter Level information in Loop 2300 and segment REF with an F8 qualifier must contain The Plan’s WellCare Control Number (WCN). This can be found in the 277CA that is sent along with the 999 and the 277U (if requested).

To submit a corrected or voided claim via paper

- For Institutional claims, provider must include the original WellCare claim number and bill frequency code per industry standards.
- For Professional claims, the provider must include the original WellCare claim number and bill frequency code per industry standards. When submitting a Corrected or Voided claim, enter the appropriate bill frequency code left-justified in the left-hand side of Box 22.

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 Institutional (TR3) Implementation Guide.

Providers and Vendors must have the 837 Institutional (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 Encounter 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 Encounter Submission Only

Per the 837 Institutional (TR3) Implementation Guide, all Submitters are required to supply the National Drug Code (NDC) for all HCPCS J-codes submitted on the Encounter. 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.

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 – THIRD PARTY ORGANIZATION NOTES.

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, you 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.
Additionally, The Plan can help you with setup.

Reporting States Notes:

Illinois Notes:

Inpatient Claims – All Inpatient encounters must have at least 1 room and board service line and 1 ancillary service line.

Outpatient Claims – All Outpatient encounters must follow APL and Ambulatory guidelines dictated by IL.

Value Code 54 for Birth Weight – Hospitals are required to include Value Code 54 for newborns who are 28 days of age or less on the date of admission. This Value Code is to be reported with the baby's birth weight in grams, right-justified to the left of the dollars/cents delimiter and will be used in the APR-DRG determination. Claims that do not have this value reported will be rejected.

Taxonomy – For HFS, the billing provider taxonomy code will be utilized to derive the Department's unique categories of service. The HIPAA Provider Taxonomy code is a 10-character code and associated description specified for identifying each unique specialty for which a provider is qualified to provide health care services.

Home Health – If the home health services follow the Subscriber's discharge from a hospital, the facility must report the hospital discharge date in the Occurrence Information (HI) of Loop 2300, using Occurrence Code "22". If the date is not reported, follow the prior approval requirements described in the Home Health Handbook.

If more than one skilled nursing visit per day is needed within 60 days of hospital discharge, providers must submit a prior approval request for the total number of visits required for the approval period. Prior approval is required regardless of whether the Encounter is billed electronically or on paper. If billing electronically, the provider must omit the discharge date from the Occurrence Information (HI) of Loop ID 2300 and indicate the number of visits in Loop ID 2400 SV205.

Covered and Non-covered Days – HFS requires that for all inpatient Encounters the covered and non-covered days, when applicable, must be reported. The information is to be sent in the 2300 Loop – HI Value Information segment.

Valid Values

- "80" = Covered Days
- "81" = Non Covered Days

For HFS Outpatient series Encounters, the number of series days for which outpatient services were provided must also be reported as Value Code "80" = Covered Days.

Qualifier Reference Identification – For HFS a secondary identification number is always required when loop 2320 is used. Must be the 3-digit TPL Code followed by the 2-digit Status Code assigned by HFS to other payers.

For example: REF*2U*91001~

Code “910” = Medicare Part B

Code “909” = Medicare Part A

For other TPL codes, please see Appendix 1 in Chapter 200 of the Handbook for your provider type.

www.hfs.illinois.gov/handbooks/chapter200.html

www.hfs.illinois.gov/assets/100app9.pdf

Nebraska Notes:

NE Medicaid Nursing Facility Claims require:

- Revenue codes 0100 through 0179 to report nursing facility days
- Revenue code 0183 to report nursing facility therapeutic leave days
- Revenue code 0185 to report nursing facility hospital leave days
- Revenue code 0180 to report non-billable days

Leave days are not to be reported on Assisted Living claims or Swing Bed Claims.

NE Medicaid Residential Treatment Center Claims require:

- Revenue code 0183 to report therapeutic leave days along with the applicable procedure code for the service provided

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 For Clearinghouse submitters, use ID as per the clearinghouse.
	ISA08	Interchange Receiver ID	M	1		For Direct submitters, use “WELLCARE” Note: Please make sure the Receiver ID is left-justified with trailing spaces for a total of 15 characters. Do not use leading ZEROS. 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 that is used in the ISA06 For Clearinghouse submitters, use ID as per the clearinghouse.
	GS03	Receivers Code	M	1		For Direct submitters, use WellCare ID “WELLCARE” For Clearinghouse submitters, use ID as per the clearinghouse.

The WellCare Group of Companies
5010 8371 Encounter Data
Companion Guide

Header:						
Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
0100	BHT06	Encounter Identifier	R	1		Use the value of "RP" – Reporting Encounters. The Plan will reject any Encounters that have "31" – Subrogation Demand.
LOOP ID - 1000A – Submitter Name					1	
020	NM109	Submitter Identifier	R			For Direct submitters, use the "ETIN" i.e., The Plan Submitter ID or 6-digit trading partner ID assigned during the EDI enrollment process. For Clearinghouse submitters, use ID as per the clearinghouse.
LOOP ID - 1000B – Receiver Name					1	
02000	NM103	Receiver Name	R	1		For Direct submitters, use value "WELLCARE HEALTH PLANS, INC" (e.g., WellCare Health Plans of Georgia, WellCare Health Plans of New York) For Clearinghouse submitters, use ID as per the clearinghouse.
0200	NM109	Receiver Primary ID	R	1		For Direct submitters, use the value of Payer ID that is in the ISA06. For Clearinghouse submitters, use ID as per the clearinghouse.

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Detail:						
Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
LOOP ID - 2000A – Billing/Pay-To Provider Hierarchical Level					≥1	
0030	PRV03	Billing/Pay-To Provider Specialty Information	S	1		Billing Provider Taxonomy Code must be sent when not sent in the 2310B Provider Loop.
LOOP ID - 2010AA – Billing Provider Name					1	
0150	NM108	Billing Provider Primary Type	R	1		All States All non-Atypical submitters must have value of "XX". All Atypical submitters must not use this element.
0150	NM109	Billing Provider ID	R	1		All States All non-Atypical submitters must have NPI. All Atypical submitters must not use this element.
0350	REF01	Billing Provider Tax Identification	R	1		All States All Atypical and non-Atypical submitters are required to use the value of "EI".
0350	REF02	Billing Provider Tax Identification	R	1		All States All submitters are required to send in their "TAX ID".
0350	REF01	Billing Provider UPIN/License Information	R	2		All States Only Atypical submitters may use this REF segment.
0350	REF02	Billing Provider UPIN/License Information	R	2		All States Only Atypical submitters may use this REF segment.
LOOP ID - 2010AB – Pay-to Provider's Name					1	
015	NM108	Provider Primary Type	S-R	1		Must have the value of "XX"
015	NM109	Pay-to Provider's Identifier	R	1		Must have NPI
035	REF01	Reference Identification Qualifier	S-R	8		All States All submitters are required to use the value of "EI".
035	REF02	Billing Provider Additional Identifier	R	8		All States All submitters are required to send in their "TAX ID".
LOOP ID - 2000B – Subscriber Hierarchical Level					≥1	
005	SBR01	Payer Responsibility Sequence Number Code	R	1		Use the value of "P" if The Plan is the primary payer.
005	SBR09	Encounter Filing Indicator Code		1		Value equal to Medicaid or Medicare filing.
LOOP ID - 2010BA – Subscriber Name					1	
0150	NM108	Subscriber Primary Identification code Qualifier	S-R			Use the value "MI".
0150	NM109	Subscriber Primary Identifier				Subscriber Medicaid/Medicare ID, The Plan ID
0320	DMG03	Subscriber Demographic Information	S-R	1		All States All submitters must send in "F" - Female or "M" - Male only.

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LOOP ID - 2010BB – Payer Name					1	
0150	NM108	Identification code Qualifier				Use value "PI".
0150	NM109	Identification code				Use value PayerID.
LOOP ID – 2300 – Encounter Information					1	
1300	CLM5-3	Encounter Frequency Type Code	R	1		<p>All States Use "1" on original Encounter submissions.</p> <p>Use "7" for Encounter Replacement (Adjustment).</p> <p>Use "8" for Encounter void.</p> <p>Both "7" and "8" must include the original WellCare Control Number (WCN), as indicated in Loop 2300 REF02 (Original Reference Number).</p>
1400	CL103	Institutional Claim Code	S-R	1		<p>State Note NE – Medicaid requires a patient status code of 30 on interim billings.</p>
1800	REF02	Prior Authorization Number	S-R	1		<p>All States This is now a single segment for just the Prior Authorization Number.</p> <p>All submitters are required to send this segment when The Plan has assigned a Prior Authorization Number.</p>
1800	REF02	Referral Number	S-R	1		<p>All States This is now a single segment for just the Referral Number.</p> <p>All submitters are required to send this segment when The Plan has assigned a Referral Number.</p>
1800	REF02	Service Authorization Exception Code	S-R	1		<p>State Note NY – Service Authorization Exception Codes "1" – "6" are to be used in accordance with Medicaid Policy. Code "7" (Special Handling) is expected when the Encounter is intended to be processed using a UT exempt NYS DOH specialty code.</p>
1900	NTE02	Encounter Note – Note	R	1	10	<p>State Note MO – See Reporting States Notes for Home Health Care.</p>
2310	HI01-1	Condition Identification Code Qualifier	S-R	1	24	<p>State Notes OH – See below if needed</p> <p>IL – For inpatient claims must use 'BR'. For outpatient claims leave blank</p>

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2310	HI01-2	Condition Identification Value Code	R	1	24	<p>State Notes OH – For nursing facility room and board Encounter adjustments, use the Condition Codes (Encounter Change Reasons)</p> <ul style="list-style-type: none"> • D0 change to Service Dates • D1 change to charges • D2 change to revenue codes • D6 cancel only to repay a duplicate or OIG overpayment • D7 change to make Medicare the secondary payer • D8 change to make Medicare the primary payer • D9 any other change • E0 change in patient status <p>IL – Principal Procedure Code: For inpatient, must use ICD-10 codes; for outpatient, must use HCPCS codes in SV201 of the 2400 loop.</p> <p>NY – NYS DOH will process applicable and compliant Value Codes, as defined in the NUBC Manual under Code List Qualifier Code “BE”:</p> <p>Value Code 22: Used to report patient contributions toward the cost of care, also known as Net Available Monthly Income (NAMI), patient participation amount, or surplus.</p> <p>Value Code 24: NYS DOH Medicaid Rate Code</p>
2310	HI01-1	Value Information Identification Code Qualifier	S-R	1	24	<p>State Notes: GA / IL - “BE” Newborn Birth Weight Required</p> <p>NY - - NYS DOH will process applicable and compliant Value Codes, as defined in the NUCBC Manual under Code List Qualifier Code “BE”:</p> <p>Value Code 22: Used to report patient contributions toward the cost of care, also known as Net Available Monthly Income (NAMI), patient participation amount, or surplus.</p> <p>Value Code 24: NYS DOH Medicaid Rate Code</p>

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2310	HI01-1	Value Information Identification Code Qualifier	S-R	1	24	<p>State Note: GA / IL – “BE” Newborn Birth Weight Required</p> <p>NY – NYS DOH will process applicable and compliant Value Codes, as defined in the NUBC Manual under Code List Qualifier Code “BE”:</p> <p>Value Code 22: Used to report patient contribution toward the cost of care, also known as Net Available Monthly Income (NAMI), patient participation amount, or surplus.</p> <p>Value Code 24: NYS DOH Medicaid Rate Code</p>
2310	HI01-2	Value Information Identification Value Code	R	1	24	<p>State Notes GA / IL – Value Code Information for Newborn “BE” Qualifier along with “54” + Newborn Weight in Grams Required</p> <p>IL – Value Code ‘24’. For hospital outpatient Medicare/Medicaid crossover claims, use Value ‘24’ to report the total number of departments visited by the patient during the billing period. Report all other value codes as appropriate/applicable</p>
LOOP ID – 2310A – Attending Provider Name					1	
2500	NM108	Attending Provider’s Identification Code Qualifier for NPI	S-R	1		<p>All States All non-Atypical submitters must have value of “XX”.</p> <p>All Atypical submitters must not use this Element</p>
2500	NM109	Attending Provider NPI Number	R	1		<p>All States All non-Atypical submitters must have NPI.</p> <p>All Atypical submitters must not use this Element</p>
2550	PRV03	Attending Taxonomy Code	S-R	1		<p>All States All submitters must send the Rendering Provider Taxonomy Code.</p> <p>State Notes CT GA IN LA submitters are required to send in the Taxonomy Codes</p> <p>MO submitters are required to send in the Taxonomy Codes if submitter has multiple MO HealthNet Legacy Provider IDs</p>
2710	REF01	Attending Reference Identification Qualifier	S	3		<p>All States Only Atypical submitters can use this Segment</p>

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2710	REF02	Attending Provider Secondary Identification	S	3		All States Only Atypical submitters can use this Segment
LOOP ID – 2310E Service Facility Location					1	
2500	NM1	Service Facility Location	S-R	1		All States All submitters must use this Loop when the Physical Location where the service took place is different from the Address in the Billing Provider Name (2010AA) Loop.
2650	N301	Service Facility Location Address	R	1		All States All submitters must send in Physical Address. The Plan will reject any Encounters that use a P.O. Box in this segment.
2710	REF01	Service Facility Reference Identification Qualifier	S	3		All States Only Atypical submitters can use this Segment.
2710	REF02	Service Facility Location Secondary Identification	S	3		All States Only Atypical submitters can use this Segment.
LOOP ID – 2320 – Other Subscriber Information					10	
2900	SBR01	Payer Responsibility Sequence Number Code	R	1		All States All Vendor/Provider submitters that adjudicate Encounters for The Plan must make themselves the Primary "P". In the SBR01 Element in the Subscriber Information (2000B) must be sent to the next available Payer Responsibility Number Code.
3000	AMT02	Coordination of Benefits (COB) Payer Paid Amount	S	1		All States All Vendor/Provider submitters that adjudicate Encounters for The Plan must send this Segment unless the Payer Amount is Zero. This Element must be the amount paid by the Vendor to the Provider.
LOOP ID – 2330B Other Payer Name			S		1	
2250	NM103	Name Last or Organization Name	R	1		All States All Vendor/Provider Submitters that Adjudicate Encounters for the Plan must send this Segment. In this Element, use: For a Medicaid Payment: WELLCAREMCD For a Medicare Payment: WELLCAREMCR
2250	NM109	Identification Code	R	1		All States All Vendor/Provider Submitters that adjudicate Encounters for The Plan must send this Segment.

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						<p>The Vendor/Provider submitters who are paying the Encounter(s) must have IDs below:</p> <p>For a Medicaid Payment: WELLCAREMCD For a Medicare Payment: WELLCAREMCR</p> <p>This will be used in the Line Adjudication Information (2430) Loop in the SVD01.</p>
3550	REF01	Other Payer Secondary Identifier	S	2		<p>State Note IL – For HFS, a secondary identification number is always required when loop 2320 is used. The REF01 = 2U</p>
3550	REF02	Other Payer Secondary Identifier	S	2		<p>State Note: IL – For HFS, a secondary ID number is always required when loop 2320 is used. Must be the 3-digit TPL Code followed by the 2-digit Status Code assigned by HFS to other payers.</p> <p>For example: REF*2U*91001~ Code "910" = Medicare Part B Code "909" = Medicare Part A For other TPL codes, please see Appendix 1 in Chapter 200 of the Handbook for your provider type. (See URL in state's notes in the State Reporting Notes.)</p>
LOOP ID – 2400 – Service Line						1
2310	SV201	Service Line Revenue Code	R	1		<p>All Medicare States Medicare SNF Claims – must have revenue code 022 on 1 line and 1 line only. HH – must have revenue code 023 on 1 line and 1 line only. HIPPS codes should be used with revenue codes 022 & 023.</p> <p>State Note IL – For outpatient encounters, use HCPCS procedure code with the appropriate revenue code (SV201). For additional information, see 'APL Outpatient' under billing instructions.</p> <p>MO – For outpatient and hospice Encounters, refer to the MO HealthNet Policy manuals for specific requirements. For nursing home Encounters, select revenue code from one of the following categories:</p>

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						<p>1. Select revenue code to indicate reserve time periods:</p> <ul style="list-style-type: none"> • 0180 equals non-covered leave of absence • 0182 equals home leave for patient convenience • 0183 equals home leave for therapeutic leave • 0184 equals hospital leave to an ICF/MR • 0185 equals hospital leave for non-ICF/MR facility • 0189 equals Medicare qualifying stay days <p>2. Select revenue code to indicate skilled nursing services</p> <ul style="list-style-type: none"> • 0190 equals subacute care general classification • 0191 equals subacute care - level I • 0192 equals subacute care - level II • 0193 equals subacute care - level III • 0194 equals subacute care - level IV • 0199 equals subacute care other <p>Indicating any of the above revenue codes does not alter the amount of your per diem payment. Use these codes when you previously would have used a skilled nursing indicator of 'Y'.</p> <p>3. Select revenue code to indicate non-skilled nursing time periods:</p> <ul style="list-style-type: none"> • 0110 equals room-board/private • 0119 equals other/private • 0120 equals room-board/semi • 0129 equals other/2-bed <p>Indicating any of these does not alter the amount of your per diem payment. Use these codes when you previously would have used a skilled nursing indicator of 'N' or blank.</p> <p>NE – NE Medicaid Nursing Facility Claims require use of Revenue Codes:</p> <p>0100 through 0179 to report nursing facility days</p> <p>0183 to report nursing facility therapeutic leave days</p> <p>0185 to report nursing facility hospital leave days</p> <p>0180 to report non-billable days</p>
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						<p>Leave days are not to be reported on Assisted Living claims or Swing Bed Claims.</p> <p>NE Medicaid Residential Treatment Center Claims require Revenue Code:</p> <p>0183 to report therapeutic leave days, along with the applicable procedure code for the service provided</p>
	NTE01	Note Reference Code	R-S	1		<p>All States When sending an ASO Line Payment, you must use this NTE segment and you must use "TPO" as an indicator.</p>
	NTE02	Note Description	R	1		<p>All States When a Line Payment is made for ASO, this element must be "ASO"</p>
LOOP ID – 2430 Line Adjudication Information					15	
5400	SVD01	Identification Code	S-R	1		<p>All States All Vendor/Provider Submitters that adjudicate Encounters for The Plan must send this Segment</p> <p>The Vendor/Provider Submitters who are Paying the Encounter(s) must use ID below:</p> <p>For a Medicaid Payment: WELLCAREMCD For a Medicare Payment: WELLCAREMCR</p> <p>This will be the same as in the Other Payer Name (2330B) Identification Code in the NM109.</p>
5400	SVD02	Monetary Amount	R	1		<p>All States All Vendor/Provider Submitters that adjudicate Encounters for The Plan must send this Segment</p> <p>This is how much was Paid by the Vendor/Provider after check run.</p>

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

Term	Definition
	provisions of HIPAA, which apply to health plans, health care providers, and health care 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 (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 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 transmissions.
ATTENDING PROVIDER	The primary individual provider who attended to the client/member during an in-patient hospital stay. Must be identified in 837I, Loop 2310A, REF02 Segment, by their assigned Medicaid/Medicare ID number assigned by State to the individual provider while the client was inpatient.
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 Encounter 837 transaction sets. The Implementation Guides are available from Washington Publishing Company.

Term	Definition										
PAY-TO PROVIDER	This entity may be a medical group, clinic, hospital, other institution, or the individual provider who rendered the service.										
REFERRING PROVIDER	Identifies the individual provider who referred the client or prescribed Ancillary services/items such as Lab, Radiology and Durable Medical Equipment (DME).										
RENDERING PROVIDER	The primary individual provider who attended to the client/member. They must be identified in 837I.										
TRADING PARTNERS (TPs)	Includes all of the following; payers, switch vendors, software vendors, providers, billing agents, clearinghouses										
DATE FORMAT	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 date element is a 6-character date in the YYMMDD format.										
DELIMITERS	<p>A delimiter is a character used to separate two 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:</p> <table border="1" data-bbox="586 1075 1365 1232"> <thead> <tr> <th data-bbox="586 1075 976 1106">CHARACTER</th> <th data-bbox="976 1075 1365 1106">PURPOSE</th> </tr> </thead> <tbody> <tr> <td data-bbox="586 1106 976 1138">* Asterisk</td> <td data-bbox="976 1106 1365 1138">Data Element Separator</td> </tr> <tr> <td data-bbox="586 1138 976 1169">^ Caret</td> <td data-bbox="976 1138 1365 1169">Repetition Separator</td> </tr> <tr> <td data-bbox="586 1169 976 1201">: COLON</td> <td data-bbox="976 1169 1365 1201">Sub-Element Separator</td> </tr> <tr> <td data-bbox="586 1201 976 1232">~ Tilde</td> <td data-bbox="976 1201 1365 1232">Segment Terminator</td> </tr> </tbody> </table>	CHARACTER	PURPOSE	* Asterisk	Data Element Separator	^ Caret	Repetition Separator	: COLON	Sub-Element Separator	~ Tilde	Segment Terminator
CHARACTER	PURPOSE										
* Asterisk	Data Element Separator										
^ Caret	Repetition Separator										
: COLON	Sub-Element Separator										
~ Tilde	Segment Terminator										

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 X12N997 files, when opened, will display as one complete string without carriage returns or line feeds.

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'