Utah Department of
Health & Human Services
Integrated Healthcare

HIPAA Transaction
Standard Companion Guide

Health Care Claim: Institutional (837)
ASC X12N/005010X223

July 18, 2024

This page is intentionally left blank.

Disclosure Statement

Disclosure, distribution, and copying of this guide is permitted. However, be aware that changes to items found in this guide may occur at any time without notice.

The intended purpose and use of this guide, is to provide information supporting the Health Care Claim: Institutional (837) transaction.

Due to the copyright protection of the 5010 Implementation Guides (TR3), Utah Medicaid will not publish items found on the ASC X12 Implementation Guides (TR3), other than to convey the Utah Medicaid system limitations and usage iterations.

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 electronic health data with Utah Medicaid. 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.

The Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. It is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

This Companion Guide will provide information regarding the exchange of an Electronic Data Interchange (EDI) transaction with Utah Medicaid regarding Health Care Claim transactions. It also includes information about EDI enrollment, testing, and customer support.

Utah Medicaid is publishing this Companion Guide to clarify, supplement, and further define specific data content requirements to be used in conjunction with, and not in place of, the ASC X12N TR3 mandated by HIPAA. This Companion Guide can be accessed at https://medicaid.utah.gov/hipaa/providers/#companion-guides.

All References to Medicaid are used for simplicity, but other programs supported by the Utah Department of Health Division of Medicaid and Health Financing (DMHF) are also included, for example, Medicaid, CHIP, Integrated Medicaid, Baby Your Baby, and so forth.

Utah Medicaid provides services to eligible members using two coverage models:

- Managed Care Organizations (MCO) - Are Plans who provide medical, dental, and behavioral health services to eligible Medicaid and CHIP members.
- Fee for Service (FFS) - Consists of all Medicaid plans where services are paid for a member who is not enrolled in an MCO or the service that is needed is not covered by the MCO plan.

Table of Contents

Figures

No table of figures entries found.

Tables

1 INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires all entities exchanging health data to comply with the Electronic Data Interchange (EDI) standards for healthcare as established by the Secretary of Health and Human Services. The Accredited Standards Committees (ASC) X12 Standards for Electronic Data Interchange Technical Report Type 3 (TR3) are the standards of compliance. The TR3s are published by the Washington Publishing Company (WPC) and are available at: https://x12.org/products.

This section describes how the ASC X12N Implementation Guides (IGs) adopted under HIPAA will be detailed with the use of tables. The tables contain a row for each segment that, due to the Utah Medicaid system limitation and business needs, may require information in addition to, or 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, and composite or simple data element pertinent to trading electronically with Utah Medicaid.

In addition to the row for each segment, one or more additional rows are used to describe the Utah Medicaid usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail.

Table 1 specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides.

Table 1. Columns and Usage

Page #	Loop ID	Reference	Name	Notes/Comments
85	2010AA	NM103	Name Last or Organization Name	Billing Provider Last or Organization Name of the Institution
114	2010BA	NM109	Reference Identification	10-digit Beneficiary ID Number
327	2310B	NM103	Operating Physician Last Name	Last Name of the Operating Physician

Scope

The Companion Guide addresses the Utah Medicaid technical and connectivity specifications for the Health Care Claim: Institutional (837I) transaction. It highlights business rules, system limitations, and data requirements for generating a successful Health Care Claim: Institutional (837I) transaction.

Table 2. Transactions Covered by this Companion Guide

Transactions	Versions
Health Care Claim: Institutional (837)	005010X223
Implementation Acknowledgment for Health Care Insurance (999) Interchange Acknowledgment (TA1)	005010X231A1

Overview

The Companion Guide was written to assist providers in designing and implementing transaction standards to meet the Utah Medicaid processing methodology. The guide is organized in the following sections:

- Section 1 INTRODUCTION: Section includes scope, overview, references and additional information.
- Section 2 GETTING STARTED: Section includes information on enrolling as a Utah Medicaid Provider, EDI enrollment, and the testing process.
- Section 3 TESTING WITH UTAH MEDICAID: Section includes detailed transaction instruction on how to test with Utah Medicaid.
- Section 4 CONNECTIVITY WITH THE PAYER/COMMUNICATIONS: Section includes information on Medicaid transmission procedures, and communication and security protocols.
- Section 5 CONTACT INFORMATION: Section includes Medicaid telephone numbers, mailing and email addresses, and other contact information.
- Section 6 CONTROL SEGMENT/ENVELOPES: Section includes information needed to create the ISA/IEA, GS/GE, and ST/SE control segments to be submitted to Utah Medicaid.
- Section 7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS: Section includes detailed transaction testing information. Web services connection is needed to send transactions.
- Section 8 ACKNOWLEDGEMENTS AND/OR REPORTS: Section includes information on all EDI reports such as 999s, or TA1.

- Section 9 TRADING PARTNER AGREEMENTS: Section contains information regarding Trading Partner EDI Enrollment requirements for the 834 transaction.
- Section 10 TRANSACTION SPECIFIC INFORMATION: Section contains specific information regarding 834 transactions, system limitations, scheduled and non-scheduled system downtime notifications, holiday hours, and other information that would be helpful to Trading Partners.
- APPENDICES: This section will lay out transmission examples, frequently asked questions, an implementation checklist, business scenarios, and a change summary.

References

- **5010 ASC X12 Technical Report Type 3 (TR3) Guides:**

  Due to system limitation and business needs, Utah Medicaid will identify loops, segments, and data elements to convey additional information to process electronic requests successfully.

  The TR3s may be purchased through Washington Publishing Company (WPC) at https://x12.org/products.

- **Utah Health Information Network (UHIN) Standards and Specifications:**

  All payers in Utah, including Medicaid, have adopted the UHIN Standards and Specifications set forth by the Utah Health Insurance Commission. UHIN is an independent, not-for-profit, value added network serving providers and payers in Utah. To access specific documents such as Standards, Technical Manuals, Specifications, and so forth, a provider must request access to https://my.uhin.org from UHIN.

  - UHIN Home Page: http://www.uhin.org
  - UHIN Standards: https://support.uhin.org/hc/en-us/categories/360002051651-Standards
  - UHIN UTRANSEND Technical Reference Manual (TRM): https://support.uhin.org/hc/en-us/articles/360038190411-Technical-Reference-Manual-v2
  - UHIN EDI Enrollment Specification: https://support.uhin.org/hc/en-us/articles/360037342132-UHIN-EDI-Enrollment-Specification-v1-1

- **Washington Publishing Company (WPC):**

  https://www.wpc-edi.com/

- **WPC Code List:**

  https://x12.org/codes

- **CMS transaction and Code Sets Standards:**

  https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/AdoptedStandardsandOperatingRules.html

- **CMS Electronic Billing and EDI Transactions Help Lines (Part A and B):**

  http://www.cms.gov/ElectronicBillingEDITrans

- **Accredited Standards Committee (ASC):**

  https://x12.org/

Additional Information

Utah Medicaid does not offer EDI software. Some software vendors charge for each electronic transaction type (claims, eligibility, reports, and remittance advice). There are no regulations as to what software vendors can charge for the software license or their services. It is the responsibility of the provider to procure software that best fits their business needs.

Things to consider when looking for EDI software:

1. Fees and Function – What EDI transactions are included with the software license? Examples include:
   a. Health Care Eligibility Benefit Inquiry and Response (270/271)
   b. Health Care Claim Status Request and Response (276/277)
   c. Health Care Claims: Professional (837P), Institutional (837I), Dental (837D)
   d. Health Care Claim Acknowledgment (277CA)
   e. Acknowledgment Reports (Interchange Acknowledgement (TA1), Implementation Acknowledgment for Health Care Insurance (999))
   f. Health Care Claim Payment/Advice (835)
   g. Health Care Services Review - Request for Review and Response (278)
   h. Payroll Deducted and Other Group Premium Payments for Insurance Products (820)
   i. Benefits Enrollment and Maintenance (834)
2. Software License – Will the license include free regulatory updates?
3. Technical Support – Is the installation, set-up, and any subsequent assistance included with the subscription?
4. System Requirements – Will the software function with your current Operating System, hardware, and Practice Management software, or will new Operating System, Practice Management software, or hardware be needed?

5. Reports – Are data elements on received transactions viewable, for example, Claims Adjustment Reason Codes, Remittance Remark Codes, PLB segments on the 835, and so forth?
6. UHIN provides software for their members. Contact UHIN at (877) 693-3071 for more information.
7. Providers that use a billing company or clearinghouse, contact the billing company or clearinghouse for software.
8. Proprietary software can be used provided it meets HIPAA standards and mandated CORE requirements.

2 GETTING STARTED

Working with Utah Medicaid

Providers must enroll as a Utah Medicaid provider. The Utah Medicaid Provider Enrollment team may be reached at (801) 538-6155 or (800) 662-9651, option 3, then option 4, for questions regarding provider enrollment. Provider Enrollment forms, instructions, and contact information are available on the Utah Medicaid website: https://medicaid.utah.gov/become-medicaid-provider.

A provider who enrolled online will receive a Welcome Letter to access provider enrollment information.

Providers who wish to employ UHIN and use their tools and services to submit EDI Health Care Claims, Client Eligibility and Response, Claim Status Inquiry and Response, Health Care Services Review - Request for Review and Response, or receive Electronic Remittance Advice may contact UHIN at (877) 693-3071 or see the UHIN EDI Enrollment Specification at: https://support.uhin.org/hc/en-us/articles/360037342132-UHIN-EDI-Enrollment-Specification-v1-1. The Provider must ask UHIN for membership information and how to obtain an Electronic Data Interchange (EDI) Trading Partner Number (TPN).

Providers who elect to transmit or receive electronic transactions using a third party, such as a billing agent, clearinghouse, or network service, do not need to contact UHIN or acquire a TPN if the billing agent, or network service is a member of UHIN. In this case, providers must obtain the billing company's TPN to complete the Utah Medicaid EDI enrollment online.

Trading Partner Registration

Utah Medicaid requires all trading partners to complete the Utah Medicaid EDI Enrollment online. Any other form of EDI Enrollment is not accepted. To become a trading partner with Utah Medicaid, visit our website at https://medicaid.utah.gov/become-medicaid-provider.

Using the information provided in the Welcome Letter (when you first enrolled to become a Utah Medicaid provider), you may access and complete or modify the EDI Enrollment. If a Welcome Letter was not received, contact Medicaid Provider

Enrollment at (801) 538-6155 or (800) 662-9651, option 3, then option 4, to request one.

Providers may need to obtain the TPN for each EDI transaction from their clearinghouse or billing agency prior to EDI enrollment.

For Brand New Providers – Never Validated:

1. Acquire a Utah Identification (ID) from https://id.utah.gov/login if you do not have one.
   a. Create an Account
   b. Complete all the required fields
   c. Set the password interval to 90 days, using the following State of Utah password requirements:
      - Minimum of 8 characters
      - Upper case letters
      - Lower case letters
      - At least 1 number
      - Special characters
2. Visit our website at: https://medicaid.utah.gov/become-medicaid-provider.
3. Click the PRISM Portal hyperlink.
4. Enter your Utah ID and password to log in.
5. Click the Submit Enrollment Access (Converted Providers Accessing the New PRISM System for the First Time).
6. Complete and Submit Enrollment Access form. Upon successful validation, the system will redirect you to the profile selection domain page.
7. Click Manage Provider Information.
8. Complete all the validation requirements in Steps 1-3.
9. Complete all the steps for EDI Enrollment to add or modify the EDI enrollment information. Fill out the form completely and associate the Trading Partner Number (TPN) to each EDI transaction based on business needs. A different TPN may be used for each EDI transaction.
10. Click the Submit button in the last step to submit the form for processing.

For Existing Providers – Validated:

1. Visit our website at https://medicaid.utah.gov/become-medicaid-provider/.
2. Click the PRISM Portal hyperlink.
3. Enter your Utah ID and password to log in.
4. Select a Domain and Profile.

5. Click the Manage Provider Information.
6. Complete all the steps that pertain to the EDI Enrollment to add or modify the EDI enrollment information. Fill out the form completely and associate the TPN to each EDI transaction based on business needs. Different TPNs may be used for each EDI transaction.
7. Click the Submit button in the last step to submit the form for processing.

Training is available by clicking the link for the Provider Enrollment and EDI Enrollment tutorial: https://medicaid.utah.gov/pe-training.

Certification and Testing Overview

All payers in Utah, including Utah Medicaid, have adopted the UHIN Standards and Specifications set forth by the Utah Health Insurance Commission. UHIN is an independent, not-for-profit, value added network serving providers and payers in Utah.

All providers who wish to submit EDI transactions through UHIN, must test with UHIN prior to submission of electronic transactions. Contact UHIN at (877) 693-3071 to coordinate acceptance testing.

3 TESTING WITH UTAH MEDICAID

Providers who wish to submit EDI transactions through the PRISM Electronic batch are not required to do testing. If a provider wants to test prior to production, send test transactions to the Medicaid Test Trading Partner Number: HT000004-003.

Providers who wish to submit EDI transactions through UHIN, contact UHIN Help Desk at (877) 693-3071 for security access to their Test environment. Coordinate Acceptance Testing with UHIN first. UHIN will validate your EDI transactions and notify Utah Medicaid when Acceptance Testing is completed.

During provider enrollment, ensure that your UHIN Trading Partner Numbers (TPN) are associated for each transaction based on business needs prior to testing with Utah Medicaid. Registration can be done through EDI Enrollment online at the Medicaid website: https://medicaid.utah.gov/become-medicaid-provider/. See detailed instructions under the Trading Partner Registration section.

Providers should coordinate testing with Utah Medicaid, after completion of the Acceptance Testing with UHIN, by contacting the Medicaid Managed Care EDI Customer Support team at MHC-EDI@utah.gov. Medicaid Managed Care EDI Customer Support will assist with testing issues and errors.

Send your test transactions to the Medicaid Test Trading Partner Number: HT000004-003.

Providers using the UHIN software are not required to test. Contact UHIN Member Relations Team at (877) 693-3071 for technical support.

Providers using a third-party software or practice-management software need to work directly with their software vendor for software upgrades and technical support.

4 CONNECTIVITY WITH THE PAYER/ COMMUNICATIONS

Web Service connection is required to send electronic transactions through UHIN. For more information, see UHIN standards at: https://support.uhin.org/hc/en-us/categories/360002051651-Standards.

To initiate a Trading Partner relation with UHIN, contact UHIN at (877) 693-3071 for more information, or email at: customerservice@uhin.org.

UHIN Technical Specifications are available at: https://support.uhin.org/hc/en-us/articles/360038190411-Technical-Reference-Manual-v2.

5 CONTACT INFORMATION

EDI Customer Service

The UHIN Help Desk can be contacted at either (877) 693-3071 or by email at customerservice@uhin.org.

Trading Partners may call Utah Medicaid for assistance in researching problems with submitted EDI transactions. Utah Medicaid will not edit Trading Partner data or resubmit transactions for processing on behalf of a Trading Partner. The Trading Partner must correct any transmission or data errors found and resubmit.

Utah Medicaid Manage Care EDI Customer Support team may be contacted by email: MHC-EDI@utah.gov.

Notes: Do not send non-encrypted PHI to this email address.

If Utah Medicaid receives a regular, unencrypted email containing protected health information (PHI), there may be some risk that the information in the email could be intercepted and read by a third-party during transmission.

This may be a reportable incident under the HIPAA Privacy and Security Rules. Please follow your organization's incident reporting procedure and notify your compliance officer.

If you need to send PHI or other sensitive information to us electronically, we strongly encourage you to use a secure method.

EDI Customer Support hours are Monday through Friday from 8 A.M. to 5 P.M.

EDI Customer Support is closed during Federal and State Holidays.

Utah Medicaid will broadcast messages through the Medicaid Information Line, ListServ, and through UHIN alerts for unexpected system down time, for unexpected delay in generation and transmission of EDI reports, delay in the release of provider payments, to announce the release of new or interim Medicaid Information Bulletin (MIB), and so forth.

To sign up for the Medicaid ListServ, click: https://medicaid.utah.gov/utah-medicaid-official-publications.

Trading partners may also sign up to receive UHIN alerts for urgent broadcast and notification sent by various Utah Payers including Utah Medicaid at: http://www.uhin.org.

Applicable Websites/E-mail

Utah Medicaid Managed Care EDI email address is: MHC-EDI@utah.gov

Utah Medicaid Web Page: https://medicaid.utah.gov/

Utah Medicaid Companion Guide: https://medicaid.utah.gov/hipaa/providers/#companion-guides/

Utah Medicaid Provider training: https://medicaid.utah.gov/provider-training-0/

Utah Medicaid EDI Enrollment: https://medicaid.utah.gov/become-medicaid-provider/

Utah Medicaid Registration and EDI Enrollment Tutorial: https://medicaid.utah.gov/pe-training

To sign up for the Utah Medicaid ListServ: https://medicaid.utah.gov/utah-medicaid-official-publications

UHIN: https://uhin.org

UHIN Help Desk: customerservice@uhin.org

UHIN Standards and Specifications: https://support.uhin.org/hc/en-us/categories/360002051651-Standards

Connectivity requirements, click the UHIN website at this link: https://support.uhin.org/hc/en-us/articles/360038190411-Technical-Reference-Manual-v2

To sign up to receive UHIN alerts: https://uhin.org

UHIN Hardware Requirements: https://support.uhin.org/hc/en-us/articles/360038190411-Technical-Reference-Manual-v2

6 CONTROL SEGMENT/ENVELOPES

In all transactions, the ISA06 and ISA08 must contain the designated Trading Partner Number (TPN) of the submitter and receiver, respectively. The trading partner defines the value carried in GS02 and GS03. If there is not an agreement between trading partners as to the value carried in these segments, then the default will be the TPN of the submitter and receiver (that is, the same numbers that are in ISA06 and ISA08, respectively).

For security purposes, neither the ISA04 nor the GS02 will be used to carry the Trading Partner Password or User ID. The Password and User ID values will be transmitted in an outside wrapping of the transaction for authentication. For this reason, the ISA01 and ISA03 values are ‘00’ and the ISA02 and ISA04 are space filled. See Table 3 for proper usage and required value for various data elements in the ISA and GS segments.

ISA-IEA (Interchange Control Number)

To facilitate tracking and debugging, the Interchange Control number used in the ISA13 must be unique for each transaction.

Group Control Number

To facilitate tracking and debugging, the Group Control number used in the GS06, must be unique.

Originator Application Transaction Identifier

To facilitate tracking and debugging, the Originator Application Transaction Identifier used in BHT03, must be unique for each transaction.

For more information regarding the use of ISA/IEA and GS/GE control segments, see the Utah Standards available on the UHIN website at: https://support.uhin.org/hc/en-us/categories/360002051651-Standard.

Table 3. 837 – Health Care Claims Institutional Interchange Control Header

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
	ISA		**Segment – Interchange Control Header**	
	ISA	ISA01	Authorization Information Qualifier	“00” (No Authorization Information Present)
	ISA	ISA02	Authorization Information	10 Spaces
	ISA	ISA03	Security Information Qualifier	“00” (no security information present)
	ISA	ISA04	Security Information	10 Spaces
	ISA	ISA05	Interchange ID Qualifier	“ZZ” (mutually defined)
	ISA	ISA06	Interchange Sender ID	Trading Partner ID obtained from UHIN (HTXXXXXX-XXX)
	ISA	ISA07	Interchange ID Qualifier	“ZZ” (mutually defined)
	ISA	ISA08	Interchange Receiver ID	"HT000004-002" "HT000004-003" – Test followed by spaces.
	ISA	ISA13	Interchange Control Number	Set of 9 numbers. Must be unique for each transaction.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
	ISA	ISA14	Acknowledgment Requested	Always use number "1" for Interchange Acknowledgment Requested (TA1). Without this indicator, acknowledgment will not be returned for the submitted transaction if an error on the ISA segment is detected. And the submitted EDI file will not be processed.
	ISA	ISA15	Interchange Usage Indicator	Always use "P" for Production Data and "T" for Test Data.
	ISA	ISA16	Component Element Separator	<:>
	GS		**Segment – Functional Group Header**	**If a Trading Partner Number is shared between multiple providers, acknowledgment/response files generated for the Trading Partner Number will not be accessible from PRISM screens to download.**
	GS	GS02	Application Sender's Code	UHIN - Trading Partner ID obtained from UHIN (HTXXXXXX-XXX)
	GS	GS03	Application Receiver's Code	"HT000004-002" "HT000004-003" – Test

7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

Utah Medicaid accepts and supports Batch Institutional Health Care Claim (837I) transactions. For every 837I transaction submitted, system responds with a Health Care Claim Acknowledgement (277CA) transaction. Once all the encounter claims submitted in an 837I transaction are adjudicated, system responds with a 277CA transaction.

Utah Medicaid requires a unique value in the ISA13 and GS06 for all X12 transactions. Combination of Interchange Sender Identifier (ISA06) and Originator Application Transaction Identifier should be unique. If not, system will treat it as a duplicate submission and rejects the file with a 999 Acknowledgement.

You may transmit electronic 837I transactions anytime, 24 hours a day, 7 days a week.

Regular Scheduled System Downtime

Utah Medicaid systems are available to process Batch transactions 24/7 except during regularly scheduled system downtime, defined as:

Routine downtime

Regularly scheduled system downtime is Sundays, from 1 A.M. to 2 A.M.

Non-routine downtime

Medicaid will notify providers through the email ListServ, UHIN alerts, or message broadcast through the phone system, for unscheduled or emergency downtime, within one hour of discovery.

No response or acknowledgment will be returned during scheduled or non-scheduled downtime.

System Holiday Schedule

Utah Medicaid systems are available to process Batch X12 transactions 24 hours a day, 7 days a week except for our regularly scheduled system downtime, as stated previously.

Business Limitations:

- **ANSI ASC X12 837 - Transaction Set Companion Guide Rules**

Table 4. 837 Health Care Claim Institutional Transaction Set Companion Guide Rules

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
			Transaction Set Header	
	ST		**Segment - Transaction Set Header**	**PRISM accepts a maximum of 5,000 CLM segments in a single transaction (ST - SE) as recommended by the HIPAA mandated implementation guide. Submissions greater than 5,000 CLM segments in a single transaction will be rejected.**
	BHT		**Segment - Beginning of Hierarchical Transaction**	
	BHT	BHT06	Transaction Type Code	<Claim or Encounter Identifier> "RP" (Reporting)
1000A			**Loop - Submitter Name**	
1000A	**NM1**		**Segment - Submitter Name**	
1000A	NM1	NM109	Identification Code	Trading Partner ID obtained from UHIN (HTXXXXXX-XXX)
1000B			**Loop - Receiver Name**	
1000B	**NM1**		**Segment - Receiver Name**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
1000B	NM1	NM103	Receiver Name	“Utah Medicaid MCO”
1000B	NM1	NM109	Identification Code	<Receiver Primary Identifier> HT000004-002 - Encounter HT000004-003 – Test Mailbox
2000A			**Loop – Billing Provider Hierarchical Level**	
2000A	**PRV**		**Billing Provider Specialty Information**	
2000A	PRV	PRV02	Reference Identification Qualifier	"PXC" (Health Care Provider Taxonomy Code)
2000A	PRV	PRV03	Provider Taxonomy Code	RHC Providers must submit Taxonomy Code 261QR1300X
2000B			**Loop - Subscriber Hierarchical Level**	
2000B	**SBR**		**Segment - Subscriber Information**	
2000B	SBR	SBR01	Payer Responsibility Sequence Number Code	Plan should report itself in this segment. P - Primary payer S – Secondary Payer

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				T – Tertiary Payer If the member has other insurance, report Primary payer coverage with code “P” and any other insurance with codes “S” or “T”, as appropriate, for Secondary or Tertiary. If the member has no other insurance, report the health plan coverage with "P".NOTE: PMHPs and Dental should NOT consider the member’s Utah Medicaid physical health plan the primary payer.
2000B	SBR	SBR03	Reference Identification	Use State assigned 9-digit PRISM Location ID.
2000B	SBR	SBR09	Claim Filing Indicator Code	'"MC" (Utah Medicaid)
2010BA			**Loop - Subscriber Name**	
2010BA	**NM1**		**Segment - Subscriber Name**	
2010BA	NM1	NM104	Name First	Send “NoFirst” if there isn’t a first name for the subscriber
2010BA	NM1	NM108	Identification Code Qualifier	“MI” (Member Identification Number)
2010BA	NM1	NM109	Identification Code	<Subscriber Primary Identifier> 10-digit beneficiary ID number assigned by PRISM

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2000C			**Loop - Patient Hierarchical Level**	**PRISM business rules require that the patient is always the subscriber. Therefore, PRISM does not expect providers to submit any Loop - 2000C Patient Hierarchical Levels in a transaction set. Transaction sets that contain Loop - 2000C Patient Hierarchical Level information will be rejected.**
2300			**Loop - Claim Information**	**Note that the HIPAA mandated implementation guide allows a maximum of 100 repetitions of the Loop - 2300 Claim Information within each Loop - 2000B Subscriber Hierarchical Level. Transaction sets that do not associate Loop - 2300 Claim Information with Loop - 2000B will be rejected.**
2300	**CLM**		**Segment - Claim Information**	
2300	CLM	CLM05-3	Claim Frequency Type Code (Type of Bill)	<Claim Frequency Code> "1" Original claim submissions “2” Interim claim "7" Claim replacement "8" Claim void/cancel For both "7" and "8" include the original ERN, as indicated in Loop - 2300 REF (Payer Claim Control Number).

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				For "2" - Medicaid will allow only 1 Interim claim per stay. Interim claim should be voided, and an original claim submitted once client is discharged. Adjustments and Voids can only be performed on previously Accepted claims. An adjustment to a Rejected claim should be submitted as a new original claim. The Payer ID and Billing Provider ID must be the same as what was submitted on the original claim.
2300	**DTP**		**Segment – Repricer Received Date**	
2300	DTP	DTP01	Date/Time Qualifier	'050' <Received>
2300	DTP	DTP03	Date Time Period	Report claim entry date into MCO system
2300	**CN1**		**Segment – Contract Information**	
2300	CN1	CN101	Contract Type Code	Report applicable contract payment arrangement between the Plan and the Provider. Note: The state requires Plans to report '05' when the plan has a capitated arrangement with the billing provider.
2300	AMT	AMT02	Monetary Amount	Report Co-pay Amount applied to the claim
2300	**REF**		**Segment - Payer Claim Control Number**	

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2300	REF	REF01	Reference Identification Qualifier	"F8" (Original Reference Number)
2300	REF	REF02	Reference Identification	<Payer Claim Control Number> Include the original ERN of the previously adjudicated claim when CLM05-3 <Claim Frequency Code> indicates this claim is a replacement “7” or void "8".
2300	**HI**		**Segment - Diagnosis Related Group (DRG) Information**	
2300	HI	HI01-1	Code List Qualifier Code	‘DR’ Note: Required on all institutional claims regardless of how they are paid
2300	HI	HI01-2	Industry Code	A valid Utah DRG code is required on all institutional claims regardless of how they are paid.
2300	**HI**		**Segment – Value Information**	
2300	HI	HI01-2 thru HI12-2	Industry Code	<Value Code Information> Use 80 to report Covered Days Use 81 to report Non Covered Days Use 82 to report Co-Insurance Days Use 83 to report Lifetime Reserve Days

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2300	HI	HI01-5 thru HI12-5	Monetary Amount	Report total number of Covered Days, Non-Covered Days, Co-Insurance Days, or Lifetime Reserve Days.
2300	**HCP**		**Segment - Claim Pricing/Repricing Information**	**If paid at header level, required at header. If fully denied, segment is required at header.**
2300	HCP	HCP01	Pricing Methodology	When reporting denied claims use '00' Not Covered Under Contract. When reporting paid amount based on a staff model use '02' Priced at the standard Fee schedule.
2300	HCP	HCP02	Monetary Amount	<Repriced Allowed Amount> Put in 0, when there is 00 in HCP01 Paid amount from MCO when there is 02 in HCP01. Report this value when paid or denied at the header level as applicable.
2310D			**Loop – Rendering Provider Name**	
2310D	**REF**		**Segment – Rendering Provider Secondary Identification**	
2310D	REF	REF01	Reference Identification Qualifier	"G2" (Provider Commercial Number)

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2310D	REF	REF02	Reference Identification	Only use if REF01 is used. In the case of atypical provider or providers that do not have an NPI report PRISM Provider ID.
2320			**Loop - Other Subscriber Information**	**The 2320 Loop must be reported for each plan including the MCO.**
2320	**SBR**		**Segment - Other Subscriber Information**	
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	P - Primary payer S – Secondary Payer T – Tertiary Payer If the patient has other insurance, report Primary payer coverage with code “P” and any other insurance with codes “S” or “T”, as appropriate, for Secondary or Tertiary. If the patient has no other insurance, report the health plan coverage with "P". NOTE: PMHPs and Dental should NOT consider the member’s Utah Medicaid physical health plan the primary payer.
2320	SBR	SBR03	Reference Identification	<Insured Group or Policy Number> Subscriber’s group number (assigned by the other payer), not the number that uniquely identifies the subscriber.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
				When reporting MCO Payer information use State assigned 9-digit PRISM Location ID.
2320	SBR	SBR09	Claim Filing Indicator Code	"MC" (Utah Medicaid) when plan is reporting itself
2320	**CAS**		**Segment – Claim Level Adjustments**	**Report Denial Reasons in this segment. Information should match both CARC (Claim Adjustment Reason Code) and RARC (Remittance Advice Remark Codes) reported in 835 to the provider.** **A CAS Segment should be reported for each SBR loop.**
2320	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment
2320	CAS	CAS02	Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made
2320	CAS	CAS03	Monetary Amount	Adjustment amount.
2320	**AMT**		**Segment – Coordination of Benefits (COB) Payer Paid Amount**	**An AMT Segment should be reported for each SBR Segment.**
2320	AMT	AMT01	Amount Qualifier Code	Use 'D' to indicate Payer Amount Paid.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2320	AMT	AMT02	COB Payer Paid Amount	Amount paid by Payer identified in the SBR Segment.
2320	**MIA**		**Segment – Inpatient Adjudication Information**	**Report all RARC codes associated to other payer adjustments for Inpatient claims in this segment**
2320	MIA	MIA01	Quantity	Covered Days or Visits Count
2320	MIA	MIA05	Reference Identification	Value reported by other payer
2320	MIA	MIA20	Reference Identification	Value reported by MCO on 835 or value received from other payer
2320	MIA	MIA21	Reference Identification	Value reported by MCO on 835 or value received from other payer
2320	MIA	MIA22	Reference Identification	Value reported by MCO on 835 or value received from other payer
2320	MIA	MIA23	Reference Identification	Value reported by MCO on 835 or value received from other payer
2320	**MOA**		**Segment – Outpatient Adjudication Information**	**Report all RARC codes associated to other payer adjustments for Outpatient claims in this segment**

Commented [CA1]: What does this even mean

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2320	MOA	MOA03	Reference Identification	Value reported by MCO on 835 or value received from other payer
2320	MOA	MOA04	Reference Identification	Value reported by MCO on 835 or value received from other payer
2320	MOA	MOA05	Reference Identification	Value reported by MCO on 835 or value received from other payer
2320	MOA	MOA06	Reference Identification	Value reported by MCO on 835 or value received from other payer
2320	MOA	MOA07	Reference Identification	Value reported by MCO on 835 or value received from other payer
2330A			**Loop - Other Subscriber Name**	**Use the name of the subscriber as it appears on the files of the other payer.**
2330A	**NM1**		**Segment - Other Subscriber Name**	
2330A	NM1	NM108	Identification Code Qualifier	"MI" (Member Identification Number).
2330A	NM1	NM109	Identification Code	<Other Insured Identifier> Use the unique beneficiary number assigned to the subscriber by the other payer indicated in Loop - 2330B Other Payer Name.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2330B			**Loop - Other Payer Name**	**Loop - 2330B Other Payer Name, segment NM1 is required for all encounters. It is within this loop that the health plan is required to report themselves as an Other Payer.** **If there are other payers identified as having financial responsibility for the services being reported, the health plan would report them in subsequent iterations of Loop - 2330B.**
2330B	**NM1**		**Segment - Other Payer Name**	
2330B	NM1	NM108	Identification Code Qualifier	"PI" (Payer Identification)
2330B	NM1	NM109	Identification Code	<Other Payer Primary Identifier> When reporting Health Plan information use State assigned 9-digit PRISM Location ID
2330B	**REF**		**Segment - Other Payer Claim Control Number**	
2330B	REF	REF01	Reference Identification Qualifier	"F8" (Original Reference Number)
2330B	REF	REF02	Reference Identification	Plan’s internal Claim ID

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2400			**Loop - Service Line Counter**	**Note that the HIPAA mandated implementation guide allows a maximum of 999 repetitions of Loop - 2400 Service Line Number within each Loop - 2300 Claim Information.**
2400	**REF**		**Segment – Line Item Control Number**	
2400	REF	REF02	Reference Identification	<Line Item Control Number> It is recommended that providers submit a unique line item control number for each line submitted.
2400	**HCP**		**Segment - Line Pricing/Repricing Information**	**If paid at line level, required at line. Always report this segment for denied lines.**
2400	HCP	HCP01	Pricing Methodology	"00" (Zero Pricing (Not Covered Under Contract)) Use 00 When the line has been denied by the plan and should not be used for duplicate checking "02" (Priced at the Standard Fee Schedule)
2400	HCP	HCP02	Monetary Amount	<Repriced Allowed Amount> Put in 0, when there is 00 in HCP01 Line paid amount from MCO when there is 02 in HCP01. Report this segment when paid or denied at the line level as applicable.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2410			**Loop – Drug Identification**	
2410	**LIN**		**Segment – Drug Identification**	
2410	LIN	LIN02	Product/Service ID	N4 – National Drug Code
2410	LIN	LIN03	NDC	NDC is required on all outpatient claims with drugs containing a NDC in addition to the HCPCS/CPT code. Do not submit hyphens or spaces.
2430			**Loop - Line Adjudication Information**	
2430	**SVD**		**Segment - Line Adjudication Information**	**Report this loop for each Payer.**
2430	SVD	SVD01	ID Code	When reporting MCO Payer information use State assigned 9-digit PRISM Location ID. Do not report the 9-digit PRISM Location ID when reporting another payer's adjudication information.
2430	SVD	SVD02	Monetary Amount	Payer Paid Amount.

Loop ID	Segment ID	Data Element ID	Loop/Segment/Element Name	Companion Guide Rules
2430	**CAS**		**Segment - Line Adjustment**	**Report Denial Reasons in this segment. Information should match both CARC (Claim Adjustment Reason Code) and RARC (Remittance Advice Remark Codes) reported in 835 to the provider. A CAS Segment should be reported for each SBR loop.**
2430	CAS	CAS01	Claim Adjustment Group Code	Claim Adjustment Group Code
2430	CAS	CAS02	Claim Adjustment Reason Code	Claim Adjustment Reason Code
2430	CAS	CAS03	Monetary Amount	Adjustment Amount

Commented [CA2]: Make more clear

8 ACKNOWLEDGEMENTS AND/OR REPORTS

Implementation Acknowledgment for Health Care Insurance (999) – ASC X12N/005010X231

Edits for syntactical quality of the functional group or implementation guide compliance are documented in the 999 Acknowledgement and are returned for all batch Inbound transactions.

An Accepted 999 means the transaction file was accepted into the system for processing. A Rejected 999 means the file transmitted does not comply with the HIPAA standards identified by the syntactical analysis or implementation guide compliance.

The 999 Acknowledgment will identify the segment name, segment location (line number), Loop ID, and data element in error. For multiple errors, all errors found will be listed in the 999 Implementation Acknowledgment. Errors must be corrected before resubmitting the Inbound transaction.

Interchange Acknowledgment

The Interchange Acknowledgment (TA1) report provides the capability for the interchange receiver to notify the sender that a valid envelope was received, or that problems were encountered with the interchange control structure. The TA1 verifies the envelopes only. It is unique in that it is a single segment transmitted without the GS/GE envelope structure.

The TA1 Acknowledgment encompasses the interchange control number, interchange date and time, interchange acknowledgment code, and the interchange note code. The interchange control number and interchange date and time are identical to those that were present in the transmitted interchange from the trading partner. This provides the capability to associate the TA1 with the transmitted interchange.

TA104, the 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, the Interchange Note Code, is a numerical code that indicates the error found while processing the interchange control structure. Values for this data element indicate whether the error occurred at the interchange or functional group envelope.

EDI submitters wishing to receive a TA1 Acknowledgment must request it through data elements ISA14, using data element “1” in the transmitted interchange. If a TA1 Acknowledgment is not requested and the submitted EDI file has an envelope error, Medicaid will not generate or send an acknowledgment for the file.

9 TRADING PARTNER AGREEMENTS

Contact UHIN at: https://uhin.org or call (877) 693-3071 for membership enrollment information and Web Services connection. UHIN will assign a Trading Partner Number (TPN) for EDI.

Providers who elect to submit or receive electronic transactions using a third-party such as a billing agent, clearinghouse, or network service may not need to contact UHIN to acquire a TPN if the billing agent, clearinghouse, or network service has obtained a TPN on their behalf.

Providers who wish to exchange electronic transactions with Medicaid must complete the provider enrollment application through PRISM including all EDI steps.

If submitting through a billing agent, clearinghouse or UHIN, associate the TPN to each transaction (based on business needs). Different TPNs may be used for each transaction excluding 835, 834, and 820. For PRISM Electronic Batch submission, identify the transactions to be submitted through this method.

Utah Medicaid does not offer EDI software. It is the responsibility of the Provider to procure software capable of generating an X12 transaction, that is compatible with their Practice-Management software to meet their business needs.

Some software vendors charge for each transaction type (claims, eligibility, reports, and remittance advice). There is no federal regulation as to how much a software vendor can charge for the software license or their services.

UHIN provides software for UHIN members, and it can be downloaded from https://uhin.org. For assistance with the download, contact UHIN at (877) 693-3071.

Providers using a billing company or clearinghouse, contact the billing company or clearinghouse for software. Proprietary software can be used provided it meets HIPAA standards and the mandated CAQH CORE Operating Rules requirements.

10 TRANSACTION SPECIFIC INFORMATION

The information under this section is intended to help the trading partner understand the business context of the 837I transactions, where applicable.

Utah Medicaid only supports Batch 837I transactions.

Access to the 837I transactions by Batch transactions requires trading partners to register online with Medicaid and define usage of these transactions. Click the following link to register: https://medicaid.utah.gov/become-medicaid-provider/. An EDI Enrollment Tutorial is also available at: https://medicaid.utah.gov/pe-training.

Providers must be enrolled and open with Utah Medicaid for the date of service being reported. Utah Medicaid Providers with an open NPI or Provider ID can transmit an 837I transaction.

For Inbound Transactions, colon (:) is not accepted in any non-composite fields. If submitted, file will be rejected with a SNIP level error in the respective TA1/999 Acknowledgement Response file.

Principal Diagnosis code and Other Diagnosis Code segments combined should not contain the same diagnosis code more than once. All other diagnosis codes can only be entered once within each individual 2310 HI segment (Admitting Diagnosis, Patient's Reason for Visit, or External Cause of Injury) based off the situational rules in the implementation guide. Utah Medicaid will not accept claims with duplicate diagnoses in the same segment.

Medicaid Trading Partner Numbers (TPN)

Providers must submit 837I transactions to the following mailbox:

HT000004-002

Test Trading Partner Number:

HT000004-003

Replacement and Void Claims

If the original claim was rejected, make the necessary correction(s) and resubmit the claim as an original claim.

Use "7" as the Claim Resubmission Code for Replacement claims and "8" for Void claims.

The MCO Payer ID (2330B – NM109) and Billing Provider ID on the original claim must match the Payer ID and Billing Provider ID being submitted on the replacement or voided claim, otherwise the claim will be rejected.

The Encounter Reference Number (ERN) of the claim to be replaced or voided must be reported. Do not submit hyphens or spaces when reporting the ERN.

If the ERN of the original claim cannot be identified in the Utah Medicaid system, or the claim has already been reprocessed, the replacement/void claim will be rejected.

A replacement claim voids the original claim. The replacement claim is then processed in the Utah Medicaid system as an original claim.

If there is a line item that was not accepted on the original claim, it is not necessary to submit a replacement claim. You may submit a new claim with the services not accepted on the original claim.

If additional units are being added to an already accepted dental procedure code, or you are changing dental procedure codes, a replacement claim must be submitted.

Batch Transactions

Utah Medicaid accepts and supports Batch Health Care Claim: Institutional (837) transactions. For every 837I transaction submitted, system responds with a Health Care Claim Acknowledgement (277) transaction. Once all the encounter claims submitted in an 837I transaction are adjudicated, system responds with a 277CA transaction.

If a Trading Partner Number is shared between multiple providers, acknowledgment and response files generated for the Trading Partner Number will not be accessible from PRISM screens to download.

For questions regarding 837I transaction, Utah Medicaid Manage Care EDI Customer Support team may be contacted by email: MHC-EDI@utah.gov.

APPENDICES

Appendix A – IMPLEMENTATION CHECKLIST

1. Acquire a Utah ID at https://id.utah.gov/login.
2. Create an account (username and password).
3. Enroll as a Utah Medicaid Provider.
4. Acquire a Trading Partner Number from billing agent, clearinghouse, or UHIN (Not applicable to PRISM Electronic Batch).
5. Register transactions to be submitted to Utah Medicaid.
6. Register Trading Partner Number online with Utah Medicaid (billing agent, clearinghouse, or UHIN).
7. Contact UHIN for Acceptance Testing and Connectivity testing (billing agent, clearinghouse, or UHIN Submission).
8. Test with Utah Medicaid.
9. Go live with Utah Medicaid.

Appendix B – BUSINESS SCENARIOS

1. Trading Partners are required to submit provider and MCO payer information. Utah Medicaid will validate the NPI and MCO Payer ID for all providers sending electronic claims (837I) transactions.
2. Billing Replacement and Void Claims, Use Claim Resubmission Code "7" for Replacement claim, and "8" for Void Claims.

Transmission Examples

1. NPI and Payer ID validation:

Billing NPI Providers					
Loop	**Segment**	**Name**	**Code**	**Length**	**Notes/Comments**
2010AA	NM101	Entity ID Code	85	2	Billing Provider
2010AA	NM108	Identification Code Qualifier	XX		Qualifier for the National Provider ID (NPI) must be submitted if reporting an NPI
2010AA	NM109	Billing Provider Identifier		10	The Billing NPI must be reported here. If billing with a Group

Billing NPI Providers					
Loop	**Segment**	**Name**	**Code**	**Length**	**Notes/Comments**
					NPI, use group NPI here and report the Rendering Provider NPI in the Rendering loop.
2330B	NM109	Identification Code		9	When reporting Health Plan information use State assigned 9-digit PRISM Location ID. There should be association between the Payer and the Billing provider NPI.

2. Replacement and Void Claim

Replacement Claim					
Loop	**Segment**	**Name**	**Code**	**Length**	**Notes/Comments**
2300	CLM05-3	Claim Frequency Code	7		Replacement of Prior Claim
2300	REF01	Reference Identification Qualifier	F8		Original Reference Number qualifier
2300	REF02	Reference Identification			ERN of the claim being replaced

Void Claim					
Loop	**Segment**	**Name**	**Code**	**Length**	**Notes/Comments**
2300	CLM05-3	Claim Frequency Code	8		Void/Cancel of Prior Claim

Void Claim					
Loop	**Segment**	**Name**	**Code**	**Length**	**Notes/Comments**
2300	REF01	Reference Identification Qualifier	F8		Original reference number qualifier
2300	REF02	Reference Identification			ERN of the claim being voided

Appendix C – FREQUENTLY ASKED QUESTIONS

The following is a compilation of Questions and Answers relative to Utah Medicaid and its providers.

1. Does Utah Medicaid return acknowledgements for an 837I encounter submission?

   Utah Medicaid will return a 999 Implementation Acknowledgement for Health Care Claims (837I). This report will identify if the submitted 837I was Accepted or Rejected.

   A 277CA Health Care Claim Acknowledgement is returned after the adjudication of 837I encounter transaction that has been accepted on the 999 Acknowledgement.

   An Accepted claim on the 277CA Acknowledgement is provided with a TCN.

   A Rejected claim on this report is provided with a TCN and claim status codes associated to the errors.

   Use the Claim Status Codes from the HIPAA Code Listing at: https://x12.org/Codes to determine why the claim was rejected.

2. What Trading Partner Number should a provider use to send the electronic claims (837I) to?

   Providers billing Utah Medicaid should submit electronic encounter claims (837I) transaction to the following TPN:

   HT000004-002

3. Does Medicaid require testing?

   MCO's are not required to test but, it is recommended to complete Acceptance Testing with UHIN prior to submitting testing to Utah Medicaid. Contact Medicaid's Managed Care EDI team to coordinate testing at MHC-EDI@utah.gov.

4. Who do I contact for EDI Customer Support?

The UHIN Help Desk can be contacted at either (877) 693-3071 or by email at customerservice@uhin.org.

Trading Partners may contact Utah Medicaid for assistance in researching problems with submitted EDI transactions. Utah Medicaid will not edit Trading Partner data or resubmit transactions for processing on behalf of a Trading Partner. The Trading Partner must correct any transmission or data errors found and resubmit.

Utah Medicaid Manage Care EDI Customer Support team may be contacted by email: MHC-EDI@utah.gov.

Notes: Do not send non-encrypted PHI to this email address.

If Utah Medicaid receives a regular, unencrypted email containing protected health information (PHI), there may be some risk that the information in the email could be intercepted and read by a third-party during transmission.

This may be a reportable incident under the HIPAA Privacy and Security Rules. Please follow your organization's incident reporting procedure and notify your compliance officer.

If you need to send PHI or other sensitive information to us electronically, we strongly encourage you to use a secure method.

EDI Customer Support hours are Monday through Friday from 8 A.M. to 5 P.M.

EDI Customer Support is closed during Federal and State Holidays.

Utah Medicaid will broadcast messages through the Medicaid Information Line, ListServ, and through UHIN alerts for unexpected system down time, for unexpected delay in generation and transmission of EDI reports, delay in the release of provider payments, to announce the release of new or interim Medicaid Information Bulletin (MIB), and so forth.

To sign up for the Medicaid ListServ, click: https://medicaid.utah.gov/utah-medicaid-official-publications.

Trading partners may also sign up to receive UHIN alerts for urgent broadcast and notification sent by various Utah Payers including Utah Medicaid at: http://www.uhin.org.

Appendix D – LEGEND

Table 5 provides the color legend for Table 3 and Table 4.

Table 5. Legend of Colors

This color signifies a Loop information.
This color signifies a Segment within a Loop.

This color signifies a Composite Element within a Segment.

Appendix E – CHANGE SUMMARY

Date	Description	Change Summary
02/26/2021	Initial Submission	N/A
01/17/2023	Final Submission	N/A