# Ohio Administrative Code

## Rule 5160-1-20 Electronic data interchange (EDI) trading partner enrollment and testing.

Effective: December 1, 2022

(A) For purposes of this rule, the following definitions apply:

(1) "Covered entity" has the same meaning as in 45 C.F.R. 160.103 (as in effect on October 1, 2021).

(2) "Electronic data interchange (EDI) transactions" are transactions developed by standards development organizations recognized by the federal centers for medicare and medicaid services (CMS) and adopted by the Ohio department of medicaid (ODM). The different EDI transactions are as follows:

(a) "American national standards institute (ANSI) X12 270 eligibility, coverage, or benefit inquiry" is a transaction used to inquire about the eligibility, benefits or coverage under a subscriber's health care policy.

(b) "ANSI X12 271 eligibility, coverage, or benefit information response" is a transaction used to communicate information about, or changes to, eligibility, benefits, or coverage.

(c) "ANSI X12 274 provider information" is a transaction used to exchange demographic and educational or professional qualifications about health care providers between providers, provider networks, or any other entity that maintains or verifies health care provider information.

(d) "ANSI X12 275 patient information" is a transaction used to communicate individual patient information requests and patient information (either solicited or unsolicited) between separate care entities in a variety of settings.

(e) "ANSI X12 276 health care claim status request" is a transaction used to request the status of a health care claim.

(f) "ANSI X12 277 health care claim status notification" is a transaction used to respond to a request

regarding the status of a health care claim.

(g) "ANSI X12 278 health care services review information request and response" is a transaction used to transmit health care service information for the purpose of referral, certification, authorization, notification, or reporting the outcome of a health care services review.

(h) "ANSI X12 820 premium payment" is a transaction used to make a payment or send a remittance advice.

(i) "ANSI X12 834 monthly member roster or enrollment and disenrollment in a health plan" is a transaction used to establish communication between the sponsor of the insurance product and the payer.

(j) "ANSI X12 835 health care claims payment and remittance advice" or "835 remittance advice" is a transaction used to make a payment or send an explanation of benefits remittance advice.

(k) "ANSI X12 837 health care claim" is a transaction used to submit health care claim billing or encounter information, or both, from providers (institutional, professional, or dental) of health care services to payers, either directly or via clearinghouses.

(3) "Trading partner" is a covered entity as defined in 42 C.F.R. 160.103 (as in effect October 1, 2021) that submits, receives, routes, or translates EDI transactions directly related to the administration or provision of medical assistance provided under a public assistance program.

(B) Responsibilities of trading partners.

(1) To enroll as an EDI trading partner with ODM under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and be issued a trading partner number, a covered entity completes and submits to ODM the following:

(a) The electronic trading partner form available at https://medicaid.ohio.gov.

(b) The ODM form 06306 "Designation of an 835 or 834-820 Trading Partner" (rev. 4/2017). This

form is submitted only if the trading partner will be receiving the 835 remittance advice on behalf of its clients.

(c) A trading partner agreement. Trading partner agreements are to be signed by an authorized representative of the trading partner.

(2) Once the medicaid trading partner number is assigned, the trading partner submits EDI transactions for the testing process in accordance with paragraph (C) of this rule.

(C) Testing criteria for trading partners.

(1) All trading partners are to abide by all ODM testing criteria as outlined in paragraph (C)(2) of this rule and in the trading partner enrollment and testing information guide available at www.medicaid.ohio.gov.

(2) The testing criteria to be met is as follows:

(a) Trading partners are to submit three files per the following transaction types and pass testing: 837 (professional, institutional, dental), 270 (eligibility), and 276 (claim status inquiry).

(b) Trading partners are to test the transaction types they will be submitting in production.

(c) For batch transactions, each file is to contain a minimum of fifty claims, claim status inquiries, or eligibility inquiries.

(d) For real-time transactions of types 270 and 276, provide at least three real-time submissions for each transaction type.

(e) All EDI files are to completely pass X12 integrity testing, HIPAA syntax, and HIPAA situation testing. Trading partners are expected to modify their EDI files in accordance with new federally mandated HIPAA standards.

(f) During testing, trading partners may submit one claim file per day, per 837 transaction (one

professional, one institutional, and one dental), one eligibility inquiry, and one claim status inquiry per day. Multiple tests per day are accepted for real-time transactions of types 270 and 276.

(D) Passing criteria for transactions tested.

(1) Files containing the 270 eligibility transaction are considered passing when a successful 271 response is received without error codes 73 (invalid or missing subscriber) or 75 (subscriber not found).

(2) Files containing the 275 patient information transaction are considered passing when a successful 999 response is received.

(3) Files containing the 276 claim status transaction are considered passing when a valid 277 response is received with the requested claim information.

(4) Files containing the 278 service request transaction are considered passing when a valid 278 response is received without error codes 04 (authorized quantity exceeded) or 79 (invalid participant identification).

(5) Files containing the 837 health care claim transaction are considered passing when at least ninety per-cent of the claims are in paid status after test adjudication.

(E) Trading partners that are not actively submitting and receiving 837 health care claim transaction sets but who are actively submitting and receiving 270/271 and 276/277 transaction sets are to provide, in a manner specified by ODM, a report of all providers by national provider identifier (NPI) that the trading partner represents. The first report is due at the time of initiating a trading partner agreement with ODM. Subsequent reports are due quarterly based on the calendar year, no later than January first, April first, July first and October first. If the necessary reports are not submitted, the trading partner agreement will be denied or terminated, as applicable.

(F) If a trading partner does not submit or receive EDI transactions for a period of two years or longer, ODM may terminate the trading partner agreement without notice.

(G) Trading partners are responsible for any breach of information and will be held fully liable for any and all costs related to such a breach.