GAINWELL TECHNOLOGIES

Louisiana Medicaid
835 Health Care Claim/Payment Advice
Companion Guide

Based on
ASC X12N Version 005010X221A1

CORE v5010 Master Companion Guide
Template

Revised January 2022

Revision History

As changes are made to this document, each revision will be listed in a chart as shown below and located in Appendix 3.

Version	Date	Author	Action/Summary of Changes	Loop/Segment	Page #
1.0	01/01/2014	Gainwell	Initial Document		
1.1	08/01/2014	Gainwell	Page 18, notes added for Loop 2110, CAS segments		18
1.2	01/18/2022	Gainwell			2

Usage Information

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Preface

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

Table of Contents

Introduction

This section describes how Louisiana Medicaid specific Health Care Claim/Payment Advice (835) transaction set information will be detailed with the use of a table. The tables contain a row for each segment that Louisiana Medicaid has something additional, over and above, the information in the Technical Report Type 3 (TR3). That information can:

- Limit the repeat of loops, or segments.
- Limit the length of a simple data element.
- Specify a sub-set of the Implementation Guides internal code listings.
- Clarify the use of loops, segments, composite and simple data elements.
- Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Louisiana Medicaid.

In addition to the row for a specific segment, one or more additional rows are used to describe Louisiana Medicaid's usage for composite and simple data elements and for any other information.

Table 1: 835 Transaction Set Descriptions specifies the columns and suggested use of the rows for the detailed description of the transaction set Companion Guides.

Table 1: 835 Transaction Set Descriptions

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
137	2100	NM1	Patient Name			This type of row always exists to indicate that a new segment has begun. It is always shaded and notes or comments about the segment itself go in this cell.
139	2100	NM109	Identification Code		2/80	This type of row exists to limit the length of the specified data element.
204	2110	REF01	Reference Identification Qualifier	BB, LU		This is the only code transmitted by Louisiana Medicaid.

1.1 Scope

The purpose of the Louisiana Medicaid 835 Health Care Claim Payment Advice Companion Guide is to provide Trading Partners with a guide to the Louisiana Medicaid specific requirements reported in the 835. This Companion Guide document should be used in conjunction with the Technical Report Type 3 (TR3) and the national standard code sets referenced in that Guide.

For any questions or to begin testing, refer to Section 3, Testing with the Payer, and send an email to HipaaEDI@gainwelltechnologies.com

This section describes how the table, for the Louisiana Medicaid specific 835 transaction, is organized by columns and their descriptions. Section 10, Table 2 835 Health Care Claim/Payment Advice, should be used as a reference for 835 transactions received from Louisiana Medicaid. Table 2 contains the specific data values and descriptions used in processing the transaction. Refer to Section 10, Transaction Set Information, for more details.

Column Descriptions:

- Page Number – Corresponding page number in TR3 Implementation Guide
- Loop ID – TR3 Implementation Guide Loop
- Reference – TR3 Implementation Guide Segment
- Name – TR3 Implementation Guide segment/element name
- Codes - Data values to be sent for Louisiana Medicaid transactions. Information contained within "< >" is the description or format of the data that should be entered in the field.
- Length – A single number denotes fixed length. Two numbers separated by a slash denotes min/max length.
- Notes/Comments – Additional information specific to Louisiana Medicaid transactions.

1.2 References

This section describes the additional reference material Trading Partners must use for the specific transaction specifications for the 835 Health Care Claim/Payment Advice.

Refer to the following HIPAA version 5010A1 Technical Report Type 3 for additional information not supplied in this document, such as transaction usage, examples, code lists, definitions, and edits.

- ***Health Care Claim Payment Advice 835***
- ***Combined 005010X221 April 2006 and 005010X221A1 October 2010***

Copies of the ANSI X12 Technical Report Type 3s can be obtained from the Washington Publishing Company at the following URL: http://www.wpc-edi.com.

All required information for populating the X12 EDI transactions can be found by referencing this Louisiana Medicaid 835 Companion Guide and the HIPAA Technical Report Type 3s.

1.3 Additional Information

Refer to the 5010A1 Technical Report Type 3 for information not supplied in this document, such as code lists, definitions, and edits.

Each remittance advice generated by a MCO or Pharmacy Benefit Manager (PBM) to a pharmacist or his agent or pharmacy or its agent shall be sent on the date of payment and shall include the following information, clearly identified and totaled for each claim listed:

(1) Unique enrollee or insured identification number.
(2) Patient claim number or patient account number
(3) Date that the prescription was filled.
(4) National Drug Code.
(5) Quantity dispensed.

(6) Price submitted to the health insurance issuer or its contractor.
(7) Amount paid by the health insurance issuer or its contractor.
(8) Dispensing fee.
(9) Provider fee.
(10) Taxes.
(11) Enrollee or insured liability, specifying any coinsurance, deductible, copayment, or noncovered amount.
(12) Any amount adjusted by the health insurance issuer or its contractor and the reason for adjustment.
(13) Any other deduction or charge, listed separately.
(14) Network Identifier
(15) A toll-free telephone number for assistance with the remittance advice.

2. Getting Started

This section describes how to interact with Louisiana Medicaid regarding 835 transactions.

2.1 Working With Louisiana Medicaid

The EDI Help Desk is available to assist providers with their electronic transactions from, Monday through Friday, during the hours of 8:00 am – 5:00 pm Central, by calling 225-216-6303 or via email at HipaaEDI@gainwelltechnologies.com.

Louisiana Medicaid's MMIS system supports the following categories of Trading Partner:

- Provider
- Billing Agency
- Clearinghouse
- Health Plan

NOTE: *Providers must be enrolled and approved before registering as a Trading Partner. Billing Agencies must be associated to an approved Billing Provider in order to register as a Trading Partner.*

2.2 Trading Partner Registration

To obtain a Submitter ID visit the website: lamedicaid.com and follow the steps provided in the link titled Provider Enrollment.

Providers may have up to three billing agencies/clearinghouse submit claims on their behalf but can select only one submitter to receive the 835 transaction. This selection is made when completing the ERA enrollment forms. All claims processed for a provider in a check write cycle will be included in the 835, regardless of method of submission (i.e. hardcopy or electronic).

2.3 Certification and Testing Overview

All Trading Partners are required to submit test EDI transactions before being authorized to submit production EDI transactions. The Usage Indicator, element 15 of the Interchange Control Header (ISA) of any X12 file, indicates if a file is test or production. Authorization is granted on a per transaction basis. For example, a trading partner may be certified to submit 837P professional claims, but not certified to submit 837I institutional claim files.

2.4 Testing with the Payer

Trading Partners will submit two test files of a particular transaction type, with no set minimum of transactions within each file, and have no failures or rejections to become certified for production. Users will be notified (E-mail) of the Trading Partner Status when testing for a particular transaction has been completed.

To test an EDI transaction type, follow the steps outlined in the EDI HIPAA 5010A General Companion Guide which can be found on lamedicaid.com at the HIPAA Information link.

3. Connectivity with the Payer/Communications

This section contains information relating to the exchange methods with Louisiana Medicaid for delivery of the 835 transaction.

3.1 Process Flows

Submitters will use the Louisiana Medicaid EDI Gateway to submit and retrieve files electronically. Each submitter receives a "mailbox" where their files are stored and maintained. This mailbox is accessed to send files via the "To_Gainwell" folder and retrieve files via the "From_Gainwell" folder. 835 files are stored in the submitter's "From_Gainwell" folder and must be retrieved from this location. Louisiana Medicaid has established three communications options for the EDI Gateway.

- **Dial-up Connection Services:** An asynchronous protocol modem communication using a telephone land line and is referred to as the Bulletin Board System or BBS. This is the option available to all Trading Partners who wish to receive the 835.
- **Internet sFTP Connection Services:** Secure File Transfer Protocol to provide an end to end secure tunnel with Public/Private Key pair data encryption. Only Trading Partners who are approved to utilize this type connection service may do so to retrieve the 835 from their secure FTP pickup location.
- **CAQH/CORE Compliant SOAP or MIME Services:** Submitters that request and successfully test may retrieve the 835 utilizing SOAP+WSDL or HTTPS/MIME request/response modes.

During the testing process with EDI Department, submitters will finalize the communication methodology to be used for file submissions and file retrievals.

3.2 Transmission Administrative Procedures

The 835 is a report posted to the online Gainwell Bulletin Board System (BBS). The 835 is generally available within 2 or 3 days prior to the date payments are sent to providers' financial institutions after scheduled weekly check write dates. The check write schedule is posted to lamedicaid.com.

3.3 Re-Transmission Procedure

Providers/submitters should contact the Gainwell EDI Department via email at HipaaEDI@gainwelltechnologies.com if the 835 is late or missing.

3.4 Communication Protocol Specifications

This section describes Louisiana Medicaid's communication protocol. The information exchanged between devices, through a network or other media, is governed by rules and conventions that can be set out in a technical specification called communication protocol standards. The nature of the communication, the actual data exchanged and any state-dependent behaviors, is defined by its specification.

3.5 Passwords

Trading Partners will be assigned a user name and password during the Trading Partner Account registration process. Information for setting up the user name and password is provided in Section 4.2 of the EDI HIPAA 5010A General Companion Guide located at lamedicaid.com under the HIPAA Information link.

4. Contact Information

This section contains the contact information, including email addresses, for EDI Technical Assistance, Provider Services, and Provider Enrollment. All times are Central Time Zone.

4.1 EDI Technical Assistance

The EDI Help Desk is available to assist providers with their electronic transactions from Monday through Friday, during the hours of 8:00 am – 5:00 pm, by calling 1-225-216-6303.

4.2 Provider Service Number

The Provider Services Call Center is available to assist providers concerning the payment of claims from Monday through Friday, during the hours of 8:00 am – 5:00 pm, by calling 1-225-924-5040 or 1-800-473-2783.

The Provider Enrollment Department is available to assist provider with enrollment, changes to submitters, etc., Monday through Friday, during the hours of 8:00 am – 5:00 pm by calling 1-225-216-6370.

4.3 Applicable Websites/Email

For questions related to electronic Data interchange and EDI issues, the EDI Department can be contacted at: HipaaEDI@.gainwelltechnologies.com.

5. Control Segments/Envelopes

This section describes Louisiana Medicaid's use of the interchange, functional group control segments and the transaction set control numbers.

5.1 ISA-IEA

This section describes Louisiana Medicaid's use of the interchange control segments.

- ISA01, Authorization Information Qualifier, Value will be 00.
- ISA02, Authorization Information, Value will be spaces.
- ISA03, Security Information Qualifier, Value will be 00.
- ISA04, Security Information, Value will be spaces.
- ISA05, Interchange ID Qualifier, Value will be ZZ.
- ISA06, Interchange Sender ID: Value will be LA-DHH-MEDICAID.
- ISA07, Interchange ID Qualifier, Value will be ZZ.
- ISA08,Interchange Received ID: Gainwell assigned 7 digit Submitter ID

  (i.e. 450XXXX) followed by spaces.
- ISA13, Interchange Control Number, Value will be identical to the interchange trailer IEA02. Must be unique for every transmission submitted.
- ISA14, Acknowledgment Requested, Value will be 0 as an acknowledgment is not expected from the receiver.

- ISA15, Useage Indicator, T = Test Data and P=Production Data.
- ISA16, Component Element Separator, Must be a colon: ASCIIx3A.

- IEA01, Number of Included Functional Groups, number of groups included.
- IEA02, Interchange Control Number, Value will be identical to value in ISA13.

5.2 GS-GE

This section describes Louisiana Medicaid's use of the functional group control segments.

- GS01, Functional Identifier Code, Value will be HP for this element.
- GS02, Application Sender's Code: Value will be identical to ISA06.
- GS03, Application Receiver's Code: Value will be 7 digit Gainwell assigned Submitter ID (i.e. 450XXXX) followed by spaces.
- GS06, Group Control Number: Uniquely assigned and maintained by LA Medicaid.

- GE01, Number of Transaction Sets Included, number of sets included.
- GE02, Group Control Number, Value identical to that in GS06.

5.3 ST-SE

This section describes Louisiana Medicaid's use of the transaction set control numbers.

- ST02, Transaction Set Control Number: Must be identical to associated Transaction Set Control Number SE02.
- ST03, Implementation Convention Reference: 005010X221A1.

- SE02, Transaction Set Control Number: Must be identical to ST02.

6. Payer Specific Business Rules and Limitations

This section describes Louisiana Medicaid's business rules regarding 835 transactions.

One 835 transaction reflects a single payment (check or EFT), or one 835 per pay-to provider. The 835 must balance, meaning the total check or EFT amount reported must be supported by detail data in both Table 2 and Table 3.

Both paid and denied claims will be reported in the 835. Pended claims will be reported in the ASC X12 Health Care Claim Status Notification Transaction Set U277 (unsolicited 277) transaction and will be transmitted in the same envelope as the 835.

The 835 method 2.1.2.3 – ERA with Payment by Separate EFT (described in the 835 Implementation Guide) corresponds to the current method used to report claims and EFT transmissions separately. Service line data is required when reporting professional claims or when payment adjustments (reduction to billed charges or denial) are related to specific claim lines. Since Louisiana Medicaid is a claim line

processor, all adjustments are line specific, except for institutional claims when the per-diem is the only service line adjustment. Each claim line will be reported in the 835 as a claim. One CLP segment (Claim Payment Information) represents a single claim document. Data not supplied at the claim level must be supplied at the line level (SVC – Service Payment Information).

NOTE: National Provider Identification Numbers are returned in all 835 transactions. Atypical providers who have not registered an NPI with Louisiana Medicaid will continue to receive their legacy Medicaid Provider ID in the 835 as the only provider identifier**.**

For Louisiana Medicaid's specific business rules and limitations, refer to Section 10 Transaction Set Information, Table 2: 835 Health Care Claim/Payment Advice.

7. Acknowledgements and/or Reports

HIPAA responses and acknowledgements are available for download via BBS for a period of six months from the original creation date.

Acknowledgments are not currently required for the 835 Transactions.

7.1 Report Inventory

There are no reports associated with receipt of the 835 transaction as acknowledgements are not required.

8. Trading Partner Agreements

A Trading Partner Agreement (TPA) is a legal contract between Gainwell, acting on behalf of the State of Louisiana, Department of Health and Hospitals and a provider/billing agent/clearinghouse/health plan to exchange electronic information.

The desire to exchange by and through electronic communications, certain claims and billing information that may contain identifiable financial and/or protected health information (PHI) as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 Code of Federal Regulations Parts 160-164, and applicable regulations that implement Title V of the Gramm-Leach-Bliley Act, 15 U.S.C. § 6801, et seq. The parties agree to safeguard any and all PHI or other data received, transmitted or accessed electronically to or from each other in accordance with HIPAA. This agreement is within the TPA.

8.1 Trading Partners

A Trading Partner is defined as any entity with which Gainwell exchanges electronic data. The term electronic data is not limited to HIPAA X12 transactions. Louisiana Medicaid's Medicaid Management System supports the following categories of Trading Partner:

- Provider
- Billing Agency
- Clearinghouse
- Health Plan

Gainwell will assign Trading Partner IDs (Submitter ID) to support the exchange of X12 EDI transactions for providers, billing agencies and clearinghouses, and other health plans.

10. Transaction Specific Information

This section describes the Louisiana Medicaid specific 835 transaction set information requirements, which are outlined in Table 2: 835 Health Care Claim/Payment Advice. The table contains a row for each segment that Louisiana Medicaid has something additional, over and above, the information in the Technical Report Type 3 (TR3). That information can:

- Limit the repeat of loops, or segments.
- Limit the length of a simple data element.
- Specify a sub-set of the Implementation Guides internal code listings.
- Clarify the use of loops, segments, composite and simple data elements.
- Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with Louisiana Medicaid.

Table 2: 835 Healthcare Claim Payment Advice

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	HEADER	ISA	Interchange Control Header	ISA		
			Element Separator	*	1	
		ISA06	Interchange Sender ID	LA-DHH-MEDICAID	15	
			Element Separator	*	1	
		ISA08	Interchange Receiver ID	7 digit Gainwell Submitter number (i.e.450XXXX)	15	Unique Submitter number issued by Gainwell to authorized EDI Submitters followed by spaces
			Element Separator	*	1	
		ISA14		0	1	0 = No Interchange Acknowledgement Requested
		ISA16	Component Separator	:	1	Must be a colon
			Segment End	~	1	
	HEADER	GS	Functional Group Header	GS		
			Element Separator	*	1	
		GS01	Functional Identifier Code	HP	2	HP = Health Care Claim Payment/Advice (835)
			Element Separator	*	1	
		GS02	Application Sender's Code	LA-DHH-MEDICAID	2/15	Value will be identical to value in ISA06
			Element Separator	*	1	
		GS03	Application Receiver's Code	<Gainwell assigned Submitter ID>	2/15	Gainwell assigned Submitter ID followed by spaces.
			Element Separator	*	1	

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		GS04	Date	<CCYYMMDD>	8	NOTE: Use this date for the functional group creation date.
			Element Separator	*	1	
		GS05	Time	<HHMM>	4/8	NOTE: Use this time for the creation time.
			Element Separator	*	1	
		GS06	Group Control Number	<Assigned by Sender>	1/9	Uniquely assigned and maintained by LA Medicaid.
			Element Separator	*	1	
		GS07	Responsible Agency Code	X	1/2	X = Accredited Standards Committee X12
			Element Separator	*	1	
		GS08	Version / Release / Industry Identifier Code	005010X221	1/12	005010X221 = Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003
			Segment End	~		
		ST02	Transaction Set Control Number	<Assigned by Sender>	4/9	NOTE: Must be identical to associated Transaction Set Control Number SE02.
			Segment End	~		
	HEADER TABLE 1	BPR	Financial Information	BPR	3	
			Element Separator	*	1	
		BPR01	Transaction Handling Code	I	1/2	I = Remittance Information Only
			Element Separator	*	1	

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		BPR02	Monetary Amount	<Total Actual Provider Payment Amount>	1/18	NOTE: Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point).
			Element Separator	*	1	
		BPR03	Credit/Debit Flag code	<Credit or Debit Flag Code> C, D	1	Value will always be C = Credit
			Element Separator	*	1	
		BPR04	Payment Method Code	ACH, CHK or NON	3/3	CHK = Check ACH = EFT payment NON = No payment made
			Element Separator	*	1	
		BPR05	Payment Format Code		1/10	Value will be CCP when BPR04 = ACH
			Element Separator	*	1	
		BPR06	ID Number Qualifier		2/2	Value will be 01 when BPR04 = ACH
			Element Separator	*	1	
		BPR12	ID Number Qualifier	*	2/2	Value will be 01 when BPR04 = ACH
			Element Separator	*	1	
		BPR16	Date	<Check Issue or EFT Effective Date> <CCYYMMDD>	8/8	Value will be the EFT date when BPR04 = ACH; the Check issue date when BPR04 = CHK; the RA date when BPR04=NON
			Segment End	~		
	Summary	TRN	Reassociation Trace Number			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Element Separator	*	1	
		TRN02	Reference Notification	<Check or EFT Trace Number>	1/30	A 15 digit number assigned by sender when payment is made via EFT. Consists of routing # and sequence number. This value equals the Trace Number in the CCD+ Addenda record and can be used for reassociation of payment and remittance. Value will be check number if payment made by check or remittance number if no payment made.
			Element Separator	*	1	
		TRN03	Originating Company Identifier	<Payer Identification>	1/50	Value will be the payer's TIN preceded by a 1.
			Segment End	~		
	1000A	N1	Payer Identification	N1		
			Element Separator	*	1	
		N101	Entity Identifier Code	PR	2/3	PR = Payer
			Element Separator	*	1	
		N102	Name	<Payer Name>	1/60	
			Element Separator	*	1	
		N103	Identification Code Qualifier	XV	1/2	Not used until National Plan ID is mandated for use.
			Element Separator	*	1	
		N104	Identification Code	<Payer Identifier>	2/80	Not used until National Plan ID is mandated for use.
			Segment End	~		
	1000A	N3	Payer Address			

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Element Separator		1	
		N301	Address Information	<Payer Address Line>	1/55	Value is 628 N. 4th Street
			Element Separator		1	
		N302	Address Information	<Payer Address Line>	1/55	Value is PO Box 91030.
			Segment End	~		
	1000A	N4	Payer City, State, Zip Code			
			Element Separator	*	1	
		N401	City Name	<Payer City Name>	2/30	Value is Baton Rouge.
			Element Separator	*	1	
		N402	State or Province Code	<Payer State Code>	2/2	Value is LA.
			Element Separator	*	1	
		N403	Postal Code	<Payer Zip Code>	3/15	Value is 708219030.
			Segment End	~		
	1000B	N1	Payee Identification			
			Element Separator	*	1	
		N103	Identification Code Qualifier	XX, FI	1/2	XX = NPI FI = Federal Taxpayer ID
			Element Separator	*	1	
		N104	Identification Code	<Payee Identification Code>	2/80	Value will be NPI if provider has been assigned one, otherwise value is taxpayer ID.
			Segment End	~		
	1000B	REF	Payee Additional Information			
			Element Separator	*	1	

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		REF01	Reference Identification Qualifier	PQ, TJ	2/3	PQ = Payee Identifier TJ = Federal taxpayer's ID
			Element Separator	*	1	
		REF02	Reference Identification	<Additional Payee Identifier>		Value will be the 7 digit LA Medicaid provider ID if payee atypical and not assigned an NPI or else the TIN, EIN or SS #
			Segment End	~		
	2100	CLP	Claim Payment Information	CLP		
			Element Separator	*	1	
		CLP01	Claim Submitter's Identifier	<Patient Control Number>	1/38	NOTE: Use this number for the patient control number assigned by the provider.
			Element Separator	*	1	
		CLP02	Claim Status Code	1, 2	1/2	1 = Processed as Primary 2 = Processed as Secondary (pended claims will be reported in the unsolicited 277 transaction –U277)
			Element Separator	*	1	
		CLP03	Monetary Amount	<Total Claim Charge Amount>	1/18	NOTE: Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point).
			Element Separator	*	1	
		CLP04	Monetary Amount	<Claim Payment Amount>	1/18	Monetary amount for the amount paid for this claim.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Element Separator	*	1	
		CLP06	Claim Filing Indicator Code	MC	1/2	MC = Medicaid
			Element Separator	*	1	
		CLP07	Reference Identification	<Payer Claim Control Number>	1/50	Value will be payer's internal control number (ICN).
			Element Separator	*	1	
		CLP09	Claim Frequency Type Code	<Claim Frequency Code>	1	NOTE: This number was received in CLM05-3 of the 837 claim.
			Element Separator	*	1	
	2100	CAS	Claim Adjustment			
			Element Separator	*	1	
		CAS03	Monetary Amount	<Adjustment Amount>	1/18	Inpatient Claim level adjustments to per diem rates will be reported in this Loop/Segment.
			Element Separator	*	1	
	2100	NM1	Patient Name			
			Element Separator	*	1	
		NM108	Identification Code Qualifier	MR	1/2	MR = Medicaid recipient identification number.
			Element Separator	*	1	
		NM109	Identification Code	<Patient Identifier>	2/80	The thirteen digit LA Medicaid recipient Identification Number.
			Segment End	~		
	2100	NM1	Service Provider Name			
			Element Separator	*	1	

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		NM108	Identification Code Qualifier	XX, FI, MC	1/2	XX= NPI FI = Federal taxpayer's Identification number MC = LA Provider Medicaid ID number
			Element Separator	*	1	
		NM109	Identification Code	<Rendering Provider Identifier>	2/80	MC = 7 digit Medicaid Provider ID when provider is atypical and not assigned NPI otherwise use XX.
			Segment End	~		
	2100	REF	Other Claim Related Identification			
			Element Separator	*	1	
		REF01	Reference Identification Qualifier	EA, F8, G1	2/3	EA = Medical Record # F8 = Original Reference # G1 = Prior Authorization #
			Element Separator	*	1	
		REF02	Reference Identification	<Other Claim Related Identifier>	1/30	The former claim ICN is reported here if the claims submitted were adjustments or voids. The Prior Authorization number or Medical Record number will be reported on original claims.
			Segment End	~		
	2100	REF	Rendering Provider Identification			
			Element Separator	*	1	
		REF01	Reference Identification Qualifier	1D	2/3	La Medicaid will report the Qualifier 1D.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Element Separator	*	1	
		REF02	Reference Identification	<Provider Identifier>	1/50	Medicaid will report the 7 digit Medicaid ID of the Attending/Rendering provider as submitted on the claim or as processed using the NPI/Medicaid ID number crosswalk
			Segment End	~		
	2110	SVC	Service Information			
			Element Separator	*	1	
		SVC01-02	Product/ service ID	<Adjudicated Procedure Code>	1/48	Medicaid will report the new bundled procedure code here if as a result of McKesson ClaimCheck editing, two or more procedures are paid under one procedure code. Otherwise, the original procedure code billed will appear.
			Element Separator	*	1	
		SVC02	Monetary Amount	<Line Item Charge Amount>	1/18	Submitted service charge amount. Medicaid will report the total billed charges of the originally billed claim lines when claim lines are bundled as a result of McKesson ClaimCheck editing OR report the originally submitted claim line billed charge amount for non-bundled claims.
			Element Separator	*	1	
		SVC03	Monetary Amount	<Line Item Provider Payment Amount>	1/18	Medicaid paid amount.
			Element Separator	*	1	

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		SVC06-2	Product/Service ID	<Procedure Code>	1/48	Medicaid will report the original submitted procedure code if as a result of McKesson ClaimCheck editing the claim line was bundled and the procedure code is different from the adjudicated claims procedure code shown in SVC01-2.
			Element Separator	*	1	
	2110	CAS	Service Adjustment			Note: Refer to additional comments at bottom of this page regarding adjustment coding.
		CAS01	Claim Adjustment Group Code	CO,OA,PI,PR	1/2	Claims that have been bundled as result of McKesson ClaimCheck editing will have CO for the Claim Adjustment Reason Code.
			Element Separator	*	1	
		CAS02	Claim Adjustment Reason Code	<Adjustment Reason Code>	1/5	Claim adjustment reason code 97 will report adjustment of the original submitted code when bundling occurs as a result of McKesson ClaimCheck editing.
			Element Separator	*	1	

Note: In situations where other insurers are obligated to pay towards medical services provided to a Medicaid patient, the Medicaid program is always considered as the secondary payer. From the perspective of the secondary payer, the "impact" of the primary payer's adjudication is a reduction in the payment amount. This "impact" may be up to the actual amount of the primary payment(s) ***plus contractual adjustment(s****). The secondary payer may not report the "actual" amount of a primary's payment if different than the "impact" amount.*

The "impact" is reported in the appropriate claim or service level CAS segment with reason code 23 (Payment adjusted due to the impact of prior payer(s) adjudication including payments ***and/or adjustments****.), and Claim Adjustment Group Code OA (Other Adjustment). The claim status code in CLP02 will identify whether the claim is being processed as primary, secondary, or tertiary.*

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		CAS03	Monetary Amount	<Adjustment Amount>	1/18	The billed amount of the original submitted code will be reported for claims that are bundled as a result of the McKesson ClaimCheck® editing. The amount for the new created claim line will be the difference between the total billed charge in SVC02 and the paid amount in SVC03.
			Element Separator	*	1	
	SUMMARY TABLE 3	PLB	Provider Adjustment			.
			Element Separator	*	1	
		PLB01	Reference Identification	<Provider Identifier>	1/50	National Provider Identifier NPI
			Element Separator	*	1	
		PLB02	Date	< Date> <CCYYMMDD>	8/8	Provider Fiscal Year or December 31 of current year.
			Element Separator	*	1	
		PLB03-01	Adjustment Reason Code	<Adjustment Reason Code> Codes used will be FB, CS, IR, or LE	2/2	FB = Negative Balance Forwarded or Applied IR = IRS withholding amount LE = IRS levy CS = Financial adjustments ** See additional comments at the end of this chart regarding identification of adjustments.
			Element Separator	*	1	

****Comments: For Louisiana Medicaid There are Four Types of Adjustments:**

1. Financial adjustments - Financial adjustments, such as check cancellations or return monies for Third Party payments, will be reported in the PLB segment using Adjustment reason code (PLB03-1) "CS". Any claims associated with these financial transactions will be reported in Table 2. PLB03-02 Adjustment Identifier will carry the 10 digit Financial Control Number (FCN) assigned, followed by a description of the type of transaction.

2. Lien/Levy - Lien/Levy withholdings will be reported in the PLB segment using Adjustment reason code “LE” for Lien/Levy account type A, “IR” for account type C and “CS” for account types B, E, and F. The PLB03 -02 will carry the following descriptions: (A) Internal Revenue Service (B) State of Louisiana (C) Internal Revenue Service (E) Deferred Compensation (F) Medical Assistant Trust Fund.

3. Negative Balances - Negative balances will be reported in the PLB segment using Adjustment Reason code of "FB".
PLB03-2 Adjustment Identifier will indicate “Negative balance applied” or “Negative balance forwarded”.

4. Community Care Fee payments - These payments will be reported in the PLB loop and not in Table 2 Claims Data. One PLB loop will occur per Recipient per payment. The PLB03-1 Reason Code will contain “CS”, PLB03-2 Adjustment Identifier will carry the 13 digit Recipient Medicaid ID, followed by the 4 digit date of service (MMYY), followed by the 13 digit assigned Internal Control Number (ICN).

Appendix 1: Implementation Checklist

This appendix contains all necessary steps for submitting/receiving electronic transactions with Louisiana Medicaid.

- Providers must register to become a Trading Partner.
- Trading Partners must sign a Trading Partner Agreement.
    - Trading Partner must contact the EDI Help Desk by submitting an email to HipaaEDI@gainwelltechnologies.com or calling (225) 216-6303 to make arrangements fortesting and approval to submit production transactions.
- Trading Partners must submit two (2) test files of a particular transaction type, with no minimum number of transactions within each file, and have no failures or rejections to submit production transactions.

***NOTE**: The 835 is an outgoing only transaction. There is no requirement for the 999 acknowledgment from Trading Partners at this time.*

Appendix 2: Frequently Asked Questions

Frequently Asked Questions (FAQs) will be collected by the EDI Department staff. These FAQs will be evaluated for trends and whether the FAQs would offer helpful information to other Trading Partners. Questions identified relating to 835 transactions will be added to Appendix 4 of this Companion Guide, during regular document updates.

Appendix 3: Change Summary

This appendix will contain a summary of any changes made to this version of the 835 Health Care Claim/Payment Advice Companion Guide after the initial release.

Version	Date	Author	Action/Summary of Changes	Loop/Segment	Page #
1.0	01/01/2014	Gainwell	Initial Document		
1.1	08/01/2014	Gainwell	Add note to CAS segment	2110/CAS	18

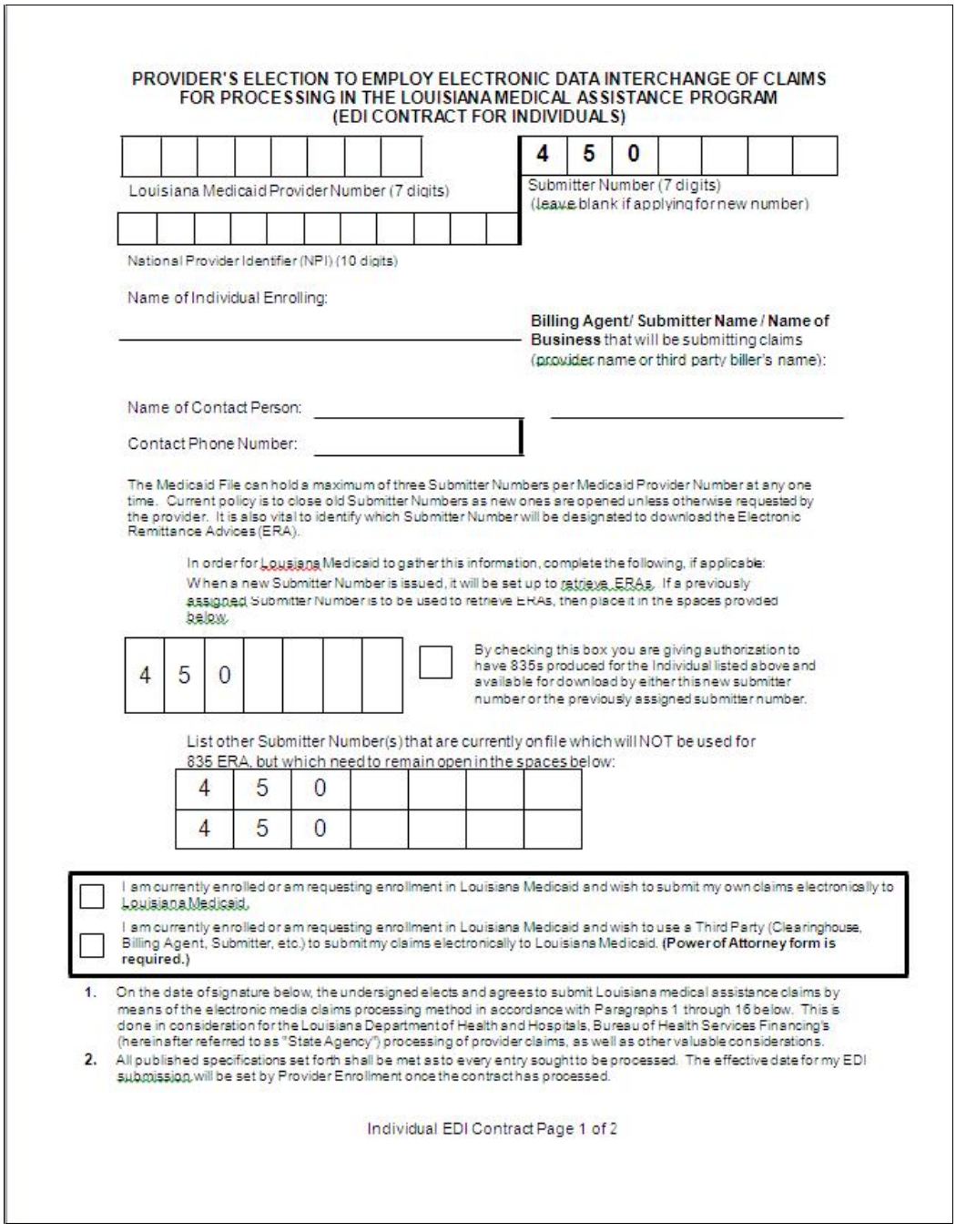
Appendix 4: Trading Partner Agreements (TPA)

This appendix contains a sample of the forms required for electronic billing or election to receive an electronic remittance (835) for Louisiana Medicaid providers. These documents can be found on lamedicaid.com website under the link titled Provider Enrollment. The documents are:

- **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (EDI CONTRACT FOR INDIVIDUALS)**
- **INDIVIDUAL MEDICAID ELECTRONIC MEDIA LIMITED POWER OF ATTORNEY (EDI POWER OF ATTORNEY)**

There are a different set of forms specified if the provider is enrolled as an entity vs. an individual. These forms are found on the same web link. These forms are to be returned to Gainwell Technologies Provider Enrollment Unit, PO Box 80159, Baton Rouge, LA 70898-0159.

Figure 4.1: EDI Contract - Page 1



PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (EDI CONTRACT FOR INDIVIDUALS)

Louisiana Medicaid Provider Number (7 digits)

Submitter Number (7 digits) (leave blank if applying for new number) — 4 5 0

National Provider Identifier (NPI) (10 digits)

Name of Individual Enrolling:

Billing Agent/ Submitter Name / Name of Business that will be submitting claims (provider name or third party biller's name):

Name of Contact Person:

Contact Phone Number:

The Medicaid File can hold a maximum of three Submitter Numbers per Medicaid Provider Number at any one time. Current policy is to close old Submitter Numbers as new ones are opened unless otherwise requested by the provider. It is also vital to identify which Submitter Number will be designated to download the Electronic Remittance Advices (ERA).

In order for Louisiana Medicaid to gather this information, complete the following, if applicable:
When a new Submitter Number is issued, it will be set up to retrieve ERAs. If a previously assigned Submitter Number is to be used to retrieve ERAs, then place it in the spaces provided below.

4 5 0 ☐ By checking this box you are giving authorization to have 835s produced for the Individual listed above and available for download by either this new submitter number or the previously assigned submitter number.

List other Submitter Number(s) that are currently on file which will NOT be used for 835 ERA, but which need to remain open in the spaces below:

4	5	0				
4	5	0				

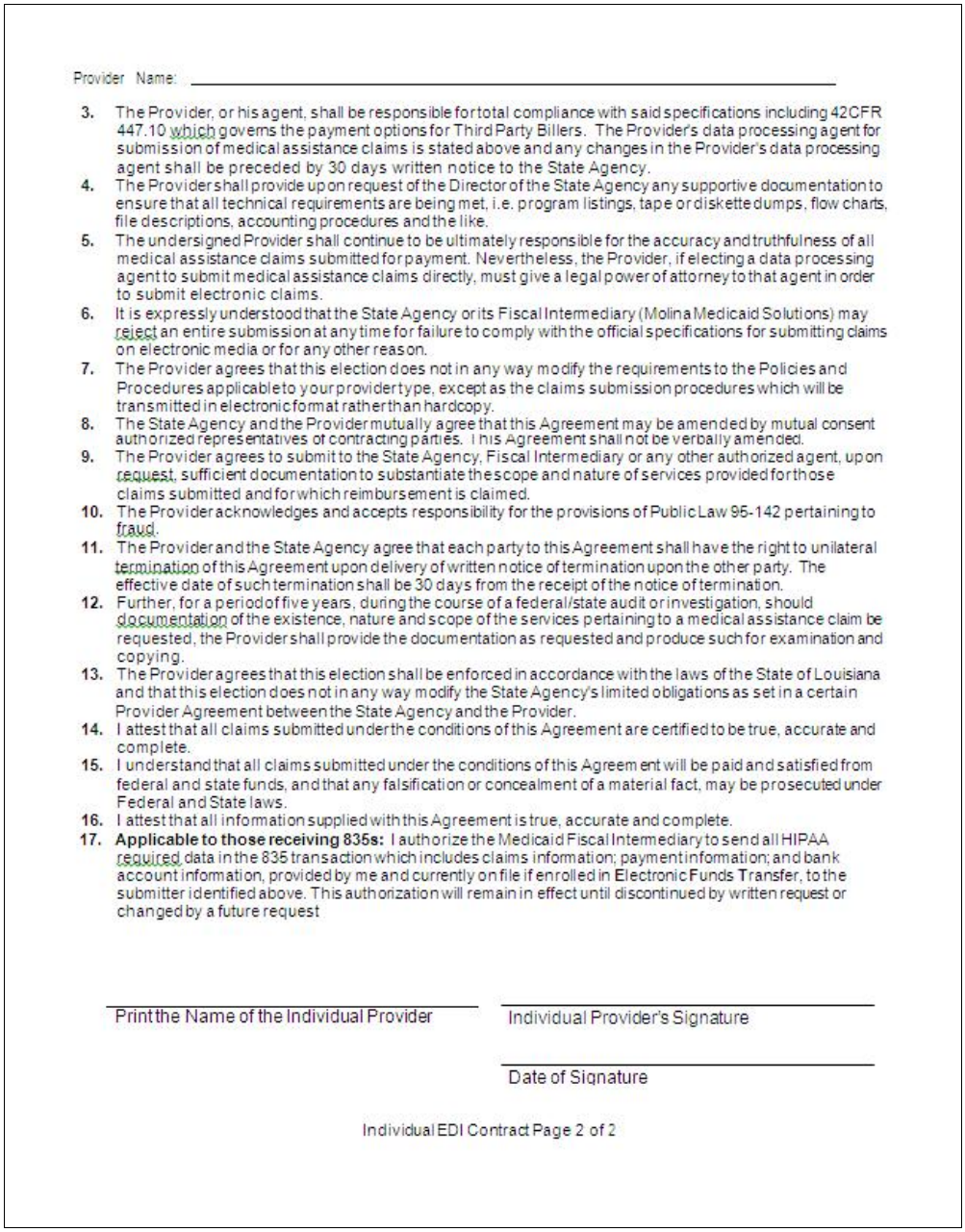
☐ I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to submit my own claims electronically to Louisiana Medicaid.

☐ I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to use a Third Party (Clearinghouse, Billing Agent, Submitter, etc.) to submit my claims electronically to Louisiana Medicaid. **(Power of Attorney form is required.)**

1. On the date of signature below, the undersigned elects and agrees to submit Louisiana medical assistance claims by means of the electronic media claims processing method in accordance with Paragraphs 1 through 16 below. This is done in consideration for the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing's (hereinafter referred to as "State Agency") processing of provider claims, as well as other valuable considerations.
2. All published specifications set forth shall be met as to every entry sought to be processed. The effective date for my EDI submission will be set by Provider Enrollment once the contract has processed.

Individual EDI Contract Page 1 of 2

Figure 4.2: EDI Contract - Page 2



Provider Name: _____

3. The Provider, or his agent, shall be responsible for total compliance with said specifications including 42CFR 447.10 which governs the payment options for Third Party Billers. The Provider's data processing agent for submission of medical assistance claims is stated above and any changes in the Provider's data processing agent shall be preceded by 30 days written notice to the State Agency.
4. The Provider shall provide upon request of the Director of the State Agency any supportive documentation to ensure that all technical requirements are being met, i.e. program listings, tape or diskette dumps, flow charts, file descriptions, accounting procedures and the like.
5. The undersigned Provider shall continue to be ultimately responsible for the accuracy and truthfulness of all medical assistance claims submitted for payment. Nevertheless, the Provider, if electing a data processing agent to submit medical assistance claims directly, must give a legal power of attorney to that agent in order to submit electronic claims.
6. It is expressly understood that the State Agency or its Fiscal Intermediary (Molina Medicaid Solutions) may reject an entire submission at any time for failure to comply with the official specifications for submitting claims on electronic media or for any other reason.
7. The Provider agrees that this election does not in any way modify the requirements to the Policies and Procedures applicable to your provider type, except as the claims submission procedures which will be transmitted in electronic format rather than hardcopy.
8. The State Agency and the Provider mutually agree that this Agreement may be amended by mutual consent authorized representatives of contracting parties. This Agreement shall not be verbally amended.
9. The Provider agrees to submit to the State Agency, Fiscal Intermediary or any other authorized agent, upon request, sufficient documentation to substantiate the scope and nature of services provided for those claims submitted and for which reimbursement is claimed.
10. The Provider acknowledges and accepts responsibility for the provisions of Public Law 95-142 pertaining to fraud.
11. The Provider and the State Agency agree that each party to this Agreement shall have the right to unilateral termination of this Agreement upon delivery of written notice of termination upon the other party. The effective date of such termination shall be 30 days from the receipt of the notice of termination.
12. Further, for a period of five years, during the course of a federal/state audit or investigation, should documentation of the existence, nature and scope of the services pertaining to a medical assistance claim be requested, the Provider shall provide the documentation as requested and produce such for examination and copying.
13. The Provider agrees that this election shall be enforced in accordance with the laws of the State of Louisiana and that this election does not in any way modify the State Agency's limited obligations as set in a certain Provider Agreement between the State Agency and the Provider.
14. I attest that all claims submitted under the conditions of this Agreement are certified to be true, accurate and complete.
15. I understand that all claims submitted under the conditions of this Agreement will be paid and satisfied from federal and state funds, and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.
16. I attest that all information supplied with this Agreement is true, accurate and complete.
17. **Applicable to those receiving 835s:** I authorize the Medicaid Fiscal Intermediary to send all HIPAA required data in the 835 transaction which includes claims information; payment information; and bank account information, provided by me and currently on file if enrolled in Electronic Funds Transfer, to the submitter identified above. This authorization will remain in effect until discontinued by written request or changed by a future request

_____ _____

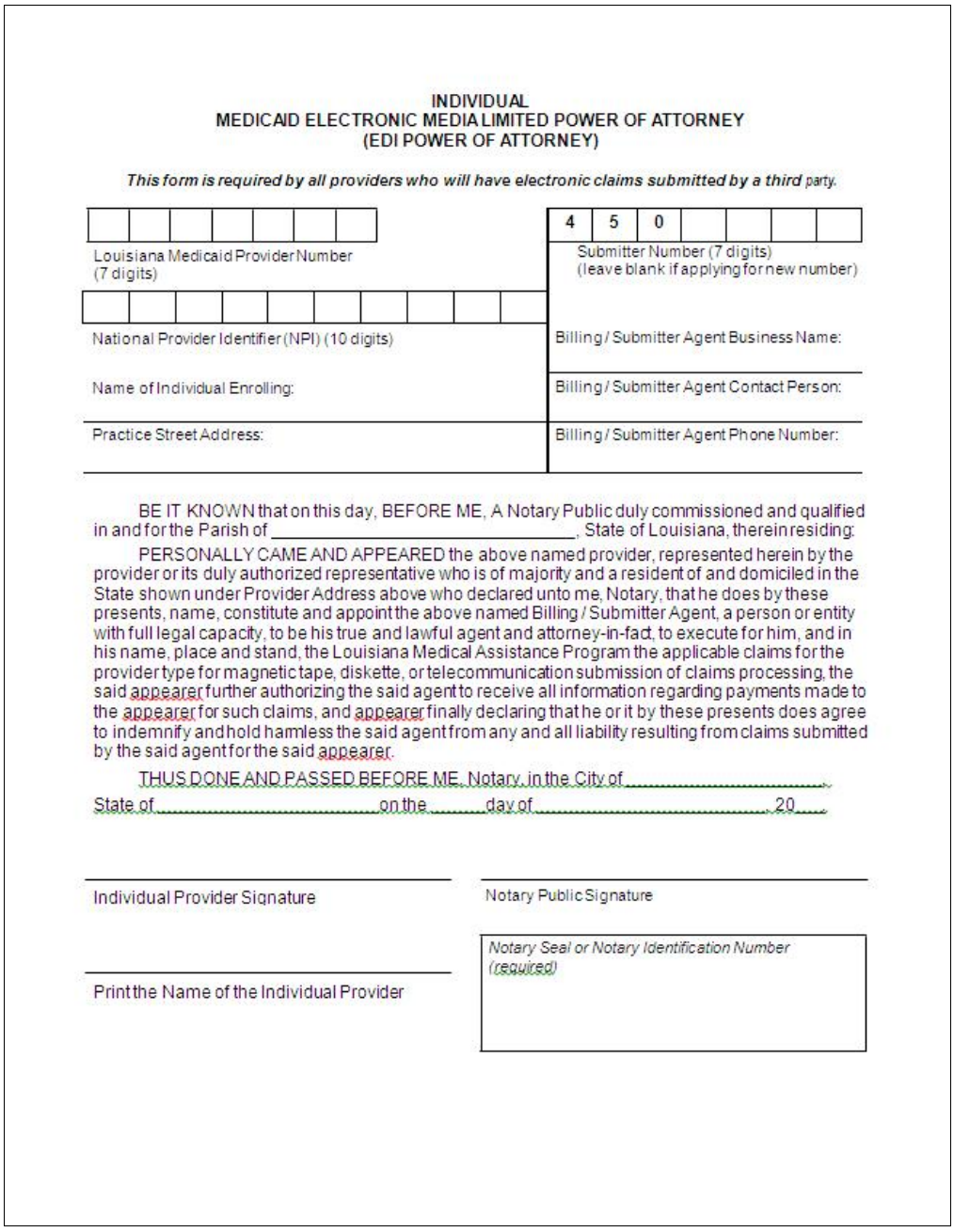
Print the Name of the Individual Provider Individual Provider's Signature

_____

Date of Signature

Individual EDI Contract Page 2 of 2

Figure 4-3: Power of Attorney - Page 1



INDIVIDUAL
MEDICAID ELECTRONIC MEDIA LIMITED POWER OF ATTORNEY
(EDI POWER OF ATTORNEY)

This form is required by all providers who will have electronic claims submitted by a third party.

Louisiana Medicaid Provider Number (7 digits)

Submitter Number (7 digits) (leave blank if applying for new number) — 4 5 0

National Provider Identifier (NPI) (10 digits)

Billing / Submitter Agent Business Name:

Name of Individual Enrolling:

Billing / Submitter Agent Contact Person:

Practice Street Address:

Billing / Submitter Agent Phone Number:

BE IT KNOWN that on this day, BEFORE ME, A Notary Public duly commissioned and qualified in and for the Parish of _____, State of Louisiana, therein residing:

PERSONALLY CAME AND APPEARED the above named provider, represented herein by the provider or its duly authorized representative who is of majority and a resident of and domiciled in the State shown under Provider Address above who declared unto me, Notary, that he does by these presents, name, constitute and appoint the above named Billing / Submitter Agent, a person or entity with full legal capacity, to be his true and lawful agent and attorney-in-fact, to execute for him, and in his name, place and stand, the Louisiana Medical Assistance Program the applicable claims for the provider type for magnetic tape, diskette, or telecommunication submission of claims processing, the said appearer further authorizing the said agent to receive all information regarding payments made to the appearer for such claims, and appearer finally declaring that he or it by these presents does agree to indemnify and hold harmless the said agent from any and all liability resulting from claims submitted by the said agent for the said appearer.

THUS DONE AND PASSED BEFORE ME, Notary, in the City of _____,
State of _____ on the _____ day of _____, 20____.

Individual Provider Signature

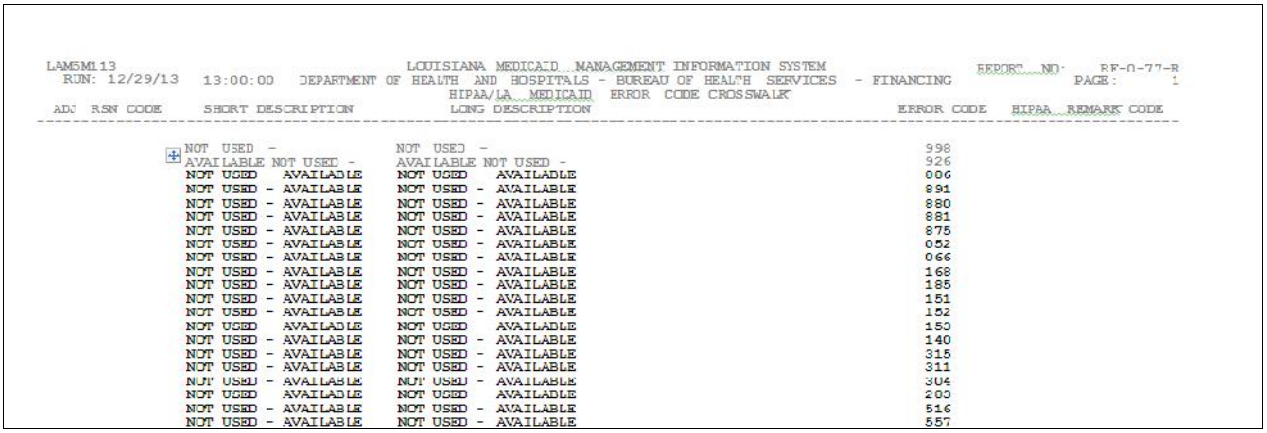
Notary Public Signature

Print the Name of the Individual Provider

Notary Seal or Notary Identification Number (required)

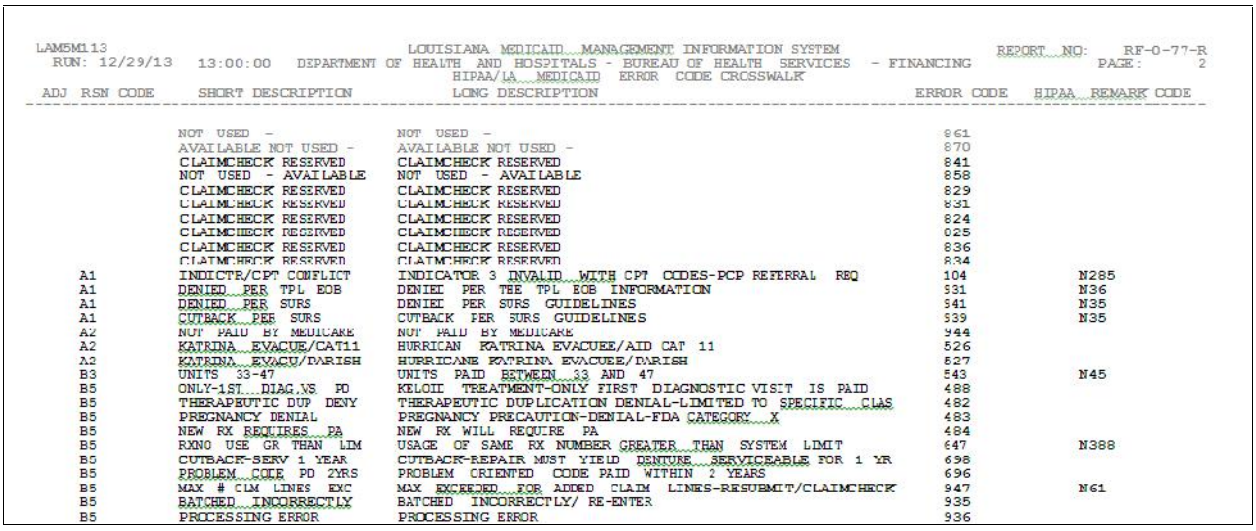
Appendix 5 CARC/RARC Crosswalk Report

This appendix contains the Hipaa Claim Adjustment Reason Code/Remittance Advice Remark Code crosswalk with the Louisiana Medicaid proprietary claim error codes. This report is updated monthly and can be found on lamedicaid.com web site under Forms/Files/User Manuals link.



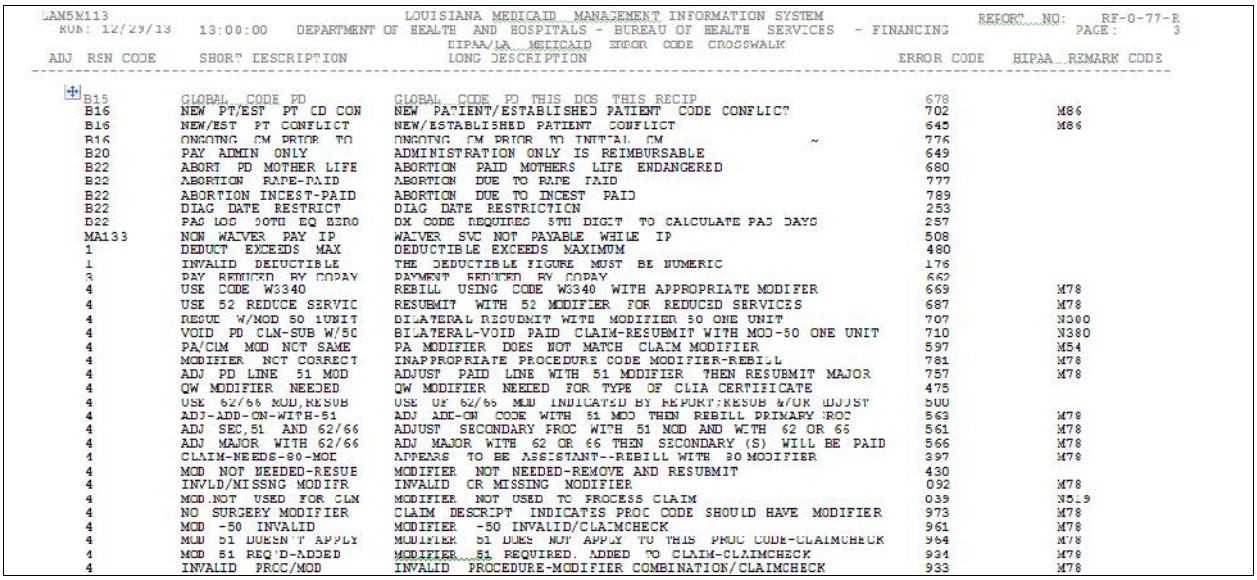
LAM5M113 LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEM REPORT NO: RF-0-77-R
RUN: 12/29/13 13:00:00 DEPARTMENT OF HEALTH AND HOSPITALS - BUREAU OF HEALTH SERVICES - FINANCING PAGE: 1
HIPAA/LA MEDICAID ERROR CODE CROSSWALK

ADJ RSN CODE	SHORT DESCRIPTION	LONG DESCRIPTION	ERROR CODE	HIPAA REMARK CODE
	NOT USED -	NOT USED -	998	
	AVAILABLE NOT USED -	AVAILABLE NOT USED -	926	
	NOT USED AVAILABLE	NOT USED AVAILABLE	006	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	891	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	880	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	881	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	875	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	052	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	066	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	168	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	185	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	151	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	152	
	NOT USED AVAILABLE	NOT USED AVAILABLE	150	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	140	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	315	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	311	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	304	
	NOT USED AVAILABLE	NOT USED AVAILABLE	200	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	516	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	557	



LAM5M113 LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEM REPORT NO: RF-0-77-R
RUN: 12/29/13 13:00:00 DEPARTMENT OF HEALTH AND HOSPITALS - BUREAU OF HEALTH SERVICES - FINANCING PAGE: 2
HIPAA/LA MEDICAID ERROR CODE CROSSWALK

ADJ RSN CODE	SHORT DESCRIPTION	LONG DESCRIPTION	ERROR CODE	HIPAA REMARK CODE
	NOT USED -	NOT USED -	961	
	AVAILABLE NOT USED -	AVAILABLE NOT USED -	870	
	CLAIMCHECK RESERVED	CLAIMCHECK RESERVED	841	
	NOT USED - AVAILABLE	NOT USED - AVAILABLE	858	
	CLAIMCHECK RESERVED	CLAIMCHECK RESERVED	829	
	CLAIMCHECK RESERVED	CLAIMCHECK RESERVED	831	
	CLAIMCHECK RESERVED	CLAIMCHECK RESERVED	824	
	CLAIMCHECK RESERVED	CLAIMCHECK RESERVED	825	
	CLAIMCHECK RESERVED	CLAIMCHECK RESERVED	836	
	CLAIMCHECK RESERVED	CLAIMCHECK RESERVED	834	
A1	INDICTR/CPT CONFLICT	INDICATOR 3 INVALID WITH CPT CODES-PCP REFERRAL REQ	104	N285
A1	DENIED PER TPL EOB	DENIED PER THE TPL EOB INFORMATION	531	N36
A1	DENIED PER SURS	DENIED PER SURS GUIDELINES	541	N35
A1	CUTBACK PER SURS	CUTBACK PER SURS GUIDELINES	539	N35
A2	NOT PAID BY MEDICARE	NOT PAID BY MEDICARE	944	
A2	KATRINA EVACUE/CAT11	HURRICAN KATRINA EVACUEE/AID CAT 11	526	
A2	KATRINA EVACU/PARISH	HURRICANE KATRINA EVACUEE/PARISH	527	
B3	UNITS 33-47	UNITS PAID BETWEEN 33 AND 47	543	N45
B5	ONLY-1ST DIAG,NS PD	KELOID TREATMENT-ONLY FIRST DIAGNOSTIC VISIT IS PAID	488	
B5	THERAPEUTIC DUP DENY	THERAPEUTIC DUPLICATION DENIAL-LIMITED TO SPECIFIC CLAS	482	
B5	PREGNANCY DENIAL	PREGNANCY PRECAUTION-DENIAL-FDA CATEGORY X	483	
B5	NEW RX REQUIRES PA	NEW RX WILL REQUIRE PA	484	
B5	RXNO USE GR THAN LIM	USAGE OF SAME RX NUMBER GREATER THAN SYSTEM LIMIT	647	N388
B5	CUTBACK-SERV 1 YEAR	CUTBACK-REPAIR MUST YIELD DENTURE SERVICEABLE FOR 1 YR	698	
B5	PROBLEM CODE PD 2YRS	PROBLEM CRIENTED CODE PAID WITHIN 2 YEARS	696	
B5	MAX # CLM LINES EXC	MAX EXCEEDED FOR ADDED CLAIM LINES-RESUBMIT/CLAIMCHECK	947	N61
B5	BATCHED INCORRECTLY	BATCHED INCORRECTLY/ RE-ENTER	935	
B5	PROCESSING ERROR	PROCESSING ERROR	936	



LAN5M113 LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEM REPORT NO: RF-0-77-R
RUN: 12/29/18 13:00:00 DEPARTMENT OF HEALTH AND HOSPITALS - BUREAU OF HEALTH SERVICES - FINANCING PAGE: 3
HIPAA/LA MEDICAID ERROR CODE CROSSWALK

ADJ RSN CODE	SHORT DESCRIPTION	LONG DESCRIPTION	ERROR CODE	HIPAA REMARK CODE
B15	GLOBAL CODE PD	GLOBAL CODE PD THIS DOS THIS RECIP	678	
B16	NEW PT/EST PT CD CON	NEW PATIENT/ESTABLISHED PATIENT CODE CONFLICT	702	M86
B16	NEW/EST PT CONFLICT	NEW/ESTABLISHED PATIENT CONFLICT	645	M86
B16	ONGOING CM PRIOR TO	ONGOING CM PRIOR TO INITIAL CM	776	
B20	PAY ADMIN ONLY	ADMINISTRATION ONLY IS REIMBURSABLE	649	
B22	ABORT PD MOTHER LIFE	ABORTION PAID MOTHERS LIFE ENDANGERED	680	
B22	ABORTION RAPE-PAID	ABORTION DUE TO RAPE PAID	777	
B22	ABORTION INCEST-PAID	ABORTION DUE TO INCEST PAID	789	
B22	DIAG DATE RESTRICT	DIAG DATE RESTRICTION	253	
D22	PAS LOS 30TH EQ ZERO	DX CODE REQUIRES 5TH DIGIT TO CALCULATE PAS DAYS	257	
MA133	NON WAIVER PAY IP	WAIVER SVC NOT PAYABLE WHILE IP	508	
1	DEDUCT EXCEEDS MAX	DEDUCTIBLE EXCEEDS MAXIMUM	480	
1	INVALID DEDUCTIBLE	THE DEDUCTIBLE FIGURE MUST BE NUMERIC	176	
3	PAY REMICD BY COPAY	PAYMENT REDUCED BY COPAY	662	
4	USE CODE W3340	REBILL USING CODE W3340 WITH APPROPRIATE MODIFER	669	M78
4	USE 52 REDUCE SERVIC	RESUBMIT WITH 52 MODIFIER FOR REDUCED SERVICES	687	M78
4	RESUB W/MOD 50 1UNIT	BILATERAL RESUBMIT WITH MODIFIER 50 ONE UNIT	707	N380
4	VOID PD CLM-SUB W/50	BILATERAL-VOID PAID CLAIM-RESUBMIT WITH MOD-50 ONE UNIT	710	N380
4	PA/CLM MOD NOT SAME	PA MODIFIER DOES NOT MATCH CLAIM MODIFIER	597	M54
4	MODIFIER NOT CORRECT	INAPPROPRIATE PROCEDURE CODE MODIFIER-REBILL	781	M78
4	ADJ PD LINE 51 MOD	ADJUST PAID LINE WITH 51 MODIFIER THEN RESUBMIT MAJOR	757	M78
4	QW MODIFIER NEEDED	QW MODIFIER NEEDED FOR TYPE OF CLIA CERTIFICATE	475	
4	USE 62/66 MOD,RESUB	USE OF 62/66 MOD INDICATED BY REPORT;RESUB &/OR ADJUST	500	
4	ADJ-ADD-ON-WITH-51	ADJ ADD-ON CODE WITH 51 MOD THEN REBILL PRIMARY PROC	563	M78
4	ADJ SEC,51 AND 62/66	ADJUST SECONDARY PROC WITH 51 MOD AND WITH 62 OR 66	561	M78
4	ADJ MAJOR WITH 62/66	ADJ MAJOR WITH 62 OR 66 THEN SECONDARY (S) WILL BE PAID	566	M78
4	CLAIM-NEEDS-80-MOD	APPEARS TO BE ASSISTANT--REBILL WITH 80 MODIFIER	397	M78
4	MOD NOT NEEDED-RESUE	MODIFIER NOT NEEDED-REMOVE AND RESUBMIT	430	
4	INVLD/MISSNG MODIFR	INVALID OR MISSING MODIFIER	092	M78
4	MOD.NOT USED FOR CLM	MODIFIER NOT USED TO PROCESS CLAIM	039	N519
4	NO SURGERY MODIFIER	CLAIM DESCRIPT INDICATES PROC CODE SHOULD HAVE MODIFIER	973	M78
4	MOD -50 INVALID	MODIFIER -50 INVALID/CLAIMCHECK	961	M78
4	MOD 51 DOESN'T APPLY	MODIFIER 51 DOES NOT APPLY TO THIS PROC CODE-CLAIMCHECK	964	M78
4	MOD 51 REQ'D-ADDED	MODIFIER 51 REQUIRED. ADDED TO CLAIM-CLAIMCHECK	934	M78
4	INVALID PROC/MOD	INVALID PROCEDURE-MODIFIER COMBINATION/CLAIMCHECK	933	M78