GAINWELL TECHNOLOGIES

Louisiana Medicaid
837 Health Care Claim-Professional
Companion Guide

Based on
ASC X12N Version 005010X223A1
CORE v5010 Master Companion Guide Template

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Revision History

See Appendix C.

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. 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 purpose of this guide is to clarify Louisiana Medicaid specific requirements and information needed for inclusion in the electronic 005010**X223A2**.claim transaction. The Companion Guide does not replace the published HIPAA Implementation TR3 Guide nor is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

All Data must be formatted in upper case.

This Guide is applicable to the following Louisiana Medicaid Claim types or File extensions.

PHY   Physician, Professional* Services claims

DME   Durable Medical Equipment claims

REH   Rehabilitation Services claims

TRA   Transportation

NAM   Non-Emergency, non-ambulance transportation (Gainwell no longer accepts this type of claim)

XXB   Medicare Advantage Part B claims

*includes Adult Day Health Care (ADHC) claims with dates of service April 1, 2016 and forward.

Providers/Submitters must be enrolled and registered in Louisiana Medicaid to submit electronic claims.

Please review the 5010 EDI General Companion Guide: (https://www.lamedicaid.com/Provweb1/HIPAABilling/5010_EDI_General_Companion.pdf).

Refer to Sections 2, 3 and 4 of this 837P guide for more detailed information.

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1. Introduction

This section describes how Louisiana Medicaid specific Health Care Claim (837P) 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: 837P Transaction Set Descriptions specifies the columns and suggested use of the rows for the detailed description of the transaction set Companion Guides.

Table 1: 837P Transaction Set Descriptions

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2010BA	NM1	Subscriber 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.
	2010BA	NM109	Identification Code		2/80	This type of row exists to limit the length of the specified data element.
	2430	SVD01	Identification Code	<Third Party Carrier Code>		Enter the Louisiana Medicaid issued Third Party Carrier Code.

1.1 Scope

The purpose of the Louisiana Medicaid 837P Health Care Claim Companion Guide is to provide Trading Partners with a guide to the Louisiana Medicaid specific requirements for the 837 Professional claim transaction. 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.

The 837O claims transaction is used for submittal of the following Louisiana Medicaid claim types, each with a unique file extension as part of the naming convention for the submitted file:

PHY   Physician, Professional* Services claims

DME   Durable Medical Equipment claims

REH   Rehabilitation Services claims

TRA   Transportation

NAM   Non-Emergency, non-ambulance transportation (Gainwell no longer accepts this type of claim)

XXB   Medicare Advantage Part B claims

Additional information about naming convention and file extensions can be found in the HIPAA 5010A EDI General Companion Guide (https://www.lamedicaid.com/Provweb1/HIPAABilling/5010_EDI_General_Companion.pdf).

1.2 Overview

This companion guide is to assist trading partners test and set up electronic claim transactions to meet Louisiana Medicaid processing standards. It documents and clarifies which data elements and segments must be used and when specific code sets or codes are to be used with Louisiana Medicaid billings. The information in this guide must be used in conjunction with the TR3 Implementation Guide instructions.

This section describes how the table, for the Louisiana Medicaid specific 837P transaction, is organized by columns and their descriptions. Section 10, Table 2 837P Health Care Claim, should be used as a reference for 837P transactions submitted to 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.

1.3 References

This section describes the additional reference material Trading Partners must use for the specific transaction specifications for the 837P Health Care Claim.

Refer to the following HIPAA version 5010A2 Technical Report Type 3 for additional information not supplied in this document, such as transaction usage, examples, code lists, definitions, and edits.

- *837 Health Claim-Professional*

- *005010X223A2 October 2010*

Copies of the ANSI X12 Technical Report Type 3s are available for purchase 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 837P Companion Guide and the HIPAA Technical Report Type 3s.

1.4 Additional Information

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

Louisiana Medicaid policies and requirements are documented in the claim type specific provider billing manuals and training packets and provider notices found on www.lamedicaid.com.

2. Getting Started

This section describes how to interact with Louisiana Medicaid regarding 837P 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/Clearinghouse must be associated with 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 Instituional claim files

3. 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 **Section 3 in the HIPAA 5010A EDI General Companion Guide** (https://www.lamedicaid.com/Provweb1/HIPAABilling/5010_EDI_General_Companion.pdf). This guide provides additional information such as specific steps to follow for submitting test files, the test result reports and how to read them, file rejection reasons, etc.

4. Connectivity with the Payer /Communications

This section contains information relating to the exchange methods with Louisiana Medicaid for submittal of the 837P transaction

4.1 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_Molina" folder and retrieve files via the "From_Molina" folder. 837P files are sent to the submitter's "To_Molina" folder and associated processing reports must be retrieved from the "From_Molina" folder location. Louisiana Medicaid has established the following for the EDI Gateway:

- **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 of connection service may do so to submit 837P claim transactions to their secure FTP location.

4.2 Transmission Administrative Procedures

The TA1 and 999 transaction reports are posted to sFTP indicating whether a file has passed editing and been accepted for processing. These reports can be obtained from sFTP in the "From_Molina" folder. The deadline for claim file submission is noon on Monday through Thursday for processing in the weekend adjudication cycle. Claim files received Friday thru Sunday will be entered into the processing Daily cycle on Mondays. The Louisiana Medicaid check write schedule is posted to www.lamedicaid.com.

4.3 Re-Transmission Procedure

Providers/submitters should contact the Gainwell EDI Department via email at
HipaaEDI@Gainwelltechnologies.com if an 837P claim file is processed late or missing. If a file is
rejected, the errors must be corrected and then the file can be resubmitted but **MUST** have a different ISA
number. An ISA number can never be reused.

4.4 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.

4.4.1 EDI Gateway – sFTP Process

Louisiana Medicaid offers a secure FTP system that has been developed to allow for more
reliable and expedited electronic file exchanges for trading partners. The site is located at
ftp.lamedicaid.com.

To facilitate increased security requirements, all files sent to and received from the Gainwell
sFTP site must be encrypted using Public/Private key pair encryption technology. Gainwell
assumes any trading partner requesting access to the system will be familiar with how this
technology is used. Gnu Privacy Guard, a free open source client, is available at
http://www.gnupg.org . Symantec's PGP client is another client although it is not free.

4.4.2 File Naming Conventions – Production and Test File Names

All electronic files sent to Gainwell must have file names in accordance with the structure below. Replace the sample submitter number of 4599999 with your assigned Louisiana Medicaid submitter number. The correct file extension is crucial to having your claims edited for the correct claim type.

Transaction	Claim Type	Name	File Extension	Sample file name
837P	09	Durable Medical Equip.	.DME	H4599999.DME
837P	04	Physician, ADHC**, Pediatric Day Health Care	.PHY	H4599999.PHY
837P	05	Rehabilitation	.REH	H4599999.REH
837P	07	Ambulance Transportation	.TRA	H4599999.TRA
837P	08	Non-Emergency Transportation	.NAM	H4599999.NAM
837P	15	Medicare Advantage Part B	.XXB	H4599999.XXB

**Adult Day Health Care claims were switched to the 837P PHY extension effective for dates of service 04012016.

4.5 Passwords

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

5. Contact Information

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

5.1 EDI Customer Service

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. Or via email at HIPAAEdi@Gainwelltechnologies.com

5.2 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.

5.3 Provider Service & Provider Enrollment

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.

5.4 Applicable Websites/Email

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

6. Control Segments/Envelopes

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

6.1 ISA-IEA

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

Interchange Control Header

- 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 the 7-digit Gainwell assigned Submitter ID (i.e. 450XXXX) followed by spaces.

- ISA07, Interchange ID Qualifier: Value will be ZZ.

- ISA08, Interchange Receiver ID: Value will be LA-DHH-MEDICAID.

- ISA09, Interchange Date: The date format is YYMMDD.

- ISA10, Interchange Time: The time format is HHMM.

- ISA 11, Repetition Separator: Value will be ^ ASCIIx5E.

- ISA12, Interchange Control Version Number: Value will be 00501.
- ISA13, Interchange Control Number, Value will be identical to the interchange trailer IEA02. Must be a positive unsigned number and must be unique for every transmission submitted.

- ISA14, Acknowledgment Requested, Value will be 0 or 1.

- ISA15, Usage Indicator, **T = Test Data and P=Production Data.**

- ISA16, Component Element Separator: Must be a colon: ASCIIx3A.

- Interchange Control Trailer

- IEA01, Number of included Functional Groups.

- IEA02, Interchange Control Number, Value must be identical to value in ISA13

6.2 GS-GE

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

Functional Group Header
- GS01, Functional Identifier Code: Value will be HC for this element.

- GS02, Application Sender's Code: Value must be identical to ISA06.

- GS03, Application Receiver's Code: Value will be LA-DHH-MEDICAID.

- GS04, Date: The date format is CCYYMMDD.

- GS05, Time: The time format is HHMM.

- GS06, Group Control Number: Uniquely assigned and maintained by the sender.

- GS07, Responsible Agency Code: Value will be X.

- GS08, Version/Release/Industry Identifier Code: Value will be 005010X223A2.
Functional Group Trailer

- GE01, Number of Transaction Sets included.

- GE02, Group Control Number; Value must be identical to value in GS06.

6.3 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: Value will be 005010X223A2.

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

Only one ST-SE transaction loop is permitted per file.

7. Payer Specific Business Rules and Limitations

This section describes Louisiana Medicaid's business rules regarding 837P transactions.

Service line data is required when reporting inpatient, outpatient and home health 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 inpatient Professional claims when the per-diem is the only service line adjustment. Each claim line (other than inpatient) will be reported in the 835 as a claim. Data not supplied at the claim level must be supplied at the line level (SVC – Service Payment Information).

There is a limit of **5,000 CLM segments** in a claims file.
NOTE: National Provider Identification Numbers are to be submitted in all 837P transactions. **Atypical** providers who have not registered an NPI with Louisiana Medicaid may continue to submit their legacy Medicaid Provider ID in the 837P as the provider identifier**.**

All successful 837P transactions received prior to cutoff on Thursdays will be processed in a Weekly Adjudication cycle with payment by check or EFT scheduled for the following Tuesday. Exceptions to this schedule will be posted on lamedicaid.com.

For Louisiana Medicaid claims, the Patient and the Subscriber are always the same, therefore Patient level data **should not** be sent.

For Louisiana Medicaid's specific business rules and limitations, refer to Section 10 Transaction Set Information, Table 2: 837P Health Claim.

Coordination of Benefits (COB)--For the purposes of COB, there are two types of payers in the 837; (1) the destination payer defined in the 2010BB loop, and (2) any 'other' payers defined in the 2330B loop(s). All of the information contained in the 2300 and 2310 loops is specific to the destination payer described in the 2010BB loop. Information specific to other payers is contained in the 2320, 2330, and 2430 loops.

Description	837 Loop	Segment	Data Source
Claim Adjustment Group Code	Loop 2320	CAS Segment(s)	Other Third Party 835 or EOB
Payer Paid Amount	Loop 2320	AMT*D Segment (Qualifier D)	Other Third Party 835 or EOB
Remaining Patient Liability	Loop 2320	AMT*EAF Segment (use here when only claim level COB info provided)	Calculated by Provider

Claim Adjudication Date	Loop 2330B	DTP Segment	Other Third Party 835 or EOB
Service Line Paid Amount	Loop 2430	SVD Segment	Other Third Party 835 or EOB
Claim Adjustment Group Code	Loop 2430	CAS Segment(s)	Other Third Party 835 or EOB
Line Adjudication Date	Loop 2430	DTP Segment	Other Third Party 835 or EOB
Remaining Patient Liability	Loop 2430	AMT*EAF Segment (Use here when line level COB info provided)	Calculated by Provider

There may be other payers involved with a claim; therefore, there could be more than 1 set of COB data. If that is the situation, the other Third Party's Louisiana Carrier Code, Paid Amount, Paid Date and CAS Segments would also be reported.

Other payers must be identified in the 837 Transaction in Loop 2330B; Segment NM109 with the six-digit Louisiana Medicaid assigned Carrier Code. The Carrier codes may be found on www.lamedicaid.com under the Forms/Files/Surveys/User Manuals link. You may either enter the name of an insurer or download the complete Louisiana Carrier Code listing.

8. Acknowledgements and/or Reports

HIPAA responses and acknowledgements are available for download via sFTP for a period of 14 days from the original creation date.

8.1 Report Inventory

The TA1 notifies the sender that a valid envelope was received or that problems were encountered with the interchange control structure. The TA1 verifies the envelopes only. TA104, Interchange Acknowledgment Code, indicates the status of the interchange control structure. This data element stipulates whether the transmitted interchange was accepted with no errors, accepted with errors, or rejected because of errors. TA105, Interchange Note Code, is a numerical code that indicates the error found while processing the interchange control structure. For a listing and description of TA1 errors, refer to Section 4.6.4 in the HIPAA 5010A EDI General Companion Guide found on lamedicaid.com

The 999 informs the submitter that the functional group arrived at the destination. It may include information about the syntactical quality of the functional group and the implementation guide compliance. Reason(s) for failure of claims files will be posted in the 999 which can be retrieved from sFTP.

9. 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.

Refer to the Provider Enrollment link on www.lamedicaid.com to obtain information about the TPA forms that are required for enrollment as an electronic claims submitter.

9.1 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 837 transaction set information requirements, which are outlined in Table 2: 837P Health Claim. 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 and/or simple data element pertinent to trading electronically with Louisiana Medicaid.

Table 2: 837I Health Claim

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.3	HEADER	ISA	Interchange Control Header	ISA		
			Element Separator	*	1	
C.4		ISA06	Interchange Sender ID	<7 digit Gainwell assigned Submitter number i.e.450XXXX>	15	Enter the Unique Submitter number issued by Gainwell to authorized EDI Submitters followed by spaces
			Element Separator	*	1	
C.5		ISA08	Interchange Receiver ID	LA-DHH-MEDICAID	15	
			Element Separator	*	1	
C.6		ISA14	Acknowledgment Requested	0 or 1	1	0 = No Interchange Acknowledgement Requested 1 = Acknowledgement Requested
			Element Separator	*		
C.6		ISA15	Interchange Usage Indicator	P or T	1	P = Production Data T = Test Data
			Element Separator	*	1	
C.6		ISA16	Component Separator	:	1	Must be a colon
			Segment End	~	1	
C.7	HEADER	GS	Functional Group Header	GS		
			Element Separator	*	1	
C.7		GS01	Functional Identifier Code	HC	2	HC = Health Care Claim (837)
			Element Separator	*	1	
C.7		GS02	Application Sender's Code	<Gainwell assigned Submitter ID>	2/15	Value will be identical to value in ISA06
			Element Separator	*	1	
C.7		GS03	Application Receiver's Code	LA-DHH-MEDICAID	2/15	
			Element	*	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Separator			
		GS04	Date	<CCYYMMDD>	8	NOTE: Use this date for the functional group creation date.
			Element Separator	*	1	
			Element Separator	*	1	
C.8		GS05	Time	<HHMM>	4/8	NOTE: Use this time for the creation time.
			Element Separator	*	1	
C.8		GS06	Group Control Number	<Assigned by Sender>	1/9	Uniquely assigned and maintained by the sender
			Element Separator	*	1	
C.8		GS07	Responsible Agency Code	X	1/2	X = Accredited Standards Committee X12
			Element Separator	*	1	
C.8		GS08	Version / Release / Industry Identifier Code	005010X223A1	1/12	005010X223A1 = Standards Approved for Publication by ASC X12 Procedures Review Board
70	HEADER	ST	Transaction Set Header	ST		
			Element Separator	*	1	
70		ST02	Transaction Set Control Number	<Assigned by Sender>	4/9	NOTE: Must be identical to associated Transaction Set Control Number SE02.
			Element Separator	*	1	
70		ST03	Implementation Convention Reference	005010X222A1	1/35	Contains the same value as in GS08.
			Segment End	~	1	
74	**1000A**	NM1	Submitter Name	N1		
			Element Separator	*	1	
75		NM109	Identification Code	<7 digit Louisiana Medicaid assigned Submitter Number>	2/80	Use the 7 digit Louisiana Medicaid Submitter ID assigned by Gainwell (i.e. 450XXXX).
			Segment End	~	1	
79	**1000B**	NM1	Receiver Name			
			Element	*	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Separator			
80		NM103	Name Last or Organization Name	<Receiver Name>	1/60	Value is LOUISIANA MEDICAID
			Element Separator	*	1	
80		NM109	Identification Code	<Receiver Code>	2/80	Value is LA-DHH-MEDICAID
			Segment End	~	1	
83	**2000A**	PRV	Billing Provider Specialty Information			
			Element Separator	*	1	
83		PRV01	Provider Code	<Provider Type Identifier Code>	1/3	Value is BI=Billing Provider
			Element Separator	*	1	
83		PRV02	Reference Identification Qualifier	<Taxonomy Qualifier Code>	2/3	Value is PXC=Provider Taxonomy Code
			Element Separator	*	1	
83		PRV03	Reference Identification	<Provider Taxonomy Code>	1/50	Value is the taxonomy Codes associated with the NPI of the Billing Provider and registered with Louisiana Medicaid. In situations where a provider may have a single NPI associated with multiple LA Medicaid provider numbers, a tie-breaker such as taxonomy may be required for unique identification of the Medicaid provider ID. Use the same Taxonomy code that was registered with Louisiana Medicaid for the Billing Provider.
			Segment End	~	1	
87	**2010AA**	NM1	Billing Provider			If the Billing provider is an

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Name			*atypical* provider who has issued or registered an NPI with LA Medicaid DO NOT USE this Loop. Use Loop 2010BB and report legacy Medicaid Provider ID in REF 02 with Qualifier G2.
			Element Separator	*	1	
89		NM108	Identification Code Qualifier	<Provider Identifier Qualifier Code>	1/2	Value is XX = NPI (National Provider Identifier)
			Element Separator	*	1	
90		NM109	Identification Code	<Billing Provider NPI Identifier>	2/80	Value is the provider NPI registered with Louisiana Medicaid that corresponds to the LA Medicaid provider being reported in this Loop. For individual providers that are incorporated, enter the organizational NPI that was issued AND registered with LA Medicaid. The Billing Provider may be an individual only when the health care provider performing services is an independent, unincorporated entity. If an *atypical* provider who was registered an NPI with LA Medicaid, report the NPI in this Loop.
			Segment End	~	1	
92	**201AA**	N4	Billing Provider			

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			City, State, Zip Code			
			Element Separator	*		
93		N403	Postal Code	<Postal Zip Code>	3/15	Value is the 9-digit Zip code. In situations where a provider may have a single NPI associated with multiple LA Medicaid provider numbers, a tiebreaker such as zip code may be required for unique identification of the Medicaid provider ID. Use the same zip code that was registered with Louisiana Medicaid for the Billing Provider.
			Segment End	~		
114	**2000B**	HL	Subscriber Hierarchical Level			
			Element Separator	*		
115		HL04	Hierarchical Child Code	0	1/1	Value is 0 for this element. For LA Medicaid the subscriber **will always** equal the patient. Therefore, an additional subordinate HL is not required.
			Segment End	~	1	
116	**2000B**	SBR	Subscriber Information			
			Element Separator	*	1	
118		SBR09	Claim Filling Indicator Code	<Claim Filing Indicator Code>	1/2	Value is MC = Medicaid
			Segment End	~	1	
121	**2010BA**	NM1	Subscriber Name			
			Element Separator	*	1	
122		NM102	Entity Type Qualifier	<Entity Type Qualifier>	1/1	Value is 1
			Element Separator	*	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		NM108	Identification Code Qualifier	<Member ID Qualifier>	1/2	Value is MI = Member Identification
			Element Separator	*	1	
123		NM109	Identification Code	<13 digit Louisiana Medicaid Recipient ID Number>	2/80	Value is the thirteen digit Medicaid Recipient ID
			Segment End	~	1	
133	**2010BB**	NM1	Payer Name			
			Element Separator	*	1	
134		NM108	Identification Code Qualifier	<Code Qualifier>	1/2	Value is PI = Payer Identification
			Element Separator	*	1	
134		NM109	Identification Code	LA-DHH- MEDICAID	2/80	Value is LA-DHH-MEDICAID
			Segment End	~	1	
140	**2010BB**	REF	Billing Provider Secondary Identification			This Loop is used by *atypical* providers that <u>DO NOT</u> have an NPI registered with Louisiana Medicaid. If an *atypical* provider has an NPI, use Loop 2010AA NM109 REF segment and <u>do not send</u> this REF.
			Element Separator	*	1	
140		REF01	Reference Identification Qualifier	<Reference Qualifier>	2/3	Value is G2 = Provider Commercial Number
			Element Separator	*	1	
141		REF02	Reference Identification	<7-digit Louisiana Medicaid Provider ID>	1/50	Value is the 7 digit Louisiana Medicaid Provider Number
			Segment End	~	1	
157	**2300**	CLM	Claim Information			
			Element Separator	*	1	
157		CLM01	Claim Submitter's Identifier	<Submitter's Claim Identifier/Patient Account Number>	1/20	Enter a unique number up to 20 characters
			Element	*	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Separator			
158		CLM02	Monetary Amount	<Billed Charge Amount>	2/80	Enter the total charges for the billed services. This amount must be LESS than one million dollars.
			Segment Separator	*	1	
159		CLM05	Health Care Service Location Information			CLM05 information applies to all service lines unless over written at the line level. Adult Day Health Care providers are to use Place of Service code = 99.
159		CLM05-1	Facility Code Value	<Place of Service code>	1/2	Use Place of Service codes from Code Source 237-US DHHS CMS.
159		CLM05-2	Facility Code Qualifier	B	1/2	Value is B = Place of Service Code for Professional Services
159		CLM05-3	Claim Frequency Type Code	<Third position of the UB Bill Type Code>	1/1	Value 1 = Original claim Value 7 = Adjustment of a previous claim Value 8 = Void of a previous claim
			Element Separator	*	1	
	2300	REF	Service Authorization Exception Code			
			Element Separator	*	1	
		REF01	Reference Identification Qualifier	<Reference Qualifier>	2/3	Value is 4N = Special Payment Reference Number
			Element Separator	*	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		REF	Reference Identification	\<Service Authorization Exception Code\>	1/500	Value 1 = billing for services associated with low level complexity which corresponds to the level of care noted in the definition of Evaluation and Management CPT codes 99281 and 99282 Value 3 = billing for services associated with moderate to high level emergency physician care which corresponds to the level of care noted in the definition of Evaluation and Management CPT codes 99283, 99284 and 99285
			Segment End	~	1	
193	2300	REF	Referral Number			
			Element Separator	*		
193		REF01	Reference Identification Qualifier	\<Qualifier Code\>	2/3	Value is 9F = Referral Number
			Element Separator	*		
193		REF02	Reference Identification	\<Referral number\>	1/50	Value is the appropriate referral number issued for the service being billed
194	2300	REF	Prior Authorization			
			Element Separator	*		
194		REF01	Reference Identification Qualifier	\<Qualifier Code\>	2/3	Value is G1 = La Medicaid Prior Authorization number
			Element Separator	*		
195		REF02	Reference Identification	\<Prior Authorization Number\>	1/50	Value is the Gainwell assigned Prior Authorization Number for the service being billed. ADHC providers use 9 digit number assigned by LDH designated

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
						authorizing entity.
			Segment End	~	1	
	2300	REF	Clinical Laboratory Improvement Amendment (CLIA) Number			
			Element Separator	*	1	
		REF01	Reference Identification Qualifier	\<Qualifier Code\>	2/3	Value is X4 = Clinical Laboratory Improvement Amendment Number
			Element Separator	*	1	
		REF02	Reference Identification	\<CLIA Number\>	1/50	Value is the CLIA Certificate Number
			Segment End	~	1	
211	**2300**	CR1	Ambulance Transport Information			
			Element Separator	*	1	
212		CR105	Unit or Basis for Measurement Code	\<Units Indicator\>	2/2	Value is DH = Miles
			Element Separator	*	1	
213		CR106	Quantity	\<Transport Distance\>	1/15	Number of miles of transport
			Element Separator	*	1	
223	2300	CRC	EPSDT Referral			
			Element Separator	*	1	
223		CRC01	Code Category	ZZ	2/2	Value is ZZ = EPSDT Screening Referral
			Element Separator	*	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
224		CRC03	Condition Indicator	S2,ST,NU	2/3	S2 = Under Treatment, use when patient currently under treatment. ST = New Services Requested, patient scheduled for follow-up or referred to another provider for treatment of 1 condition discovered in screening NU = Not Used, use when CRC02 is N.
			Element Separator	*	1	
226	2300	HI	Health Care Diagnosis Code			Adult Day Health Care Code providers should use ICD 10 diagnosis code of Z76.89 for services after DOS 10/01/2016
			Element Separator	*		
		HI01-1	Code List Qualifier Code	<Principal Diagnosis Code Qualifier>	1/3	Code BK = Use for service/discharge dates **before** 10/01/2015 Code ABK = Use for service/discharge dates **on or after** 10/01/2015
			Element Separator	*	1	
227		HI01-2	Industry Code	<Principal Diagnosis Code>	1/30	Value is **ICD-9** codes for service/discharge dates **before** 10/01/2015;**ICD-10** codes for service/discharge dates **after** 10/01/2015
			Element Separator	*	1	
228		HI02-1	Code List Qualifier Code	<Other Diagnosis Code Qualifier	1/3	BF = Use for service/discharge dates **before** 10/01/2015 ABF = Use for service/discharge dates **on or after** 10/01/2015
			Element Separator	*	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
228		HI02-2	Industry Code	<Other Diagnosis Code>	1/30	Value is **ICD-9** codes for service/discharge dates **before** 10/01/2015;**ICD-10** codes for service/discharge dates **after** 10/01/2015
			Element Separator	*	1	
257	2310A	NM1	Referring Provider Name			Use this Loop to report the Referring provider when appropriate. For services for a Lock-In recipient, identify the Lock-In Physician. If ACA services are delivered by a PA or APRN, the name of the supervising ACA certified physician is required (This requirement ended with date of service 01/01/2015.) Adult Day Health providers are not required to send Referring Provider information.
			Element Separator	*	1	
258		NM101	Entity Identifier Code	<Provider Identifier Qualifier Code>	2/3	Value is DN = Referring Provider
			Element Separator	*	1	
258		NM103	Name Last	<Last name of Referringprovider>	1/60	Value is the last name of the referring provider; see notes in shaded area above.
			Element Separator	*	1	
258		NM104	Name First	<First name of Referring Provider>	1/36	Value is the first name of the referring provider; see notes in shaded area above.
			Element Separator	*	1	
259		NM108	Identification Code Qualifier	<Provider Identifier Qualifier Code>	1/2	Value is XX = National Provider Identifier
			Element Separator	*	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
259		NM109	Identification Code	<NPI of Referring Provider>	2/80	Value is the NPI registered with Louisiana Medicaid that corresponds to the Medicaid provider being reported in this Loop. The Referring Provider must be enrolled in LA. Medicaid.
			Segment End	~	1	
260	**2310A**	REF	Referring Provider Secondary Identification			Use this Loop for atypical providers who do not have an NPI. Otherwise, do not use this this loop.
			Element Separator	*	1	
260		REF01	Reference Identification Qualifier	G2	2/3	G2=Provider Medicaid Number
			Element Separator	*	1	
261		REF02	Reference Identification	<7-digit Louisiana Medicaid Provider Number>	1/50	Value is the 7-digit Medicaid provider number of an atypical provider who has not registered an NPI with Louisiana Medicaid.
			Segment End	~	1	
262	**2310B**	NM1	Rendering Provider Name			Adult Day Health Care providers are not required to send Rendering Provider info.
			Element Separator	*	1	
264		NM108	Entity Identifier Code	<Provider Identifier Qualifier Code>	1/2	Value is XX = National Provider Identifier
			Element Separator	*	1	
264		NM109	Identification Code	<NPI of Rendering Provider>	2/80	Value is the NPI registered with Louisiana Medicaid that corresponds to the Medicaid provider being reported in this Loop
			Segment End	~	1	
265	2310B	PRV	Rendering Provider Specialty Information			

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Element Separator	*	1	
265		PRV02	Reference Identification Qualifier	<Taxonomy Code Qualifier>	2/3	Value is PXC=Provider Taxonomy Code
			Element Separator	*	1	
265		PRV03	Reference Identification	Provider Taxonomy Code	1/50	Value is the taxonomy Code associated with the NPI of the Rendering Provider and registered with Louisiana Medicaid. In situations where a provider may have a single NPI associated with multiple LA Medicaid provider numbers, a tie-breaker such as taxonomy may be required for unique identification of the Medicaid provider ID. Use the same Taxonomy code that was registered with Louisiana Medicaid for the Rendering Provider.
			Segment End	~	1	
267	**2310B**	REF	Rendering Provider Secondary Identification			
			Element Separator	*	1	
267		REF01	Reference Identification Qualifier	G2	2/3	Value is G2 = Provider Medicaid Number
			Element Separator	*	1	
268		REF02	Reference Identification	<7-digit Louisiana Medicaid Provider ID>	1/50	Value is the 7-digit Medicaid provider number of an *atypical* provider who has <u>not</u> registered an NPI with Louisiana Medicaid. **Otherwise, do not use this Loop.**
			Segment End	~	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
295	**2320**	SBR	Other Subscriber Information			
			Element Separator	*	1	
298		SBR09	Insurance Type Code	11,12,13,14,15,16,17,AL,BL,CH,CI, DS,FI,HM,LM,TV, VA,ZZ,MB	1/2	Do **NOT use MC** for this segment when reporting information about <u>another payer</u> involved in this claim. **Must use MB** if filing Medicare Advantage claim.
			Segment End	~	1	
299	**2320**	CAS	Claim Level Adjustments			Required if other payers are known to be involved in paying on this claim. May repeat up to 6 sets of CAS01/CAS02 groupings. Codes and associated amounts must come from either paper remittance advice or 835s (Electronic Remittance Advice) received on the claim. Adjustment amounts explain the difference between submitted charges and the amount paid.
			Element Separator	*	1	
301		CAS01	Claim Adjustment Group Code	CO,CR,OA,PI,PR	1/2	Value is code received from other payer reported in this Loop. When PR is used, include segments for Deductible, Coinsurance and/or Co-payment amounts as appropriate.
			Element Separator	*	1	
		CAS02	Claim Adjustment Reason Code	<Standard Claim Adjustment Reason Code>	1/5	Value is code received from other payer reported in this Loop.
			Element Separator	*	1	
		CAS03	Monetary Amount	<Dollar Value of Adjustment>	1/18	Value is the amount of adjustment associated with CAS Code pairing

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Element Separator	*	1	
320	2330B	NM1	Other Payer Name			Add information here when another payer has processed the claim before it is sent to Louisiana Medicaid.
			Element Separator	*	1	
321		NM108	Identification Code Qualifier	PI	1/2	Value is PI = Payer Identification
			Segment Separator	*	1	
321		NM109	Identification Code	<Louisiana Medicaid Carrier Code>	6	Value is the 6-digit Louisiana **Medicaid Carrier Code** for the Payer identified in Loop 2320.The LA Medicaid TPL Carrier Code list can be found on lamedicaid.com under Forms/Files/User Manuals navigational link. **DO NOT** enter dashes, hyphens etc.
			Segment End	~	1	
350	**2400**	LX	Service Line Number			
			Element Separator	*	1	
350		LX01	Assigned Number	<Service Line Number>	1/6	Louisiana Medicaid will process and store up **to 50 lines** for professional claims.
			Segment End	~	1	
351	2400	SV1	Professional Service			
			Element Separator	*	1	
354		SV102	Monetary Amount	<Service Line Charge Amount>	1/8	Value is total charge amount for service line. Format is 999999.99 which is a Limit of 6 whole numbers followed by 2 decimal places. ADHC providers enter 0 for service line charges.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Element Separator	*	1	
355		SV103	Unit or Basis of Measurement Code	<Measurement Qualifier Code>	2/2	Value is MJ = Minutes or UN = Unit. ADHC providers must use UN.
			Element Separator	*	1	
355		SV104	Quantity	<Service Unit count>	1/4	Value must be a whole number with a limit to 4 whole numbers. ADHC providers enter number of 15 minute units for the billed service; cannot exceed 40 units per day; 200 units per week.
			Element Separator	*	1	
357		SV109	Yes/No Conditionor Response Code	Y,N	1/1	This element is used to derive Type of Service for Ambulance claims. If an emergency service, value will be Y; if non-emergency value will be N.
			Element Separator	*	1	
357		SV111	Yes/No Conditionor Response Code	Y,N	1/1	Required when Medicaid services are the result of a screening referral. Value is Y = yes or N = no.
			Element Separator	*	1	
357		SV112	Yes/No Conditionor Response Code	Y,N	1/1	Value is indicator of family planning services involvement. Value is Y = yes or N = no.
			Element Separator	*	1	
358		SV115	Copay Status Code	0	1/1	Value of 0 required if patient is exempt from co-payment.
			Segment End	~	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2400	CR1	Ambulance Transport Information			
			Element Separator	*	1	
		CR105	Unit or Basis of Measurement Code	<Unit Qualifier Code>	2/2	Value is DH = Miles
			Element Separator	*	1	
		CR106	Quantity	<travel distance>		Value is number of miles traveled
			Segment End	~	1	
380	**2400**	DTP	Date-Service Date			
			Element Separator	*	1	
		DTP01	Date/Time Qualifier	472	3/3	Value is 472 = Service Date
			Element Separator	*	1	
		DTP02	Date Time Period Format Qualifier	D8, RD8	2/3	Value is D8 = CCYYMMDD or RD8 = Range of Dates CCYYMMDD-CCYYMMDD
			Element Separator	*	1	
381		DTP03	Date Time Period	<Date or Time Period>	1/35	Date(s) of service. When billing for services that have been prior authorized, and the intent is to bill for the entire approved amount, use span dates that equal those given on the Gainwell Approval Letter. Adult Day Health Care providers bill for each day of service authorized. All dates of service must be within a single month; do not span date across months of the year.
			Segment End	~	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
	2400	REF	Referral Number			Required when this service line involved a referral number that is different than the number reported at the claim level (Loop-ID 2300).
			Element Separator	*	1	
		REF01	Reference Identification Qualifier	9F	2/3	Value is 9F = Referral Number
			Element Separator	*	1	
		REF02	Reference Identification	<Referral Number>	1/50	Value is the Referral Number as appropriate for the service billed.
			Segment End	~	1	
	2400	REF	Prior Authorization			Required when service line involved a prior authorization number that is different than the number reported at the claim level (Loop ID-2300).
			Element Separator	*	1	
		REF01	Reference Identification Qualifier	<Prior Authorization Qualifier Code>	2/3	Value is G1 = Prior Authorization Number
			Element Separator	*	1	
		REF02	Reference Identification	<Prior Authorization Number>	1/50	Value is the Gainwell assigned Prior Authorization number for the service billed or the number issued by the LDH designated authorizing
			Segment End	~	1	
	2400	REF	Clinical Laboratory Improvement Amendment (CLIA) Number			Required for CLIA covered services if the number is different from that reported at the claim level in Loop 2300.
			Element Separator	*	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		REF01	Reference Identification Qualifier	<CLIA Identifier Qualifier Code>	2/3	Value is X4 = Clinical Laboratory Improvement Amendment Number
			Element Separator	*	1	
		REF02	Reference Identification	<CLIA Number>	1/50	Value is the CLIA certificate number of the entity for the service billed.
			Segment End	~	1	
423	2410	LIN	Drug Identification			A federal statue mandates that providers must report National Drug Code (NDC) information for all physician- administered drugs on LA Medicaid claims submissions. This requirement applies to both electronic and hardcopy claims. Providers are required to submit NDC information for the corresponding HCPCS code for physician-administered drugs. Claims must reflect the NDC from the label of the product administered. LA Medicaid also requires DME providers to report NDC information associated with HCPCS codes on claims for enteral therapy products. This requirement also applies to pharmacies that dispense DME supplies to Medicaid Recipients.
			Element Separator	*	1	
425		LIN02	Product/Service ID Qualifier	<Drug Code Qualifier>	2/2	Value is N4 = National Drug Code in 5-4-2 format.
			Element Separator	*	1	
425		LIN03	Product/Service ID	<NDC Code>	1/48	Value is the National Drug Code associated with the physician-administered drug identified in Loop 2400 SV101-2.

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Segment End	~	1	
426	**2410**	CTP	Drug Quantity			
			Element Separator	*	1	
426		CTP04	Quantity	<Units Administered>	1/10	Value is the quantity or actual units administered. The maximum quantity that can be entered for LA Medicaid is **seven whole numbers and three decimal places.**
			Element Separator	*	1	
427		CTP05-01	Unit or Basis of Measurement Code	F2, GE, ME, ML, UN	2/2	F2 = International Unit GR = Gram ME = Milligram ML = Milliliter
			Segment End	~	1	
430	**2420A**	NM1	Rendering Provider Name			Adult Day Health Care providers are not required to enter Rendering Provider info.
			Element Separator	*	1	
432		NM108	Identification Code Qualifier	<Provider Identifier Qualifier Code>	1/2	Value is XX = National Provider Identifier
			Element Separator	*	1	
432		NM109	Identification Code	<National Provider Identification>	2/80	Value is the NPI registered with Louisiana Medicaid that corresponds to the Louisiana Medicaid Provider being reported in this Loop. If the provider is considered an *atypical* provider and has not registered an NPI with Louisiana Medicaid, continue to use Loop 2420A, REF 02 with qualifier G2 to provider the Louisiana Medicaid Provider ID.
			Segment End	~	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
433	**2420A**	PRV	Rendering Provider Specialty Information			
			Element Separator	*	1	
433		PRV01	Provider Code	<Provider Type Code>	1/3	Value is PE= Performing Provider
			Element Separator	*	1	
433		PRV02	Reference Identification Qualifier	<Taxonomy Qualifier Code>	2/3	Value is PXC=Provider Taxonomy Code
			Element Separator	*	1	
433		PRV03	Reference Identification	<Provider Taxonomy Code>	1/50	Value is the taxonomy Code associated with the NPI of the Rendering Provider and registered with Louisiana Medicaid. In situations where a provider may have a single NPI associated with multiple LA Medicaid provider numbers, a tiebreaker such as taxonomy may be required for unique identification of the Medicaid provider ID. Use the same Taxonomy code that was registered with Louisiana Medicaid for the Rendering Provider.
			Segment End	~	1	
434	**2420A**	REF	Rendering Provider Secondary Information			Required when the Rendering Provider NM1 information is different than that carried in the Loop ID 2310B Rendering Provider.
			Element Separator	*	1	
		REF01	Reference Identification Qualifier	G2	2/3	Value is G2 = Louisiana Medicaid 7- digit Provider Number.
			Element Separator	*	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		REF02	Reference Identification	\<Louisiana Medicaid Provider Number\>	1/7	If the Rendering Provider is an *atypical* **provider** who has not registered an NPI with Louisiana Medicaid, you may send the 7-digit legacy Medicaid Provider number in this Loop.
			Segment End	~		
	2420E	NM1	Ordering Provider Name required			Ordering provider Name & NPI information are for certain Medicaid services including all DME claims, Independent Lab claims, and EPSDT Personal Care Services. Long Term PCS claims do not require an Ordering Provider. Refer to lamedicaid.com web notices for additional information regarding these requirements. When required, the Ordering provider MUST be enrolled in the Louisiana Medicaid Program.
			Element Separator	*	1	
		NM101	Entity Identifier Code	DK	2/3	Value is DK=
			Element Separator	*	1	
		NM103	Name Last		1/60	Value is the last name of the Ordering Provider.
			Element Separator	*	1	
		NM104	Name First		1/35	Value is the first name of the Ordering Provider.
			Element Separator	*	1	
		NM108	Identification Code Qualifier	\<Provider Identifier Qualifier Code\>	1/2	Value is XX = National Provider Identifier.
			Element Separator	*	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
		NM109	Identification Code	<National Provider Identification>	2/80	Value is the NPI of the Ordering Provider who must be enrolled in Louisiana Medicaid.
			Segment End	~	1	
465	**2420F**	NM1	Referring Provider Name			Required when this service line involves a referral, and the Referring provider differs from that reported at the claim level (loop 2310A). When billing for services for a Lock-In recipient, identify the Lock-In Physician. Adult Day Health Care providers are not required to enter Referring Provider info.
			Element Separator	*	1	
		NM101	Entity Identifier Code	<Referring Provider Qualifier Code>	2/3	Value is DN = Referring Provider
			Element Separator	*	1	
		NM103	Name Last	<Referring Provider Last Name>	1/60	Value is the last name of the referring provider.
			Element Separator	*	1	
		NM104	Name First	<Referring Provider First Name>	1/35	Value is the first name of the referring provider.
			Element Separator	*	1	
467		NM108	Identification Code Qualifier	<Provider Identifier Qualifier Code>	1/2	Value is XX = National Provider Identifier
			Element Separator	*	1	
		NM109	Identification Code	<NPI of Referring Provider>	2/80	Value is the NPI registered with Louisiana Medicaid that corresponds to the provider being reported in the Loop. The Referring Provider must be enrolled in Louisiana Medicaid.
			Segment End	~		

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
471	**2420F**	REF	Referring Provider Secondary Identification			Required when this service line involves a referral, and the referring provider differs from that reported at the claim level (Loop 2310A). Do not use this Loop if Referring Provider has an NPI.
			Element Separator	*	1	
		REF01	Reference Identification Qualifier	G2	2/3	Value is G2 = Louisiana Medicaid 7- digit Provider Number.
			Element Separator	*	1	
472		REF02	Reference Identification	<Louisiana Medicaid Provider Number>	1/7	If the Referring Provider is an *atypical* provider who has not registered an NPI with Louisiana Medicaid, you may send the 7-digit legacy Medicaid Provider number in this Loop.
			Segment End	~	1	
480	**2430**	SVD	Line Adjudication Information			Required when the claim has been previously adjudicated by payer identified in Loop ID 2330B and this service line has payments and/or adjustments applied to it.
			Element Separator	*	1	
480		SVD0	Identification Code	<Louisiana Medicaid Carrier Code>	2/80	Value is the 6-digit Louisiana **Medicaid Carrier Code.** Number should match NM109 in Loop 2330B identifying the Other Payer. The LA Medicaid TPL Carrier Code list can be found on lamedicaid.com under Forms/Files/User Manuals navigational link.
			Element Separator	*	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
481		SVD02	Monetary Amount	<Service Line Paid Amount>	1/10	Value is the amount Other Payer paid for this service line.
			Element Separator	*	1	
484	**2430**	CAS	Line Adjustment			Required when the payer identified in Loop 2330B made line level adjustments which caused the amount paid to differ from the amount originally charged. Providers are to enter the information as received on the remittance from the Other Payer. The "adjustment trio" is composed of adjustment reason code, adjustment amount, and adjustment quantity (when needed).
485		CAS01	Claim Adjustment Group Code	CO, OA, PI, PR	1/2	When using Value of PR, include amounts for Deductible, Co-insurance and Co-Pay as appropriate.
			Element Separator	*	1	
486		CAS02	Claim Adjustment Reason Code	<Claim Adjustment Reason Code>	1/5	Value is the CARC code received from the Other Payer for the associated service.
			Element Separator	*	1	
486		CAS03	Monetary Value	Adjustment Amount	1/8	Value is the monetary adjustment amount received from the Other Payer for the associated service.
			Element Separator	*	1	
	TRAILER	SE	Transaction Set Trailer			
			Element Separator	*	1	
		SE01	Transaction Segment Count	<Number>	1/10	Value is the total number of Segments included.
			Element	*	1	

TR3 Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
			Separator			
		SE02	Transaction Set Control Number	\<Identifying Control Number>	4/9	Unique control number and must be identical in ST02 and SE02.
			Segment End	~	1	
	TRAILER	GE	Functional Group Trailer			
			Element Separator	*	1	
		GE01	Number of Transaction	\<Number>	1/16	Value is the number of Transaction sets included.
			Element Separator	*	1	
		GE02	Group Control Number	\<Sender Assigned Number>	1/9	Value must be identical to value in GS06.
			Segment End	~	1	
	TRAILER	IEA	Interchange Control Trailer			
			Element Separator	*	1	
		IEA01	Number of Functional Groups	\<Number>	1/5	Value is number of Functional Groups included.
			Element Separator	*	1	
		IEA02	Interchange Control Number	\<Sender Assigned Number>	9/9	Value must be identical to value in ISA13.
			Segment End	~	1	

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Appendices

Appendix A – Implementation Checklist

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

- Providers must register to become a Trading Partner (TP) and be assigned a TP Submitter number.
- 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 for testing 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 be approved to submit production transactions. The test claims should be representative of the type of service you will be providing.
- Confirm all NPIs used in testing are valid for Louisiana Medicaid and if zip-code or taxonomy are needed as tiebreakers.
- Review all reports produced by the Gainwell EDI test system.
- Once TP receives email approval from the EDI Department, may begin submitting claim files to Production environment.

Appendix B – Business Scenarios and Claim/Encounter Example

This section describes a few special billing scenarios and transaction examples that follow. The first scenario is for Adult Day Health Care claims which were previously billed on the 837I transaction and switched to the 837P transaction effective with date of service April 1, 2016 and forward. The claim example points out both the CLM and LX segment details in Appendix 11.3, Example 1.

The second scenario describes the electronic billing to Medicaid for medical services of recipients dually eligible for both Medicare and Medicaid. In situations where Medicare has **denied** a service which may be covered by Medicaid, the claim may be billed directly to Medicaid. This type claim will be submitted as a Medicaid claim and not a Medicare crossover. In the past these type claims were mandated to be billed hardcopy with the Medicare EOBs attached. The correct placement of the 837P Segments related to Medicare third party information is shown in the scenario 2 example. The Louisiana Department of Health has identified the unique Louisiana Carrier code for NM109 in the 2330B Loop when reporting the Medicare information as MOL001.

The third scenario describes electronic billing for **Medicare Advantage** Part B claims with and without a second third party carrier.

The fourth scenario describes specific information needed for submitting Subrogation encounters. Only Managed Care Trading Partners are permitted to bill Subrogation type encounters.

When a Managed Care Entity (MCE) Member Linkage is retroactively removed and the Member retains Louisiana Medicaid eligibility for the same period, the MCE the Member was linked to may have paid claims for the Member during that period. Retroactive disenrollment may be performed by the Enrollment Broker due to retroactive Medicare coverage changes, the Member opting out of Medical MCE coverage,

retroactive linkage of the Member to a Long-Term Care facility or the Program for the All-Inclusive Care for the Elderly (PACE) program.

Any claims already billed to and paid by the MCE during this period would then be excused from the MCEs scope of responsibility. The MCE would be entitled to void any such claims and request the billing provider resubmit their claims to Gainwell for Fee For Service (FFS) Medicaid adjudication and payment.

Subrogation outlines the means by which MCEs may submit electronic transactions as a remedy to the covering plan, and to mitigate provider abrasion created by having the biller's previous payment recovered and requesting them to rebill elsewhere. Medicaid Subrogation is a process recognized by CMS and ANSI allowing reimbursement between Payers. Subrogation will allow an MCE previously identified as the payer of last resort for a Member to request reimbursement directly from Gainwell on the basis of encounters previously reported for any such claims paid to the billed provider. This solution provides for direct payment to the MCE without placing any burden of action on the original billing provider.

Do not Void the original encounter that is being subrogated. Subrogation requires an original Approved encounter be on file.

Rejected or Voided encounters may not be subrogated at this time.

a. Scenario 1 – Example (837P Claim 005010X222A1)

ADULT DAY HEALTH CARE CLAIM EXAMPLE

HL*2*1*22*0~ SBR*P*18*******MC~.
NM1*IL*1*DEAN*JAMES****MI*123456780123~
N3*2000 ROCKETRD APT 1~
N4*ANYWHERE*LA*711110000~
DMG*D8*19420731*M~
NM1*PR*2*LA-DHH-MEDICAID*****PI*LA-DHH-MEDICAID~
N3*POBOX 91021~
N4*BATON ROUGE*LA*708210000~
CLM*1234567*187.2***99:B:1*Y*A**Y~
DTP*435*D8*20120802~
REF*G1*100000009~
REF*EA*12345678~
HI*ABK:Z7689~ *(ICD-10 code for claims with date of service on or after 04/1/2016)*
LX*1~
SV1*HC :S5100*3 1. 2*UN *12***1~ *(Quantity of 12 = twelve 15-minute units for total of 3 hours)*
                                 One unit equals one 15-minute period
DTP*472*RD8*20160404-20160404~
REF*G1*100000009~
LX*2~
SV1*HC:S5100*62.4*UN*24***1~
DTP*472*RD8*20160405-20160105~
REF*G1*100000009~
LX*3~
SV1*HC:S5100*31.2*UN*12***1~
DTP*472*RD8*20160406-20160106~
REF*G1*100000009~
LX*4~ SV1*HC:S5100*31.2*UN*12***1~
DTP*472*RD8*20160407-20160107~
REF*G1*100000009~
LX*5~
SV1*HC:S5100*31.2*UN*12***1~
DTP*472*RD8*20160408-20160108~
REF*G1*100000009~

Note: ADHC cannot exceed10 hours (40 units) each day and 50 hours (200 units) per week.

b. Scenario 2 – Example (837P Claim 005010X222A1)

CLAIM FOR DUAL MEDICAID/MEDICARE ELIGIBLE WHEN **DENIED** BY MEDICARE

The following professional claim example is presented as a tool to assist with proper build of electronic 837P for a Dual eligible recipient with Medicare denial information. This example does not represent a complete claim; it gives emphasis to the information needed for identifying the Medicare denial reason(s).

NM1*IL*1*SMITH*JOY****MI*2223344445555~
N3*111 MAIN STREET~
N4*BATON ROUGE*LA*70809
DMG*D8*19300101*F~
NM1*PR*2 *LOUISIANA MEDICAID*****PI*LA-DHH-MEDICAID~
N3*4456 SOUTH SHORE BLVD~
N4*BATON ROUGE*LA*444440056~
CLM*26407777*151.5***81:B:1**Y*A*Y*Y~
REF*X4*11D1234567
REF*EA*A0023456~
HI*ABK:Z0000~
HI*ABF*Z202~
NM1*DN*1*KILDAIRE*ROSALYN****XX*1234567890~
LOOP 2320
SBR*P*18**MEDICARE PART B*****MB~
AMT*D*0~
OI***Y*P**Y~

LOOP 2330B
NM1*PR*2*Medicare Part B*****PI*MOL001~ <u>Must</u> use this Carrier Code
N3*POBOX 14079~
N4*Baton Rouge*LA*70808~
DTP*573*D8*20160327~

Loop 2400
LX*1~
SV1*HC:84443**110*UN*1~
DTP*472*D8*20160312~

LOOP 2430
SVD*MOL001*0*HC:84443**1~
CAS*PR*96*110~ (Non-covered charge(s))
DTP*573*D8*20160327~
AMT*EAF*110~

LOOP 2400
LX*2~
SV1*HC:85025**41.5*UN*1~
DTP*472*D8*20160312~

LOOP 2430
SVD*MOL001*0*HC:85025**1~
CAS*PR*96*41.5~ (Non-covered charge(s))
DTP*573*D8*20160327~
AMT*EAF*41.5~

c. Scenario 3 – Scenario 3 Example (837P Claim 005010X222A1)

CLAIM FOR MEDICAID RECIPIENT COVERED BY **MEDICARE ADVANTAGE** PLAN
The following professional claim example is presented as a tool to assist with proper build of electronic
837P for an eligible recipient enrolled with a **Medicare Advantage** Plan. This example does not represent
a complete claim; it gives emphasis to the information needed for identifying the Medicare Advantage
Plan coverage and CAS segments. Example of a one-line claim from Medicare Advantage Plan for Part
B, no other third party involved.

Incoming file must use File Extension of .XXB

```
SBR*S*18**MEDICAID OF LA*****MC~
NM1*IL*1*SHELL*ANGEL****MI*3604448899901~
N3*12111 SERVICE ROAD~
N4*NEW BRUNSWICK*LA*70000~
DMG*D8*19840622*F~
NM1*PR*2*MEDICAID OF LA*****PI*LA-DHH-MEDICAID ~
N3*PO BOX 91020~
N4*BATON ROUGE*LA*708219020~
CLM*888888888*333**23:B:1*Y*A*Y*Y*B~
REF*EA*2222222~
HI*ABK:78900*ABF:53550~
NM1*82*1*DOE*JOHN*A***XX*1555555555~
NM1*77*2*ANY TOWN HOSPITAL*****XX*1888888888~
N3*1111 JEFFERSON HWY~
N4*NEW BRUNSWICK*LA*700002222~
```

LOOP 2320
SBR*P*18*******MB~ *Must use the qualifier of MB for claim from Medicare Advantage Part B*
```
AMT*D*137.06~
OI***Y*S**Y~
NM1*IL*1*SHELL*ANGEL****MI*12224445~
N3*12111 SERVICE ROAD~
N4*NEW BRUNSWICK*LA*70000~
```

LOOP 2330B
NM1*PR*2*WELLCARE MEDICARE HMO*****PI*H19030~ *Must use the Medicare Advantage*
Louisiana Carrier Code
```
LX*1~
SV1*HC:99285*333*UN*1***1:2~
DTP*472*RD8*20151010-20151010~
REF*6R*111222333~
```

LOOP 2430
SVD*H19030*137.06*HC:99285**1~ *Info for same Carrier in NM109*
CAS*CO*45*158.18~
CAS*PR*3*37.76~ *Send **all** CAS segments received from the Med Adv Carrier*
DTP*573*D8*20151031~

Example of a Multi-line claim from Medicare Advantage Part B. There is no other third-party coverage involved. Claim example abbreviated to show relevant elements.

```
SBR*S*18**MEDICAID OF LA*****MC~
NM1*IL*1*MOON*JUDY*C***MI*1234567894601~
N3*70008*BOXER AVE~
N4*NEW ORLEANS*LA*70115~
DMG*D8*19501031*F~

NM1*PR*2*MEDICAID OF LA*****PI*00170~
N3*PO BOX 91020~
N4*BATON ROUGE*LA*708219020~
CLM*888888888*53***23::1*Y*A*Y*Y*B~
REF*EA*123456~
HI*BK:7295~
NM1*DN*1*DENNIS*JACK****XX*1111111111~
NM1*82*1*FRIENDLY*GARY*B***XX*2222222222~
NM1*77*2*BAPTIST HOSPITAL*****XX*3333333333~
N3*2700 NAPOLEON AVE~
N4*NEW ORLEANS*LA*701156969~
```

LOOP 2320
```
SBR*P*18*******MB~
```
Must use the qualifier of MB identifying Medicare Advantage Part B
```
AMT*D*21.73~
DMG*D8*19000101*U~
OI***Y*S**Y~
NM1*IL*1*MOON*JUDY*C***MI*45454545~
N3*7008 BOXER AVE~
N4*NEW ORLEANS*LA*70115~

NM1*PR*2*WELLCARE MEDICARE HMO*****PI*H19030~
```
Must use the Medicare Advantage Louisiana Carrier Code
```
LX*1~
SV1*HC:73610:26*17*UN*1***1~
DTP*472*RD8*20141017-20141017~
REF*6R*148537261~
AMT*T*1605400001002~
SVD*H19030*7.03*HC:73610:26**1~
CAS*CO*223*.14**45*8.04~
CAS*PR*2*1.79~
DTP*573*D8*20141106~
LX*2~
SV1*HC:73560:26*19*UN*1***1~
DTP*472*RD8*20141017-20141017~
REF*6R*148537262~
AMT*T*1605400001002~
SVD*H19030*7.67*HC:73560:26**1~
CAS*CO*223*.16**45*9.21~
CAS*PR*2*1.96~
DTP*573*D8*20141106~
LX*3~
SV1*HC:73590:26*17*UN*1***1~
DTP*472*RD8*20141017-20141017~
REF*6R*148537263~
AMT*T*1605400001002~
SVD*H19030*7.03*HC:73590:26**1~
CAS*CO*223*.14**45*8.04~
CAS*PR*2*1.79~
DTP*573*D8*20141106~
```

Example of a one-line claim from Medicare Advantage Plan for Part B with <u>other third party coverage</u> involved. Claim example abbreviated to show relevant elements.

```
SBR*S*18**MEDICAID OF LA*****MC~
NM1*IL*1*SHELL*ANGEL****MI*3604448899901~
N3*12111 SERVICE ROAD~
N4*NEW BRUNSWICK*LA*70000~
DMG*D8*19840622*F~
NM1*PR*2*MEDICAID OF LA****PI*LA-DHH-MEDICAID ~
N3*PO BOX 91020~
N4*BATON ROUGE*LA*708219020~
CLM*888888888*333**23:B:1*Y*A*Y*Y*B~
REF*EA*2222222~
HI*ABK:78900*ABF:53550~
NM1*82*1*DOE*JOHN*A***XX*1555555555~

NM1*77*2*ANY TOWN HOSPITAL*****XX*1888888888~
N3*1111 JEFFERSON HWY~
N4*NEW BRUNSWICK*LA*700002222~
```

LOOP 2320
SBR*P*18*******<mark>MB</mark>~ *Must use the qualifier of MB identifying Medicare Advantage Part B*
AMT*D*137.06~
OI***Y*S**Y~
NM1*IL*1*SHELL*ANGEL****MI*122244455~
SBR*P*18*******<mark>CI</mark>~ *Must use the qualifier of CI identifying OTHER payer*
AMT*D*100~
OI***Y*S**Y~
NM1*IL*1*SHELL*ANGEL****MI*111222111~

LOOP 2330B
NM1*PR*2*WELLCARE MEDICARE ADVANTAGE*****PI*<mark>H19030</mark>~ *Must use the Medicare Advantage Louisiana Carrier code*
NM1*PR*2*ALLCOVERAGE*****PI*<mark>270711</mark>~*Must use appropriate Louisiana Carrier Code for OTHER third-party payer*

LOOP 2400
LX*1~
SV1*HC:99285*333*UN*1***1:2~
DTP*472*RD8*20151010-20151010~
REF*6R*111222333~

LOOP 2430
SVD*<mark>H19030</mark>*137.06*HC:99285**1~ *Info for same Medicare Advantage Carrier in NM109*
CAS*CO*45*158.18~
CAS*PR*3*37.76~ *Send all CAS segments received from the Medicare Advantage Carrier*
DTP*573*D8*20151031~

SVD*<mark>270711</mark>*100*HC:99285**1~ *Info for same Other Carrier in NM109*
CAS*CO*45*183~
CAS*PR*1*50~ *Send **all** CAS segments received from the Other third-party Carrier*
DTP*573*20150901

d. Scenario 4 – ENCOUNTERS FOR SUBROGATION

The following encounter example is presented as a tool to assist with properly building an 837P for Subrogation. This example does not represent a complete encounter; it gives emphasis to the information needed for identifying the claims as Subrogation.

This scenario applies only to Managed Care Trading Partners. Only Managed Care Trading Partners are permitted to bill using Transaction Code 31.

BHT – Beginning of Hierarchical Transaction

BHT*0019*00*02754534990001*20231110*130010*31~ **Must use Transaction Code 31**

LOOP 2010AC
NM1*PE*2*MCE ORGANIZATION NAME*****PI*9999999999~ **Must include LOOP 2010AC**
N3*999 STREET ADDRESS~   This is the Primary Payer Information
N4*CITY*LA*999999999~
REF*EI*999999999~

LOOP 2300   In Loop ID-2300 data element CLM01, enter the Gainwell
CLM*4275127042400*500***11:B:7*Y*   assigned ICN number rather than the Provider's Patient Control
A*Y*|*P~   Number.

                                                  In element CLM05-3 use Claim Frequency Type Code 7: Debit or
                                                  Replacement adjustment.

LOOP 2320   In Loop ID-2320 include all the required segments/elements that
SBR*T*18*****MC~   indicate Gainwell's adjudication of the original encounter.
...
AMT*D*411~   AMT02 represents the amount Gainwell reported paid.

LOOP 2330B   In Loop ID-2330B, enter Gainwell's information
NM1*PR*2*LOUISIANA MEDICAID*****PI* LA-DHH-MEDICAID~
N4*BATON ROUGE*LA*70809
DTP*573*D8*20150527~

Appendix C - Change Summary

This appendix will contain a summary of any changes made to this version of the 837P Health Care Claim Companion Guide after the initial release.

Ver.	Date	Author	Action/Summary of Changes	Loop/Segment
1.0	08/01/2017	Molina	Initial Document in CAQH/CORE Master Companion Guide required standard format.	
1.1	01/01/2018	Molina	Added information regarding billing Medicare Advantage Part B claims electronically.	SBR Appendix B
1.2	04/37/2018	DXC	Additional information on Medicare Advantage billing	SBR; NM109
1.3	11/15/2108	DXC	LIFT 11467: Rebranded Molina ☐ DXC	
1.4	2/23/2024	Gainwell	Rebranded DXC → Gainwell. Updated 2.1, 4.1, 4.2, 4.3, 4.4, 5.1, 5.2, 5.3, 5.4, 6.1, 8, 9, 10, Appendix A. Appendix B	
1.5	10/09/2024	Gainwell	Revised the Preface to provide a link to the 5010 EDI General Companion Guide. Added link to the 5010 EDI General Companion Guide to 1.1. Corrected the first paragraph of Appendix B for usage issues. Scenario 4 of Appendix B was added (subrogation). Re-designed document for paging issues. Corrected email addresses and links as needed. Appendix D removed. Appendix E renamed to Appendix D and sample forms converted to links.	n/a n/a n/a n/a n/a n/a n/a
1.6	1/14/2025	Gainwell	Revised Appendix B Scenario 3.	n/a

1.7	02/20/2025	Gainwell	In Section 7, changed **20,000 CLM segments** to **5,000 CLM segments**	n/a

Appendix D - Trading Partner Agreements (TPA)

This appendix contains links to the forms required for electronic billing or election to receive an electronic remittance (835) for Louisiana Medicaid providers.

There are separate forms for an individual enrollment and an entity/business enrollment. Links to the forms are provided below.

EDI Contract and Power of Attorney for Individual:

https://www.lamedicaid.com/Provweb1/Provider_Enrollment/EDI%20Individuals.pdf

EDI Contract and Power of Attorney for Entity/Business:

https://www.lamedicaid.com/Provweb1/Provider_Enrollment/EDI%20Entities-Businesses.pdf

Completed forms are to be sent to Gainwell Provider Enrollment Unit, PO Box 80159, Baton Rouge, LA 70898- 0159.