Indiana Health Coverage Programs

HIPAA Transaction Standard Companion Guide

Refers to the Implementation Guides Based on ASC X12 version 005010

Health Care Payer Unsolicited Claim Status Response (277U)

Companion Guide Version Number: 3.3
Revision Date: March 2022

Preface

This companion guide to the v5010 ASC X12N implementation guides and associated errata adopted under the Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with the Indiana Health Coverage Programs (IHCP). Transmissions based on this companion guide, used in tandem with the v5010 ASC X12N implementation guides, are compliant with both ASC X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the ASC X12N implementation guides adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the implementation guides.

Table of Contents

1 INTRODUCTION

This section describes how ASC X12N implementation guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that the Indiana Health Coverage Programs (IHCP) has something additional, over and above the information in the IGs. That information can:

- Limit the repeat of loops, or segments
- Limit the length of a simple data element
- Specify a sub-set of the IGs 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 the IHCP.

In addition to the row for each segment, one or more additional rows are used to describe the IHCP's usage for composite and simple data elements and for any other information. Notes and comments are placed at the deepest level of detail. For example, a note about a code value is placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a Notes/Comments column to provide additional information from the IHCP for specific segments provided by the TR3 implementation guides. The following is an example of the type of information that would be elaborated on in *Section 10: Transaction-Specific Information*.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
193	2100C	NM1	Subscriber Name			This type of row always exists to indicate that a new segment has begun. It is always shaded at 10% and notes or comments about the segment itself go in this cell.
195	2100C	NM109	Subscriber Primary Identifier		15	This type of row exists to limit the length of the specified data element.
196	2100C	REF	Subscriber Additional Identification			
197	2100C	REF01	Reference Identification Qualifier	18, 49, 6P, HJ, N6		These are the only codes transmitted by the IHCP.
			Plan Network Identification	N6		This type of row exists when a note for a particular code value is required. For example, this note may say that value N6 is the default. Not populating the first three columns makes it clear that the code value belongs to the row immediately above it.
218	2110C	EB	Subscriber Eligibility or Benefit Information			
231	2110C	EB13-1	Product/Service ID Qualifier	AD		This row illustrates how to indicate a component data element in the Reference column and also how to specify that only one code value is applicable.

1.1 SCOPE

The transaction instruction component of this companion guide must be used in conjunction with an associated ASC X12 implementation guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 implementation guides and is in conformance with ASC X12's Fair Use and Copyright statements.

1.2 OVERVIEW

1.2.1 OVERVIEW OF HIPAA LEGISLATION

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial healthcare transactions primarily between healthcare providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.2.2 COMPLIANCE ACCORDING TO HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked "not used" in the standard's implementation specifications or are not in the standard's implementation specification(s).
- Change the meaning or intent of the standard's implementation specification(s).

1.2.3 COMPLIANCE ACCORDING TO ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.3 REFERENCES

In addition to the resources available on the Indiana Medicaid Provider website (in.gov/medicaid/providers), there are other websites that contain helpful information to assist in the implementation of the electronic data interchange process. Links to these websites are listed below and are separated by category for easy reference.

1.3.1 GOVERNMENT AND OTHER ASSOCIATIONS

Center for Medicare and Medicaid Services (CMS): http://www.cms.hhs.gov
WEDI – Workgroup for Electronic Data Interchange: http://www.wedi.org

1.3.2 ASC X12 STANDARDS

Washington Publishing Company: http://www.wpc-edi.com
Data Interchange Standards Association: http://www.disa.org
American Nation Standards Institute: http://www.ansi.org
Accredited Standards Committee: http://www.x12.org

1.4 ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979, ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of nonstandard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X 12 standard is recognized by the United States as the standard for North America. Electronic Data Interchange (EDI) adoption has been proved to reduce the administrative burden on providers.

The intended audience for this companion guide is the technical and operational staff responsible for generating, receiving, and reviewing electronic healthcare transactions.

National Provider Identifier

As a result of HIPAA, the federal HHS adopted a standard identifier for healthcare providers. The Final Rule published by the HHS adopted the National Provider Identifier (NPI) as the standard identifier.

The NPI replaces all payer-specific identification numbers (such as the Medicaid provider number, known in Indiana as the IHCP Provider ID) on nationally recognized electronic transactions (also known as standard transactions); therefore, all healthcare providers are required to obtain an NPI to identify themselves on these transactions. The NPI is the only identification number that should be submitted on these transactions from a healthcare provider.

For all non-healthcare providers where an NPI is not assigned, the IHCP Provider ID should be submitted.

Additional information can be found on the *National Provider Identifier* page under the Provider Enrollment section of the Indiana Medicaid Provider website at in.gov/medicaid/providers.

2 GETTING STARTED

2.1 WORKING WITH THE IHCP

Indiana Medicaid trading partners exchange electronic healthcare transactions with the IHCP via the Secure File Transfer Protocol-SFTP (File Exchange) or HTTPS/S Web Services connection.

After establishing a transmission method, each trading partner must successfully complete testing. Additional information is provided in *Section 3: Testing With the Payer*. Trading partners are permitted to enroll for Production connectivity after successful completion of testing.

2.2 TRADING PARTNER REGISTRATION

All trading partners enrolling for Production connectivity are required to complete the IHCP Trading Partner Profile and Trading Partner Agreement, accessible from the *Electronic Data Interchange (EDI) Solutions* page, in the Business Transactions section of the Indiana Medicaid Provider website at in.gov/medicaid/providers.

Those trading partners that are using a currently enrolled billing agent, clearinghouse, or software vendor do not need to enroll separately. Only one trading partner ID is assigned per submitter location per connection type. If multiple trading partners are needed for the same address location please attach a letter to the Trading Partner Agreement explaining the need for the additional trading partner ID. Providers must use the IHCP Provider Healthcare Portal to delegate a clearinghouse, billing agent or software vendor access to retrieve their 835 (Electronic Remittance Advice). Information on how to delegate access is found in the *Provider Healthcare Portal* reference module.

Current trading partners that would like to request an update to their existing account must complete the IHCP Trading Partner Profile.

2.3 CERTIFICATION AND TESTING OVERVIEW

The Health Insurance Portability and Accountability Act (HIPAA) requires that all healthcare organizations that exchange HIPAA transaction data electronically with the Indiana Health Coverage Programs (IHCP) establish an electronic data interchange (EDI) relationship. All entities requesting to exchange data with the IHCP must be tested and approved by the IHCP before production transmission begins.

Vendors must review the X12N transaction HIPAA implementation guides and the IHCP companion guides to carefully assess the changes needed to their businesses and technical operations to meet the requirements of HIPAA. The national X12N transaction HIPAA implementation guides are available on the Washington Publishing Company website at wpc-edi.com.

3 TESTING WITH THE PAYER

The following steps describe the testing process for EDI vendors that have not yet been approved by the IHCP.

1. **Complete the Trading Partner Profile**

   The IHCP requires each testing entity exchanging data directly with the IHCP to complete and submit the IHCP Trading Partner Profile (accessible from the Indiana Medicaid Provider website at in.gov/medicaid/providers) to initiate the testing process. When the IHCP receives the profile form, testing information is sent to the vendor. Follow the instructions received in the testing information to ensure accuracy and completeness of testing.

2. **Conduct application development**

   Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional and mutually defined components of the transaction. The vendor must modify its business application systems to comply with the IHCP companion guides.

3. **Test each transaction**

   Connectivity testing performed with the transmissions ensures a successful connection between the sender and receiver of data. Two levels of data testing are required:

   - **Compliance Testing**

     All transactions must pass data integrity, requirements, balancing, and situational compliance testing. Although third- party HIPAA certification is not required, the preceding levels of compliance are required and must be tested.

     Compliance is accomplished when the transaction is processed without errors. The software used by the IHCP for compliance checking and the translation of the HIPAA transaction is Edifecs.

   - **IHCP Specification Validation Testing**

     Specification validation testing ensures conformity to the IHCP companion guides. This testing ensures that the segments or records that differ based on certain healthcare services are properly created and produced in the transaction data formats. Validation testing is unique to specific relationships between entities and includes testing field lengths, output, security, load/capacity/volume, and external code sets.

4. **Become an IHCP-approved software vendor**

   The testing and approval process differs slightly for software developers, billing services, and clearinghouses. The processes are described in the following subsections:

   Software Developers

   Entities whose clients will be submitting directly to the IHCP are not required to become IHCP trading partners. When testing and approval are complete, the IHCP sends certification of approval to the software developer. On receipt of this approval, the software developer should inform its clients that its software has been approved. However, providers are required to complete the procedures outlined in *Section 2.2: Trading Partner Registration* to enroll for Production connectivity.

Billing Services, Clearinghouses, and Managed Care Entities

At completion of testing and approval, a certification of approval notification is sent to the vendor.

Billing services, clearinghouses, and managed care entities (MCEs) must submit a signed IHCP Trading Partner Agreement. The Trading Partner Agreement is a contract between parties that have chosen to become electronic business partners. This document stipulates the general terms and conditions under which the partners agree to exchange information electronically. The signed Trading Partner Agreement must be emailed to INXIXTradingPartner@gainwelltechnologies.com or faxed to 317-488-5185.

4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS

4.1 PROCESS FLOWS

One 277U is generated per trading partner daily. The 277U reports all claims submitted by the trading partner that received errors with the billing provider information. Clearinghouses and billing services that submit claims for multiple providers will receive one 277U reporting error information for all providers and claims.

Managed care entities will receive a 277U for encounters that deny for billing provider information and/or invalid/missing MCE ID.

The 277U is returned once daily, Monday through Friday, and is posted to IHCP File Exchange server in the /Home/ directory of the trading partner.

- Claims submitted by 6 p.m. Eastern Time Monday–Friday will be reported after 7 p.m. Eastern Time the same day.
- Claims submitted after 6 p.m. Eastern Time Monday–Thursday will be reported after 7 p.m. Eastern Time the following day.
- Claims submitted after 6 p.m. Eastern Time on Friday will be reported after 7 p.m. Eastern Time the following Monday.

The file naming convention for the 277U is:
FILEID_TRACKINGID_TradingPartner ID_277UX12BATCH_CCYYMMDD.dat

4.2 COMMUNICATION PROTOCOL SPECIFICATIONS

FTPS and SFTP using:

- File Exchange

More information can be found in the *IHCP Connectivity Guide*, available from the *IHCP Companion Guides* page at in.gov/medicaid/providers.

4.3 PASSWORDS

By connecting to the IHCP File Exchange server, Trading partners agree to adhere to the password policy including changing passwords every 90-days. Trading partners are responsible for managing their own data. Each trading partner is responsible for managing access to their organization's data through the IHCP security function. The contact on file for the login/user ID will receive a notification five days before the password expires and is required to manually log in and change the password. Accounts will be locked during the five- day period until the password is changed. Accounts will be disabled if the password is not changed within the five-day period. Locked and disabled accounts will cause automated connection scripts to receive an error and fail to connect. When the password is manually changed in File Exchange, the same change must be applied to all automated scripts to ensure uninterrupted service.

5 CONTACT INFORMATION

5.1 GAINWELL EDI TECHNICAL ASSISTANCE

PHONE: 800-457-4584, option 3, then option 1
FAX: 317-488-5185
EMAIL: INXIXTradingPartner@gainwelltechnologies.com

5.2 PROVIDER SERVICE

PHONE: 800-457-4584, please listen to the entire message before making your selection.

5.3 APPLICABLE WEBSITES/E-MAIL

Indiana Medicaid Provider website: in.gov/medicaid/providers

Trading partner information can be found in the Business Transactions section of the Indiana Medicaid Provider website, on the *Electronic Data Interchange (EDI) Solutions* page and its subpages.

For email addresses and other contact information, see the *Contact Us* page and the *IHCP Quick Reference Guide*, available under the Contact Information section of the website.

6 CONTROL SEGMENTS/ENVELOPES

6.1 ISA - IEA

Claim Status Response 277U Interchange Control Header

- ISA06 (Interchange Sender ID): IHCP
- ISA08 (Interchange Receiver ID): This is the four-byte sender ID assigned by the IHCP.

6.2 GS – GE

Claim Status Response 277U Functional Group Header

- GS02 (Application Sender Code): IHCP
- GS03 (Application Receiver's Code): This is the four-byte sender ID assigned by the IHCP.

7 PAYER-SPECIFIC BUSINESS RULES AND LIMITATIONS

All references to "IHCP" in this companion guide refer to the Indiana Health Coverage Programs. All references to "IHCP Provider ID" in this companion guide refer to the Medicaid provider number assigned by the IHCP to a particular provider service location.

The 277U Unsolicited Claim Status Response is returned to trading partners to report claim denials as a result of insufficient billing provider information submitted on the 837 Health Care Claim transaction:

- Invalid Billing Provider – The billing provider submitted is not found in the IHCP database
- NPI/IHCP Provider Service Location Crosswalk – The IHCP uses a crosswalk to establish a one-to-one match between the provider NPI and the IHCP Provider ID. The crosswalk must successfully identify a unique IHCP billing provider service location. The IHCP billing provider service location must represent an active provider.

Three data elements on the 837 Health Care Claim transaction that are used to identify a unique IHCP billing provider service location are:

- NPI – Loop 2010AA NM109
- Taxonomy Code – Loop 2000A PRV03
- Billing Provider Service Location ZIP Code plus four – Loop 2010AA N403

All data submitted is used to identify a service location. Any claim submitted with data that does not match what is on file with the IHCP will deny.

Providers who receive a 277U can follow these steps to troubleshoot the error:

1. Verify the billing Provider ID submitted on the claim is valid.
2. Verify the three crosswalk data elements (NPI, taxonomy, service location ZIP) submitted on the 837 Health Care Claim transaction are current for the provider's enrollment with the IHCP.

   Note**:** This information is available on the IHCP Provider Healthcare Portal. The Provider Maintenance link in the Provider section of the Portal's *My Home* page allows users to verify their enrollment data used for the NPI/IHCP provider service location crosswalk. The Provider Maintenance function is available to any user within the provider's organization who has been granted access to this function by his or her provider representative. More information on the IHCP Provider Healthcare Portal can be found on the *IHCP Provider Healthcare Portal* webpage and in the *Provider Healthcare Portal* provider reference module, available from the Indiana Medicaid Provider website at in.gov/medicaid/providers.
3. Perform the necessary updates to either the original submitted claim or the provider enrollment data and resubmit the claim.

Encounters

The 277U Unsolicited Claim Status Response is returned to managed care entities to report encounter claim denials as a result of an invalid or missing MCE ID and/or insufficient billing provider information submitted on the Encounter 837 Health Care Claim transaction.

- MCE ID – Missing or invalid ID submitted in Loop2010BB Segment REF
- Invalid Billing Provider – The billing provider submitted is not found in the IHCP database
- NPI/IHCP Provider Service Location Crosswalk – The IHCP uses a crosswalk to establish a one-to-one match between the provider NPI and the IHCP Provider ID. The crosswalk must successfully identify a unique IHCP billing provider service location. The IHCP billing provider service location must represent an active provider.

Three data elements on the 837 Health Care Claim transaction that are required to identify a unique IHCP billing provider service location are:

- NPI – Loop 2010AA NM109
- Taxonomy Code – Loop 2000A PRV03
- Billing Provider Service Location ZIP Code plus four – Loop 2010AA N403

All data submitted is used to identify a service location. Any claim submitted with data that does not match what is on file with the IHCP will deny.

8 ACKNOWLEDGEMENTS AND/OR REPORTS

The 277U is an outbound transaction only, and there are no associated responses.

9 TRADING PARTNER AGREEMENTS

The IHCP Trading Partner Agreement is a contract between parties that have chosen to become electronic business partners. The Trading Partner Agreement stipulates the general terms and conditions under which the partners agree to exchange information electronically. If billing providers send multiple transaction types electronically, only one signed Trading Partner Agreement is required. Billing providers must print and complete a copy of the Trading Partner Agreement. The signed copy must be submitted to the IHCP EDI Solutions Unit.

More information can be found in the *Electronic Data Interchange (EDI) Solutions* webpage, in the Business Transactions section of the Indiana Medicaid Provider website at in.gov/medicaid/providers.

10 TRANSACTION-SPECIFIC INFORMATION

This section describes how ASC X12N implementation guides (IGs) adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that the IHCP has something additional, over and above, the information in the IGs. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the IGs internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, composite or simple data element pertinent to trading electronically with the IHCP.

In addition to the row for each segment, one or more additional rows are used to describe the IHCP's usage for composite and simple data elements and for any other information. Notes and comments are placed at the deepest level of detail. For example, a note about a code value is placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides.

10.1 HEALTH CARE PAYER UNSOLICITED CLAIM STATUS RESPONSE (277U)

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
N/A	BHT	Beginning of Hierarchical		
N/A	BHT03	Reference Identification		IHCP uses Trading Partner ID and date: H999CCYYMMDD
N/A	BHT06	Transaction Type	NO	NO – Notice
2000A	HL	Information Source Level		
2000A	HL01	Hierarchical ID Number	1	The first HL01 value will be 1 and each HL will increment by one throughout the transaction set.
2000A	HL02	Hierarchical Parent ID Number	0	0 – Hierarchical Parent ID Number
2000A	HL03	Hierarchical Level Code	20	20 – Information Source
2000A	HL04	Hierarchical Child Code	1	1 – Additional subordinate HL data segments exist in this structure
2100A	NM1	Payer Name		
2100A	NM103	Name Last or Organization Name	HP	IHCP uses HP
2100A	NM108	Identification Code Qualifier	PI	PI – Payor Identifier
2100A	NM109	Identification Code	752548221	IHCP uses 752548221
2000B	HL	Information Receiver Level		
2000B	HL01	Hierarchical ID Number		Incremented by 1 from the previous HL segment in the Transaction Set
2000B	HL02	Hierarchical Parent ID Number		The value in this data element will reference the Parent HL01 at the Information Source Level.
2000B	HL03	Hierarchal Level Code	21	21 – Information Receiver

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
2000B	HL04	Hierarchical Child Code	1	1 – Additional subordinate HL data segments exist in this structure
2100B	NM1	Information Receiver Name		
2100B	NM101	Entity Identifier Code	41	41 – Submitter
2100B	NM102	Entity Type Qualifier	2	2 – Non Person Entity
2100B	NM108	Identification Code Qualifier	46	46 – Electronic Transmitter Identification Number
2100B	NM109	Identification Code		Trading Partner ID supplied by the IHCP
2000C	HL	Service Provider Level		
2000C	HL01	Hierarchical ID Number		Incremented by 1 from the previous HL segment in the Transaction Set
2000C	HL02	Hierarchical Parent ID Number	2	The value in this data element will reference the parent HL01 at the Information Source Level
2000C	HL03	Hierarchical Level	19	19 – Provider of Service
2000C	HL04	Hierarchical Child Code	1	1 – Additional subordinate HL data segments exist in this structure
2100C	NM1	Provider Name		
2100C	NM101	Entity Identifier Code	1P	1P – Provider
2100C	NM102	Entity Type Qualifier	2	2 – Non Person Entity
2100C	NM103	Name Last or Organization Name		Claims submitted with an invalid NPI or IHCP Provider ID – PROVIDER UNKNOWN On claims that deny for *Provider Not Found* or *Unsuccessful NPI Crosswalk*, the Provider Name submitted on the claim will be returned.
2100C	NM108	Identification Code Qualifier	SV, XX	
2100C	NM109	Identification Code		NM108=SV – Provider's IHCP Provider ID submitted in 2010BB REF02 of the 837 claim file. NM108=XX – Provider's NPI submitted in 2010AA NM109 of the 837 claim file.
2000D	HL	Subscriber Level		
2000D	HL01	Hierarchical ID Number		Hierarchical ID Number
2000D	HL02	Hierarchical Parent		Parent ID Number
2000D	HL03	Hierarchical Level Code		Subscriber Information
2000D	HL04	Hierarchical Child Code	0	0 – No subordinate HL segment in this hierarchical structure
2100D	NM1	Subscriber Name		
2100D	NM101	Entity Identifier Code	QC	QC – Patient
2100D	NM102	Entity Type Qualifier	1	1 – Person
2100D	NM103	Name Last or Organization Name		Member's Last Name
2100D	NM104	Name First		Member's First Name
2100D	NM105	Name Middle		Member's Middle Initial
2100D	NM108	Identification Code Qualifier	MI	

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
2100D	NM109	Identification Code		MI – Member's Medicaid ID submitted on the 837 claim file. The IHCP Member ID for Medicaid is 12 digits.
2200D	TRN	Claim Status Tracking		
2200D	TRN01	Trace Type Code	2	2 – Referenced Transaction Trace Numbers
2200D	TRN02	Reference Identification		This segment is being used to pass back the Patient Control Number from the associated 837 2300 Loop CLM – Claim Segment. If not received on original claim, 'PatAcct Missing' will be returned.
2200D	STC	Claim Level Status Information		
2200D	STC01-1, STC010-1 and STC11-1	Health Care Claim Status Category Code	F2	From Code List 507 Claim Status Category Codes are available at www.wpc-edi.com F2 – Finalized/Denial – The claim has been denied.
2200D	STC01-2, STC10-2 and STC11-2	Health Care Claim Status Code	132 153	From Code List 508 Claim Status Category Codes are available at www.wpc-edi.com 132 – Entity's Medicaid Provider ID. – Returned for claims that denied for billing provider errors. See *Section 7: Payer-Specific Business Rules and Limitations* for more information. 153 – Entity's ID Number – Returned for encounter claims that denied for missing or invalid MCE ID. See *Section 7* for more information.
2200D	STC01-3, STC10-3 and STC11-3	Entity Identifier Code	1P QK	1P – Provider – Returned for claims that denied for billing provider errors. See *Section 7* for more information. QK – Managed Care – Returned for encounter claims that denied for missing or invalid MCE ID. See *Section 7* for more information.
2200D	STC02	Date	CCYYMMDD	Billed Date
2200D	STC04	Monetary Amount		Total Claim Charge Amount
2200D	REF	Payer Claim Control Number		
2200D	REF01	Reference Identification Qualifier	1K	1K – Payor's Claim Number
2200D	REF02	Reference Identification		IHCP 13-digit Claim ID (ICN)
2200D	REF	Institutional Bill Type Identification		
2200D	REF01	Reference Identification Qualifier	BLT	BLT – Billing Type Note: This REF segment is only sent if the original claim was billed on an 837I transaction for EDI.
2200D	REF02	Reference Identification		Type of Bill that was submitted on the original claim.

LOOP ID	REFERENCE	NAME	CODES	NOTES/COMMENTS
2200D	REF	Claim Identification Number for Clearinghouses and Other Transmission Intermediaries		
2200D	REF01	Reference Identification Qualifier	D9	D9 - Claim Number
2200D	REF02	Reference Identification		This segment is being used to pass back Other Payer Claim Control Number (F8 qualifier) from the associated 837 2330B Loop REF – Other Payer Claim Control Number segment. In the case of multiple 837 2320 Other Payer Loops, the first one is used. If not received on original claim, the segment will not be returned.
2200D	DTP	Claim Service Date		
2200D	DTP01	Date Time Qualifier	472	472 – Service
2200D	DTP02	Date Time Period Format Qualifier	D8 RD8	D8 – Service Date RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD
2200D	DTP03	Date Time Period		The Date(s) associated with this claim for Header level information. The system will take the earliest from date and the latest to date and report that information.

11 APPENDICES

11.1 IMPLEMENTATION CHECKLIST

See trading partner information linked from the *Electronic Data Interchange (EDI) Solutions* webpage, on the Indiana Medicaid Provider website at in.gov/medicaid/providers.

11.2 TRANSMISSION EXAMPLE

```
ISA*00*      *00*       *ZZ*IHCP       *ZZ*TPID       *170101*1900*^*00501*123456789*0*P*:~
GS*HN*IHCP*TPID*20170101*1900*123456*X*005010X228~
ST*277U*000000001*005010X228~
BHT*0010*08*TPID20170101*20170101*1900*NO~
HL*1**20*1~
NM1*PR*2*HP*****PI*752548221~
HL*2*1*21*1~
NM1*41*2*SUBMITTER*****46*TPID~
HL*3*2*19*1~
NM1*1P*2*PROVIDER*****XX*1000000000~
HL*4*3*22*0~
NM1*QC*1*LNMEMBER*FNMEMBER*MID***MI*100000000000~
TRN*2*PAT ACCT NUM~
STC*F2:132:1P*20170101**0.00~
REF*1K*IHCP ICN~
REF*BLT*131~
REF*D9* Other Payer Claim Control Number ~
DTP*472*D8*20161230~
SE*19*000000001~
GE*1*123456~
IEA*1*123456789~
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11.3 CHANGE SUMMARY

This section describes the differences between the current companion guide and previous guide(s).

*Core*MMIS Change Summary

Version	DDI CO	CO Name	Revision Date	Revision Status	Revision Page Numbers / Change / Update Details	Completed By
3.0			Aug 2017	Implemented	New Transaction Implementation	Systems
3.1			Sep 2017	Implemented	Pg. 8, Section 4.1 – Updated to include information for Managed Care Entities and encounter claims. Pg. 10, Section 7 – Added Encounter information Pg. 14 2200D STC – Added codes for MCE ID	Systems
3.2	59059	Updates to the 277U	Jan 2019	Implemented	Pg. 14 – Updated to clarify that the segment is being used to pass back the Patient Control Number from the associated 837 2300 Loop CLM – Claim Segment Pg. 15 – Added information about Loop 2200D, REF segment - segment is being used to pass back Other Payer Claim Control Number (F8 qualifier) from the associated 837 2330B Loop REF – Other Payer Claim Control Number segment. Pg. 15 – Updated Transmission Example	Systems
3.3		Updates to 277U	Mar 2022	Implemented	Updated DXC to Gainwell. Updated website links. Updated trading partner email address. Updated text formatting.	Systems