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

837 Institutional

Claims Submission

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REVISION HISTORY

Date	Rev #	Author	Description
06/11/2010	1.0 Review	EDI-IT	State Review
02/25/2011	1.01 Update	EDI-IT	Updated Verbiage for errata dates
02/25/2011	1.01 Update	EDI-IT	Updated the Clearinghouse verbiage
02/25/2011	1.01 Update	EDI-IT	Updated the File Size Requirements
06/14/2011	1.02 Update	EDI-IT	Updated the Verbiage for COB - MOOP
06/20/2011	1.02 Update	EDI-IT	Updated the Verbiage to add the all the "Plans" and added a page that has all the Plans names on it.
07/05/2011	1.03 Update	EDI-IT	Updated Guide for State requirements
12/19/2011	2.0 Review / Update	EDI-Ops	Updated Guide with Business Requirements
12/27/2011	2.01 Update	EDI-IT	Reviewed the KY Requirements and small revisions

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INTRODUCTION

The WellCare Group of Companies ("the Plan") uses the standard format for Claims Data reporting from Providers and Trading Partners (TPs). WellCare X12N 837 Institutional Claim Companion Guide is intended for use by the Plan's Providers and TPs in conjunction with HIPAA ANSI ASC X12N Technical Report Type 3 Electronic Transaction Standard (Version – TR3) and its related errata X223A2 Implementation Guide.

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

- UAT 5010 X223A2 Start Date – 9/1/2011 for inbound FFS claims
- Production 5010 X223A2 Start Date – 01/01/2012 for inbound FFS claims
- Production 5010 X223A2 Mandate Date – 4/1/2012 for inbound FFS claims

The Plan's Companion Guides are provided to assist those Providers and Vendors implementing the X12 837I Healthcare Claim Institutional transactions. The Plan's Companion Guides do not contradict, disagree, oppose, or otherwise modify the HIPAA Technical Report Type 3 (TR3) in a manner that will make its implementation by users to be out of compliance.

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

The 837 Institutional Healthcare Claim TR3 Implementation Guides (IG)

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

This Companion Guide contains data clarifications derived from specific business rules that apply exclusively to claims processing for the Plan. Field requirements are located in the ASC X12N 837I (005010X223A2) TR3 Implementation Guide.

Submitters are advised that updates will be made to the Companion Guides on a continual basis to include new revisions, and will be made available on the Plans. Submitters are encouraged to check our websites periodically for updates to the Companion Guides.

States Affiliations

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

Connecticut
Florida
Georgia
Hawaii
Illinois
Indiana
Kentucky
Louisiana
Missouri
New York
New Jersey
Ohio
Texas

Front-End WEDI SNIP Validation

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

WEDI SNIP Level 1: EDI Syntax Integrity Validation

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

  Examples of these errors include but not limited to:
  - Invalid date or time
  - Invalid telephone number
  - The data element is too long (i.e. the claim form field expects a numerical figure 9 characters long but reads 10 or more characters)
  - Field 'Name' is required on the Reject Response Transaction (i.e. Field 'ID' is missing. It is required when Reject Response is "R")
  - The sign is not allowed as a value (i.e. date of service is expected to a numerical only format of MM/DD/CCYY and is entered improperly)

WEDI SNIP Level 2: HIPAA Syntactical Requirement Validation

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

  Examples of these errors include but are not limited to:
  - Social Security Number is not valid.
  - Procedure Date is required when ICD-9-CM Code is reported.
  - Claim number limit per transaction has been exceeded.
  - 'Name' is required when ID is not sent.
  - Revenue Code should not be used when it is already used as a Procedure Code.
  - NPI number is invalid for 'Name'.
  - State code is required for an auto accident.
  - Employer Identification Number (EIN) is invalid.
  - Missing/invalid Patient information. Member identification missing or invalid. Patients city, state, or zip is missing or invalid.
  - Invalid character or data element. The data element size is invalid or has invalid character limits.
  - Missing NPI. WellCare requires NPI numbers on claims as of May 23rd, 2008 in accordance with HIPAA guidelines. A NPI must be a valid 10-digit number.
  - Legacy ID still on claim. Legacy numbers include Provider IDs, Medicaid and Medicare IDs, UPIN and State License numbers. All legacy numbers need to be removed from claims

WEDI SNIP Level 3: Balancing Validation

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

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

WEDI SNIP Level 4: Situational Requirements

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

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

WEDI SNIP Level 5: External Code Set Validation

- This level only validates the code sets but also make sure the usage is appropriate for any particular transaction and appropriate with the coding guidelines that apply to the specific code set.

  Examples of these errors include but not limited to:
  - Validates CPT code
  - ICD-9
  - Zip code
  - National Drug Code (NDC)
  - Taxonomy Code validation
  - State code
  - Point of Origin for Admission or Status codes Box 15 (UB-04)
  - Adjustment Reason Codes and their appropriate use within the transaction

WEDI SNIP Level 7: Custom Health Plan Edits

- This level is intended for specific Business Requirements by the Health Plan that is not covered within the WEDI SNIP and the Implementation Guide.

Paper Claim Submission:

- All paper claims are subjected to WEDI SNIP Validation, as stated above. The Plan requires a "Clean Claim" submission for all paper claims. This means that the claims must be in the nationally accepted HIPAA paper format along with the standard coding guidelines with no further information, adjustments, or alteration in order to be processed and paid by the Health Plan.
    - Paper claims must be submitted on the original "red claims" Approved OMB-0938-0999) Form CMS-1500 (08-05) OR UB-04 claim forms with "drop out" red ink. These forms are available for purchased on the CMS website.
    - In addition to CMS, mandating the use of Red Claims, the Health Plan requires certain standards, since all Paper claims are read through Optical Character Recognition (OCR) software. This technology allows the Health Plan to process claims for higher accuracy and speed.
        - All forms should be printed or typed in **large**, capitalized black font.
        - The font theme should be Arial with a font type of 10, 11, or 12 .
    - The Health Plan will not accept the following:
        - Hand-written claims
        - Faxed or altered claim forms
        - Black and white copied forms
        - Out-dated CMS claim forms

Electronic Submission

The Plan can only process one (1) ISA GS and IEA GE Segments per File sent. The Plan can process Multiple ST & SE Transactions of the Same Transaction Type with in the ISA GS and IEA GE Segments

Institutional Fee-for-Service (FFS) claims submitted using the TS3 format must be in a separate file from all Encounter reporting.

When sending Institutional FFS Claims, the Plan expects the BHT06 to be:

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

File Size Requirements

The following list outlines the file sizes by transaction type:

Transaction Type	Testing Purposes	Production Purposes
837 formats – FFS claims	50-100 claims	< 5000 claims per ST/SE. 10 ST/SE per file.

Submission Frequency

We process files twenty-four (24) hours a day, seven (7) days per week, three-hundred sixty-five (365) days per year.

Fee-for-Service (FFS) Clearinghouse Submitters

All FFS Providers and Vendors must send their claims through a Clearinghouse. See the Plan's state-specific Quick Reference Guides (QRG) for contact information for the Plan's preferred clearinghouse and the Plan's Payer ID number.

Most clearinghouses can exchange data with one another, and generally have a trading partner agreement with each other. Please contact your clearinghouse for the Plan Payer ID to use for Claim Routing and any other pertinent ID's.

Encounter File Upload for Direct Submitters

The Plan has a Secured FTP (SFTP) site for Encounter EDI files submission. All production files should be submitted to the SFTP site at https://edi.wellcare.com/human.aspx. Please refer to the Encounter Reference Guide for complete details on files and validation requirements.

THE PLAN SPECIFIC INFORMATION

Highlighted Business Rules

Patient (Dependent):

The Plan will reject and will not pay any FFS claims which indicate that the Patient is the Dependent. These Loops consist of the following:

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

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

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

Provider:

- The Billing Provider Name in Loop 2010AA must be a Billing agent, the Provider or Vendor that will receive the Payment in the 835 transaction for FFS Claims.

- The Taxonomy Code within the Billing Provider Hierarchical Level (2000A) Loop (PRV) Segment is required for all FFS claim submissions. The Taxonomy reported on the claim must match the Billing Provider's specialty, which is maintained by the National Uniform Claim Committee (NUCC).

- The Attending Provider who has overall responsibility for the patient's medical care and treatment reported in this claim must be identified for all Inpatient claim submissions. When using the Attending Provider Loop (2310A), the Plan requires that the Taxonomy Code to be populated in the PRV Segment. The Taxonomy code must match the Attending Provider's specialty, which is maintained by the National Uniform Claim Committee (NUCC).

- The Plan requires the Name and Physical Address where Services were rendered in Service Facility Location Name in Loop 2310E. This Loop must Not Contain a PO Box in the Address (N3) Segment.

Patient Control Number:

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

Subscriber Gender:

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

Prior Authorizations and/or Referral Numbers:

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

Valid National Provider Identifiers (NPI)

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

Corrected Claim Submission - Replacement (Adjustment) Claim or Void/Cancel Claim

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

Also, Per the Implementation Guide – when "7" or "8" is utilized as Claim Frequency Type Code for Replacement or Void/Cancel of Prior Claim Submission, the Claim Level information in Loop 2300 and segment REF with a F8 qualifier must contain the Plan's Claim Control Number or The Plan's Van Trace (formally known as the Original Reference Number).

Coordination of Benefits (COB) and Adjudication Information – Maximum Out-of-Pocket (MOOP)

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

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

The required Loops and Segments that are needed to be sent for a Compliant COB are as follows:

- Other Subscriber Information (2320) Loop
- Other Subscriber Name (2330A) Loop
- Line Adjudication Information (2430) Loop
    - For Out of Pocket amounts, utilize Loop ID 2430 220 Position 300 Data Element 782 for Patient Responsibility
    - This includes Co-Insurance, Co-Pays and Deductibles – Please refer to Code Set 139: for the correct Claim Adjustment Reason Code

National Drug Code (NDC) – Medicaid Claim Submission Only

Per the 837 Institutional (TR3) Implementation Guide, all Submitters are required to supply the National Drug Code (NDC) for all HCPCS J-codes submitted on the claim. The NDC must be reported in Loop 2410 Segment LIN03. Also, per the Implementation Guide, the Drug

Quantity and Price also must be reported within the CTP segment. The Plan utilizes the First Data Bank (FDB) and CMS to validate the NDC codes for the source of truth.

SECURE FILE TRANSFER PROTOCOL PROCESS for Production, Encounters, and Test files

SFTP

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

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

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

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

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

- WS_FTP PRO® (The commercial version supports automation and scripting)
  - WS_FTP PRO® has instructions on how to connect to a WS_FTPServer using SSL.
- Core FTP Lite® (The free version supports manual transfers)
  - Core FTP Lite® has instructions on how to connect to a WS_FTPServer. Additionally, the Plan can provide setup assistance.

REPORTING STATES NOTES

Georgia (Medicaid):

Any interest paid for the claim should be reported in a 2330 (Other Subscriber Information) Loop CAS (Claim Level Adjustment) segment with appropriate CAS codes. **NOTE:** do not report interest paid as a separate line item on the Claim / Encounter.

Illinois (Medicaid):

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

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

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

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

- **Valid Values:**
- "80" = Covered Days
- "81" = Non Covered Days

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

DESIGNATOR DESCRIPTION

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

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

S – Situational - If a Segment or Field is marked as "Situational", it is only sent if the data condition stated applies.

FURTHER CLAIM FIELD DESCRIPTION

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

Interchange Control Header:						
Pos	**Id**	**Segment Name**	**Req**	**Max Use**	**Repeat**	**Notes**
	ISA06	Interchange Sender ID	M	1		For Direct submitters Unique ID assigned by The Plan. Example: 123456 followed by spaces to complete the15-digit element For Clearinghouse submitters please use ID as per the clearinghouse
	ISA08	Interchange Receiver ID	M	1		For Direct submitters Use "**WELLCARE**" **Note:** Please make sure the Receiver ID is **left justified** with **trailing spaces** for a total of 15 characters. Do not use leading ZEROS. For Clearinghouse submitters please use ID as per the clearinghouse.
Functional Group Header:						
	GS02	Senders Code	M	1		For Direct submitters Use your existing Plan Submitter ID **or** the trading partner ID provided during the enrollment process. For Clearinghouse submitters please use ID as per the clearinghouse
	GS03	Receivers Code	M	1		For Direct submitters Use WC ID "**WELLCARE**"

						For Clearinghouse submitters please use ID as per the clearinghouse

Header:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
0100	**BHT06**	Claim/Encounter Identifier	R	1		Use value the value of "**CH**" – Chargeable (FFS) or "**RP**" – Reporting (Encounters) Claims. The Plan will Reject any Claims that have "**31**' – Subrogation Demand.
LOOP ID - 1000A – Submitter Name					**1**	
020	**NM109**	Submitter Identifier	R			For Direct Submitters Submitter's "**ETIN**" i.e., Use the Plan Submitter ID or6-digit trading partner ID assigned during the EDI enrollment process. For Clearinghouse submitters please use ID as per the clearinghouse
LOOP ID - 1000B – Receiver Name					**1**	
02000	**NM103**	Receiver Name	R	1		For Direct Submitters Use value "**WELLCARE HEALTH PLANS, INC**" (i.e., WellCare Health Plans of Georgia WellCare Health Plans of New York) For Clearinghouse submitters please use ID as per the clearinghouse
0200	**NM109**	Receiver Primary ID	R	1		For Direct Use the value of Payer IID For Clearinghouse submitters please use ID as per the clearinghouse

Detail:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes
LOOP ID - 2000A – Billing/Pay-To Provider Hierarchical Level					**>1**	
0030	**PRV03**	Billing/Pay-To Provider Specialty Information	S	1		Billing Provider Taxonomy Code must be Sent.
LOOP ID - 2010AA – Billing Provider Name					**1**	
0150	**NM108**	Billing Provider Primary Type	R	1		**All States:** All non-Atypical Submitters must have value of "**XX**". All Atypical Submitters must Not use this Element
0150	**NM109**	Billing Provider ID	R	1		**All States:** All non-Atypical Submitters must have NPI. All Atypical Submitters must Not use this Element
0350	**REF01**	Billing Provider Tax Identification	R	1		**All States:** All Atypical and Non Atypical Submitters are required to use the value of "**EI**".
0350	**REF02**	Billing Provider Tax Identification	R	1		**All States:** All Submitters are required to send in their "**TAX ID**".
0350	**REF01**	Billing Provider UPIN/License Information	R	2		**All States:** Only Atypical Submitters may use this REF segment.
0350	**REF02**	Billing Provider UPIN/License Information	R	2		**All States:** Only Atypical Submitters may use this REF segment.
LOOP ID - 2010AB – Pay to Provider's Name					**1**	
015	**NM108**	Provider Primary Type	S-R	1		Must have the value of "**XX**"
015	**NM109**	Pay to Provider's Identifier	R	1		Must have NPI.
035	**REF01**	Reference Identification Qualifier	S-R	8		**All States** All submitters are required to use the Use the value of "**EI**".
035	**REF02**	Billing Provider Additional Identifier	R	8		**All States:** All submitters are required to send in their "TAX ID".
LOOP ID - 2000B – Subscriber Hierarchical Level					**>1**	
005	**SBR01**	Payer Responsibility Sequence Number Code	R	1		Use the value of "**P**" if the Plan is the primary payer.
005	**SBR09**	Claim Filing Indicator Code		1		Value equal to Medicaid or

						Medicare filing.
LOOP ID - 2010BA – Subscriber Name					**1**	
0150	**NM108**	Subscriber Primary Identification code Qualifier	S-R			Use the value "**MI**".
0150	**NM109**	Subscriber Primary Identifier				Subscriber Medicaid/Medicare ID, he Plan ID
0320	**DMG03**	Subscriber Demographic Information	S-R	1		**All States:** All Submitters must send in "F" – Female or "M" – Male only.
LOOP ID - 2010BB – Payer Name					**1**	
0150	**NM108**	Identification code Qualifier				Use value "**PI**".
0150	**NM109**	Identification code				Use value Payer ID
LOOP ID – 2300 – Claim Information					**1**	
1300	**CLM5-3**	Claim Frequency Type Code	R	1		**All States:** Use "**1**" on original Claim /Encounter submissions Use "**7**" for Claim/Encounter Replacement (Adjustment) Use "**8**" for Claim/Encounter void. For both "**7**" and "**8**", include the original **the Plan Claim Number (WCN)**, as indicated in Loop 2300 **REF02 (Original Reference Number**).
1800	**REF02**	Prior Authorization Number	S-R	1		**All States**: This is now a single segment for just the Prior Authorization Number. All Submitters are required to send this segment when the Plan has assigned a Prior Authorization Number.
1800	**REF02**	Referral Number	S-R	1		**All States**: This is now a single segment for just the Referral Number. All Submitters are required to send this segment when The Plan has assigned a Referral Number.
1800	**REF02**	Service Authorization Exception Code	S-R	1		**Sate Note:** **NY -** Service Authorization Exception Codes "1" – "6" are to be used in accordance with Medicaid Policy. Code "7" (Special Handling) is expected when the claim is intended to be processed using a UT exempt NYS DOH specialty code**.**
1900	**NTE02**	Claim Note - Note	R	1	10	**State Note:** **MO -** See Reporting States Notes for Home Health Care.

2310	**HI01-1**	Condition Identification Code Qualifier	S-R	1	24	**Sate Note:** **OH** – See below if needed.
2310	**HI01-2**	Condition Identification Value Code	R	1	24	**Sate Note:** **OH -** For nursing facility room and board claims adjustments, use the Condition Codes (Claim Change Reasons) • **D0** changes to Service Dates • **D1** changes to charges • **D2** changes to revenue codes • **D6** cancel only to repay a duplicate or OIG overpayment • **D7** change to make Medicare the secondary payer • **D8** change to make Medicare the primary payer • **D9** any other change • **E0** change in patient status **NY -** NYS DOH will process applicable and compliant Value Codes, as defined in the NUBC Manual under Code List Qualifier Code "BE": Value Code 22: Used to report patient contributions toward the cost of care, also known as Net Available Monthly Income (NAMI), patient participation amount, or surplus. Value Code 24: NYS DOH Medicaid Rate Code
2310	**HI01-1**	Value Information Identification Code Qualifier	S-R	1	24	**Sate Note:** **GA -**"BE" Newborn Birth Weight Required
2310	**HI01-2**	Value Information Identification Value Code	R	1	24	**Sate Note:** **GA -**"54"+Newborn Wight in Grams Required
2310	**QTY**	Claim Quantity	S	1	4	**Sate Note:** **OH - QTY01**- Quantity Qualifier "CD" and "LA" used in adjudication of Part C claims. For nursing facility room and board claims , use • **QTY01**, Quantity Qualifier 'CA' to report covered days, including covered leave days ;

						• **QTY01**, Quantity Qualifier 'NA' to report non-covered Days, • **QTY01**, Quantity Qualifier 'CD' to report co-insurance
LOOP ID – 2310A – Attending Provider Name					**1**	
2500	**NM108**	Rendering Provider Name	S-R	1		**All States:** All non-Atypical Submitters must have value of "**XX**". All Atypical Submitters must Not use this Element
2500	**NM109**	Rendering Provider ID	R	1		**All States:** All non-Atypical Submitters must have NPI. All Atypical Submitters must Not use this Element
2550	**PRV03**	Rendering Taxonomy Code	S-R	1		**All States:** All Submitters must send the Rending Provider Taxonomy Code. **State Notes:** **CT GA IN LA** Submitters are required to send in the Taxonomy Codes **MO** Submitters are required to send in the Taxonomy Codes if submitter has multiple MO HealthNet Legacy Provider ID's
2710	**REF01**	Rendering Reference Identification Qualifier	S	3		**All States:** Only Atypical Submitters can use this Segment
2710	**REF02**	Rendering Provider Secondary Identification	S	3		**All States:** Only Atypical Submitters can use this Segment
LOOP ID – 2310E Service Facility Location					**1**	
2500	**NM1**	Service Facility Location	S-R	1		**All States:** All Submitters must use this Loop when the Physical Location where the service took place is different than the Address in the Billing Provider Name (2010AA) Loop .
2650	**N301**	Service Facility Location Address	R	1		**All States:** All Submitters must send in Physical Address. The Plan rejects any claims that contain a P.O. Box in this segment.
2710	**REF01**	Rendering Reference Identification Qualifier	S	3		**All States:** Only Atypical Submitters can use this Segment.
2710	**REF02**	Rendering Provider Secondary Identification	S	3		**All States:** Only Atypical Submitters can use this Segment.
LOOP ID – 2320 – Other Subscriber Information					**10**	
2900	**SBR01**	Payer Responsibility Sequence	R	1		**All States:** All Vendor / Provider Submitters

		Number Code				that Adjudicate Claims for the Plan must make themselve's the Primary "**P.**" In the SBR01 Element in the Subscriber Information (2000B) must be sent to the next available Payer Responsibility Number Code.
2950	**CAS02**	Claim Adjustment Reason	S	5		**State Note:** **GA** interest paid on the claim should be reported in a CAS Segment. Please use Code "225" for Interest Payments **NOTE:** Do not report interest Paid as a separate Line item on the Claim / Encounter.
3000	**AMT02**	Coordination of Benefits (COB) Payer Paid Amount	S	1		**All States:** All Vendor / Provider Submitters that Adjudicate Claims for the Plan must send this Segment. This Element must be the Amount paid by The Vendor to the Provider.
LOOP ID – 2330B Other Payer Name			S		**1**	
2250	**NM103**	Name Last or Organization Name	R	1		**All States:** All Vendor / Provider Submitters that Adjudicate Claims for The Plan must send this Segment. The Vendor / Provider Submitters who are Paying the Claim / Encounter must be in this Element.
2250	**NM109**	Identification Code	R	1		**All States:** All Vendor / Provider Submitters that Adjudicate Claims for The Plan must send this Segment. The Vendor / Provider Submitters who are Paying the Claim / Encounter must have ID. This will be used in the Line Adjudication Information (2430) Loop in the SVD01.
2950	**CAS02**	Claim Adjustment Reason	S	5		**State Note:** **GA** interest paid on the claim should be reported in a CAS Segment. Please use Code "225" for Interest Payments **NOTE:** Do not report interest Paid as a separate Line item on the Claim / Encounter.
LOOP ID – 2400 – Service Line					**1**	

2310	**SV201**	Service Line Revenue Code	R	1		**State Note:** **MO** For outpatient and hospice claims, refer to the MO HealthNet Policy manuals for specific requirements. For nursing home claims, select revenue code from one of the following categories: 1. Select revenue code to indicate reserve time periods: • 0180 equals non-covered leave of absence • 0182 equals home leave for patient convenience • 0183 equals home leave for therapeutic leave • 0184 equals hospital leave to an ICF/MR • 0185 equals hospital leave for non-ICF/MR facility • 0189 equals Medicare qualifying stay days 2. Select revenue code to indicate skilled nursing services: • 0190 equals subacute care general classification • 0191 equals subacute care - level I • 0192 equals subacute care - level II • 0193 equals subacute care - level III • 0194 equals subacute care - level IV • 0199 equals subacute care other Indicating any of the above revenue codes does not alter the amount of your per diem payment. Use these codes when you previously would have indicated a skilled nursing indicator of 'Y'. 3. Select revenue code to indicate non-skilled nursing time periods: • 0110 equals room-board/private • 0119 equals other/private • 0120 equals room-board/semi • 0129 equals other/2-bed Indicating any of these does not alter the amount of your per diem payment. Use these codes when you previously would have indicated a skilled nursing indicator of 'N' or blank.
LOOP ID – 2420A – Rendering Provider Name					**1**	
5050	**PRV03**	Taxonomy Code	S-R	1		**State Note:** **MO IL** Submitters are required to send in the Taxonomy Codes

						if submitter has multiple MO HealthNet Legacy Provider ID's
LOOP ID – 2420F – Referring Provider Name					**1**	
255	**PRV03**	Taxonomy Code	S-R	1		**State Note:** **MO IL** Submitters are required to send in the Taxonomy Codes if submitter has multiple MO HealthNet Legacy Provider ID's
LOOP ID – 2430 Line Adjudication Information					**15**	
5400	**SVD01**	Identification Code	S-R	1		**All States:** All Vendor / Provider Submitters that Adjudicate Claims for The Plan must send this Segment. The Vendor / Provider Submitters who are Paying the Claim / Encounter must have ID. This will be the same as in the Other Payer Name (2330B) Identification Code in the NM109.
5400	**SVD02**	Monetary Amount	R	1		**All States:** All Vendor / Provider Submitters that Adjudicate Claims for The Plan must send this Segment This is how much was Paid by the Vendor / Provider after Check Run.

ATTACHMENT A
Glossary

Term	Definition
HIPAA	In 1996, Congress passed into federal law the Health Insurance Portability and Accountability Act (HIPAA) in order to improve the efficiency and effectiveness of the entire health care system. The provisions of HIPAA, which apply to health plans, healthcare providers, and healthcare clearinghouses, cover many areas of concern including, preventing fraud and abuse, preventing pre-existing condition exclusions in health care coverage, protecting patients' rights through privacy and security guidelines and mandating the use of a national standard for EDI transactions and code sets.
SSL **(Secure Sockets Layer)**	SSL is a commonly used protocol for managing the security of a message transmission through the Internet. SSL uses a program layer located between the HTTP and TCP layers. The "sockets" part of the term refers to the sockets method of passing data back and forth between a client and a server program in a network or between program layers in the same computer. SSL uses the public-and-private key encryption system from RSA, which also includes the use of a digital certificate.
Secure FTP (SFTP)	Secure FTP, as the name suggests, involves a number of optional security enhancements such as encrypting the payload or including

Term	Definition
	message digests to validate the integrity of the transported files to name two examples. Secure FTP uses Port 21 and other Ports, including SSL.
AUTH SSL	AUTH SSL is the explicit means of implementing secure communications as defined in RFC 2228. AUTH SSL provides a secure means of transmitting files when used in conjunction with an FTP server and client that both support AUTH SSL.
Required Segment	A required segment is a segment mandated by HIPAA as mandatory for exchange between trading partners.
Situational Segment	A situational segment is a segment mandated by HIPAA as optional for exchange between trading partners.
Required Data Element	A mandatory data element is one that must be transmitted between trading partners with valid data.
Situational Data Element	A situational data element may be transmitted if data is available. If another data element in the same segment exists and follows the current element the character used for missing data should be entered.
N/U (Not Used)	An N/U (Not Used) data element included in the shaded areas if the Implementation Guide is NOT USED according to the standard and no attempt should be made to include these in transmissions.
ATTENDING PROVIDER	The primary individual provider who attended to the client/member during an in-patient hospital stay. Must be identified in 837I, Loop 2310A, REF02 Segment, by their assigned Medicaid/Medicare ID number assigned by State to the individual provider while the client was in-patient.
BILLING PROVIDER	The Billing Provider entity may be a health care provider, a billing service, or some other representative of the provider.
IMPLEMENTATION GUIDE (IG)	Instructions for developing the standard ANSI ASC X12N Health Care Claim 837 transaction sets. The Implementation Guides are available from the Washington Publishing Company.
PAY-TO-PROVIDER	This entity may be a medical group, clinic, hospital, other institution, or the individual provider who rendered the service.
REFERRING PROVIDER	Identifies the individual provider who referred the client or prescribed Ancillary services/items such as Lab, Radiology and Durable Medical Equipment (DME).
RENDERING PROVIDER	The primary individual provider who attended to the client/member. They must be identified in 837I.
TRADING PARTNERS (TPs)	Includes all of the following; payers, switch vendors, software vendors, providers, billing agents, clearinghouses
DATE FORMAT	All dates are eight (8) character dates in the format CCYYMMDD. The only date data element that varies from the above standard is the Interchange Date data element located in the ISA segment. The Interchange Data date element is a six (6) character date in the YYMMDD format.

Term	Definition
DELIMITERS	A delimiter is a character used to separate two (2) data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction. The following characters are used as data delimiters for all transaction segments:

CHARACTER	PURPOSE
* Asterisk	Data Element Separator
^ Carrot	Repetition Separator
: COLON	Sub-Element Separator
~ Tilde	Segment Terminator

ATTACHMENT B

999 Interpretations

The examples below show an accepted and a rejected X12 N 999. On the Plan SFTP site in the respective Provider directory the X12N 997 files, when opened, will display as one complete string without carriage returns or line feeds.

Accepted 999

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

Rejected 999

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

Partial 999

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

AK2~837~000000127~005010X222A1'
IK5~A'
AK2~837~000000128~005010X222A1'
IK3~NM1~22~2310~8'
CTX~CLM01+001-375436/483311'
IK4~4~1036~I9'
IK3~NM1~40~2310~8'
CTX~CLM01+001-375436/483312'
IK4~4~1036~I9'
IK3~NM1~58~2310~8'
CTX~CLM01+001-375436/483313'
IK4~4~1036~I9'
IK3~NM1~76~2310~8'
CTX~CLM01+001-387563/483314'
IK4~4~1036~I9'
IK3~NM1~94~2310~8'
IK5~E~I5'
AK2~837~000000129~005010X222A1'
IK5~A'
AK2~837~000000130~005010X222A1'
IK5~A'
AK2~837~000000131~005010X222A1'
IK5~A'
...
AK2~837~000000277~005010X222A1'
IK5~A'
AK2~837~000000278~005010X222A1'
IK5~A'
AK2~837~000000279~005010X222A1'
IK3~NM1~46~2310~8'
CTX~CLM01+599440'
IK4~4~1036~I9'
IK3~NM1~72~2310~8'
CTX~CLM01+599450'
IK4~4~1036~I9'
IK5~E~I5'
AK2~837~000000280~005010X222A1'
IK5~A'
AK2~837~000000281~005010X222A1'
IK5~A'
AK2~837~000000282~005010X222A1'
IK5~A'
...
AK2~837~000000729~005010X222A1'
IK5~A'
AK2~837~000000730~005010X222A1'
IK5~A'
AK2~837~000000731~005010X222A1'
IK5~A'
AK9~P~731~731~730'
SE~1696~0001'
GE~1~1'
IEA~1~000000001'

The WellCare Group of Companies (The Plan)

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

WellCare Health Insurance of Illinois, Inc.

WellCare Health Insurance of New York, Inc.

WellCare of Texas, Inc.

WellCare Health Plans of New Jersey, Inc.

WellCare of Florida, Inc.

HealthEase of Florida, Inc.

WellCare of Louisiana, Inc.

WellCare of New York, Inc.

WellCare of Connecticut, Inc.

WellCare of Georgia, Inc.

Harmony Health Plan of Illinois, Inc.

WellCare of Ohio, Inc.

WellCare of Kentucky, Inc.