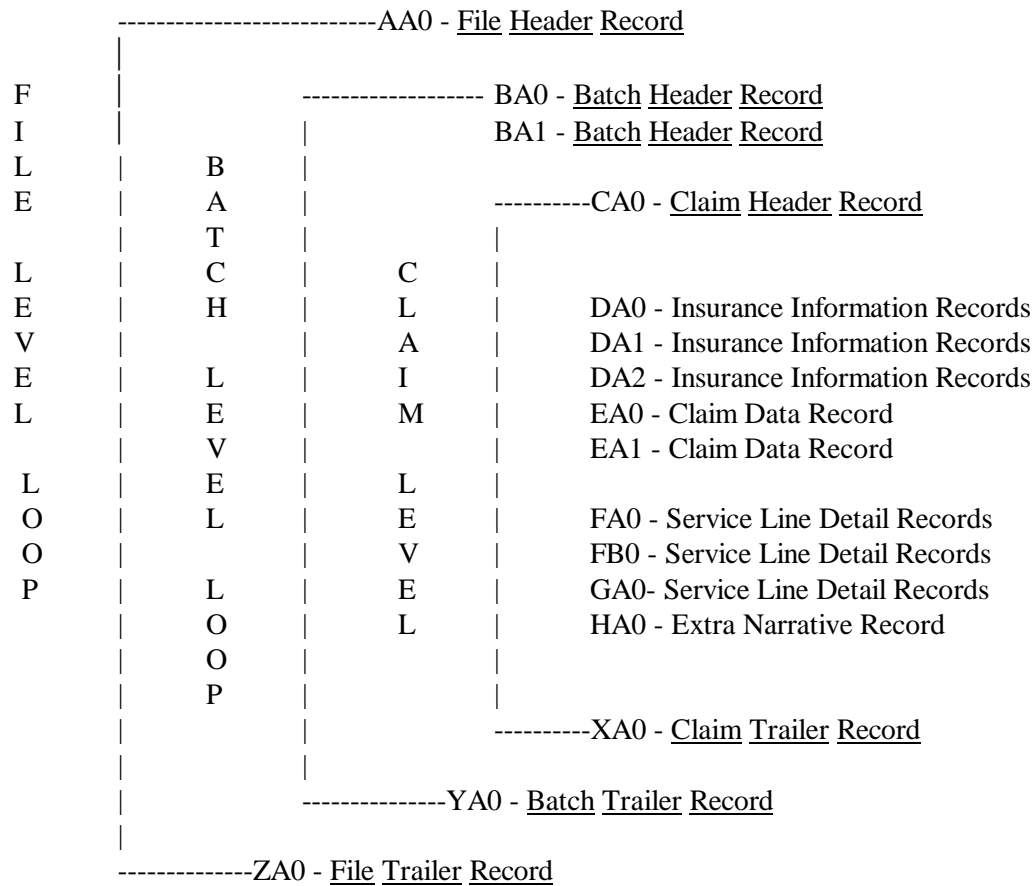


## SECTION 11 - HMO BLUE MEDICAID

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# FILE LAYOUT - GRAPHIC ILLUSTRATION



## RECORD OCCURRENCE CHART

AA0 & ZA0	A submission may contain multiple files. The total record count for the file cannot exceed 9,999,999 records.
BA0, BA1, YA0	A file may contain up to 9,999 batches. All batches within the file must be for the same payor.
CA0 & XA0	A batch may contain 9,999,999 claims. All claims within the batch must be for the same provider number.
DA0	There must be one DA0 record per claim and there cannot be more than three DA0 records per claim.
DA1, DA2,	None to three occurrences per claim.
EA0, EA1	One per claim is required.
FA0	One per claim is required. Cannot exceed 27 per claim.
FB0, GA0, HA0	None to 27 per claim.
CA1, CB0, DA3 EA2, FB1, FB2 FB3, FD0, FE0 GC0, GD0, GD1 GE0, GP0, GU0 GX0, GX1, GX2	These records are not utilized/recognized by HMO Blue Medicaid.

## NSF FIELD REQUIREMENTS HMO BLUE MEDICAID

FIELD	RECORDS															
	A A 0	B A 0	B A 1	C A 0	D A 0	D A 1	D A 2	E A 0	E A 1	F A 0	F B 0	G A 0	H A 0	X A 0	Y A 0	Z A 0
01.0	R	R	C	R	R	C	C	R	C	R	C	C	C	R	R	R
02.0	R				R	R	R			R	R	R	R		R	R
03.0		R		C	C	C	C	C	C	C	C	C	C	C		
04.0	R			R	R	C		R	C					R	R	
05.0	R	R		R	R			R		R			R	R		R
06.0					R	C								R		R
07.0					R	C		C		R		C		R		R
08.0				R		C				R		C		R	R	R
09.0				R	C					R		C		R	R	R
10.0					C					C		C		R	R	
11.0										C		C			R	
12.0		R						C				C		R		
13.0										R		C				
14.0					C	C				R		C				
15.0	R				C	C										
16.0												C				
17.0	R				C											
18.0	R				R					R		C		C		
19.0	R	R			R					C		C				
20.0	R	R			R			C		C		C				
21.0	R											C				
22.0	R					C					R	C				
23.0						C				C	R	C				
24.0				R		C						C				
25.0																
26.0																
27.0																
28.0																

## NSF FIELD REQUIREMENTS HMO BLUE MEDICAID

FIELD	RECORDS															
	A A 0	B A 0	B A 1	C A 0	D A 0	D A 1	D A 2	E A 0	E A 1	F A 0	F B 0	G A 0	H A 0	X A 0	Y A 0	Z A 0
29.0																
30.0																
31.0																
32.0								R								
33.0								C								
34.0								C								
35.0								C								
36.0																
37.0																
38.0																
39.0								C								
40.0 THRU 95.0																

## **FIELD REQUIREMENT DEFINITIONS HMO BLUE MEDICAID**

**AA0-02.0 SUBMITTER IDENTIFIER**  
Submitter ID's are assigned by Texas Health Information Network (THIN). THIN will only use the first six positions. Must be identical to the submitter identifier in file trailer (ZA0-02.0) and must match the Login ID used to access rEDI-link Blue. Contact the EDI Helpline for the correct submitter identification number.

*FILE REJECT - MESSAGE 121*

**AA0-04.0 SUBMISSION TYPE**  
Indicate the input medium or method used to transmit the data.

**AA0-05.0 SUBMISSION NUMBER**  
Must be six digit alpha-numeric value for each submission. No embedded blanks or special characters are allowed. Duplicate file IDs for a submitter (AA0-02.0) submitted within six months will be rejected.

*FILE REJECT - MESSAGE 107, 112*

**AA0-15.0 CREATION DATE**  
Indicate the date the file was created.

**AA0-17.0 RECEIVER IDENTIFICATION**  
Must equal "MDHMO" for HMO Blue Medicaid. Must equal receiver identification in file trailer (ZA0-04.0).

*FILE REJECT - MESSAGE 124*

**AA0-18.0 RECEIVER TYPE CODE**  
Must equal "D for HMO Blue Medicaid.

*FILE REJECT - MESSAGE 123*

**AA0-19.0 VERSION CODE - NATIONAL**  
Current version code is 00301. We will continue to accept version 001.04 and 002.00 until further notice.

*FILE REJECT - MESSAGE 113*

**AA0-20.0 VERSION CODE - LOCAL**  
Current version code is 00301. We will continue to accept version 001.04 and 002.00 until further notice. Must match National Version Code (AA0-19.0).

- AA0-21.0 TEST/PRODUCTION INDICATOR**  
All files are handled as production unless:
- This field contains “TEST”,
  - The provider has not completed and returned all the necessary EDI Enrollment and Agreement forms.
  - The submitter is not flagged as production in the BCBSTX submitter file.

- AA0-22.0 PASSWORD**  
Required for all submissions. The password is assigned by THIN. Must be six digit alpha-numeric. Contact the EDI Helpline for verification of the password.

*FILE REJECT - MESSAGE 122*

- BA0-03.0 BATCH TYPE**  
Batch type “100”.

*BATCH REJECT - MESSAGE 201*

- BA0-05.0 BATCH IDENTIFICATION**  
Must be six digit alpha-numeric value for each batch ID. No embedded blanks or special characters are allowed. Duplicate batch IDs for a billing provider (BA0-12.0) submitted within six months will be rejected.

*BATCH REJECT - MESSAGE 205, 212*

- BA0-12.0 PROVIDER MEDICAID NUMBER**  
Must be nine digit Medicaid solo or Group Number.

*BATCH REJECT - MESSAGE 243*

- BA0-19.0 PROVIDERS LAST NAME**  
Required.

- BA0-20.0 PROVIDERS FIRST NAME**  
Required.

- CA0-03.0 PATIENT CONTROL NUMBER**  
If a patient control number is given, it must match the patient control number entered in all records for the specific claim.

- CA0-04.0 PATIENT LAST NAME**  
Must be entered even if the same as the insured.

*BATCH REJECT - MESSAGE DBB*

- CA0-05.0 PATIENT FIRST NAME**  
Must be entered even if the same as the insured.

*BATCH REJECT - MESSAGE DBB*

**CA0-08.0 PATIENT DATE OF BIRTH**

Must be the patients date of birth.

*BATCH REJECT - MESSAGE DBK*

**CA0-09.0 PATIENT'S SEX**

Valid values are M or F.

*BATCH REJECT - MESSAGE DBH*

**CA0-24.0 TYPE OF CLAIM**

This field is required. Valid values are:

D = Dental

F = Physician/EPSDT Medical

O = Eyeglasses

**DA0-04.0 CLAIM FILING INDICATOR**

Indicate whether or not this record is being provided to obtain payment from the indicated payor or for informational purpose. Valid values are:

P = payment is being requested of this payor

I = payment is not being requested of this payor

**DA0-05.0 SOURCE OF PAYMENT**

If DA0-04.0 = "P", then DA0-05.0 must = D.

If DA0-04.0 = "I", then DA0-05.0 may = any of the following values:

A = Self Pay

B = Workers Compensation

C = Medicare

D = Medicaid

E = Other Federal Program

F = Commercial Insurance Company

H = Champus

I = HMO

J = Federal Employee's Program (FEP)

K = Central Certification

L = Self Administered

M = Family or Friends

N = Managed Care - Non-HMO

P = Blue Cross

T = Title V

V = Veterans Administration Plan (VA)

Z = Other

*CLAIM REJECT - MESSAGES 302, 303, 304, 309*

**DA0-06.0 INSURANCE TYPE CODE**

If DA0-05.0 = "D, DA0-06.0 must =

IP = Individual Policy

- DA0-07.0 PAYOR ORGANIZATION IDENTIFICATION**  
The value is MDHMO.
- DA0-09.0 PAYOR NAME**  
Required if DA0-05.0 indicates other insurance.
- DA0-10.0 GROUP NUMBER**  
Required if DA0-05.0 indicates other insurance.
- DA0-14.0 PRIOR AUTH NO**  
Enter the nine digit pre-certification number.
- DA0-15.0 ASSIGNMENT OF BENEFITS**  
Required. Valid values are:  
Y - Yes  
N - No
- DA0-16.0 PAT SIGNATURE SOURCE**  
Valid values: C - Signed HCFA - 1500 claim form on file.  
S = Signed signature authorization form for Block 12 on file.  
M = Signed signature authorization form for Block 13 on file.  
B = Signed signature authorization form or forms for both Block 12 and Block 13 are on file.  
P = Signature generated by provider because the patient was not physically present for services.
- DA0-17.0 PATIENT RELATIONSHIP TO INSURED**  
Required if DA0-05.0 indicates other insurance.
- DA0-18.0 INSURED IDENTIFICATION NUMBER**  
Must be the insured's nine digit alpha-numeric subscriber ID number.  
  
*CLAIM REJECT - MESSAGE DB2*
- DA0-19.0 INSURED'S LAST NAME**  
Enter the last name of the insured even if the same as the patient.  
  
*CLAIM REJECT - MESSAGE DBA*
- DA0-20.0 INSURED'S FIRST NAME**  
Enter the first name of the insured even if the same as the patient.  
  
*CLAIM REJECT - MESSAGE DBA*
- DA1-04.0 PAYOR ADDR1**  
Required if other insurance is indicated.
- DA1-06.0 PAYOR CITY**  
Required if other insurance is indicated.

- DA1-07.0 PAYOR STATE**  
Required if other insurance is indicated.
- DA1-08.0 PAYOR ZIP**  
Required if other insurance is indicated.
- DA1-14.0 PAYOR AMOUNT PAID**  
Required if DA0-05.0 indicates other insurance. Reflects the total amount paid by the primary payor.
- DA1-15.0 ZERO PAY INDICATOR**  
Required on other insurance claims. Valid values:  
Z - Denied (zero paid) (If DA1-14.0 = 0)  
N - Paid some amount greater than 0 (If DA1-14.0 = > 0)  
BLANK - Not filed or no notification from payor
- DA1-22.0 INS CARD EFFECTIVE DATE**  
Required if other insurance is indicated.
- DA1-23.0 INS CARD TERMINATION DATE**  
Required if other insurance is indicated.
- DA1-24.0 BALANCE DUE**  
Required if other insurance is indicated.
- DA2-12.0 INSURED EMPLOYER NAME**  
Required if other insurance is indicated.
- EA0-04.0 EMPLOYMENT RELATED INDICATOR**  
Must not be blank. Valid values are N or Y.  
  
*CLAIM REJECT - MESSAGE DBL*
- EA0-05.0 ACCIDENT INDICATOR**  
Must not be blank. If condition is not an accident, enter "N".  
When the diagnosis is accident related one of the following is required.  
A for auto  
O for other  
  
*CLAIM REJECT - MESSAGE DBM*
- EA0-07.0 ACCIDENT/SYMPTOM DATE**  
Date is required for the following:  
Accident  
Maternity  
  
*CLAIM REJECT - MESSAGE DBN*

**EA0-20.0 REFER PROV ID NO**

Required on the following types of claims:

Consultation	Radiology
Laboratory	Radiation Therapy
Birth Center	
Ambulatory Surgical Center	

**EA0-32.0 DIAGNOSIS CODE-1**

**EA0-33.0 DIAGNOSIS CODE-2**

**EA0-34.0 DIAGNOSIS CODE-3**

**EA0-35.0 DIAGNOSIS CODE-4**

All claims require a diagnosis code. Please note that ICD-9-CM codes must be coded to the highest level of specificity, i.e., coding to the fourth or fifth digit. The diagnosis code must be valid for the sex and age of the patient.

*CLAIM REJECT - MESSAGE D41, D42, D43*

**EA0-36.0 PROV ASSIGN IND**

Valid values are: Y = Assigned  
N = Not Assigned

**EA0-39.0 FACILITY/LABORATORY NAME**

Required if place of service is other than home or office.

**EA1-04.0 FACILITY/ LAB ID NO**

Required if place of service is other than home or office.

**FA0-05.0 SVC FROM DATE**

The Service FROM Date is required. Date cannot be a future date, must not be prior to patient's date of birth, must not be prior to condition date or prior to the hospital admit date.

*CLAIM REJECT - MESSAGE 337, D01, D02, D03, D04*

**FA0-07.0 PLACE OF SERVICE**

Required. Valid values are:

11, 12, 21, 22, 23, 24, 25, 26, 31, 32, 33, 34, 50, 51, 52, 53, 54, 55, 56, 61, 62, 65, 71, 72, 81, 99.

Refer to Exhibit 4 for definitions of each.

*CLAIM MESSAGE - D08*

**FA0-08.0 TYPE OF SERVICE**

Required. Numeric type of service codes must be right justified and zero filled (“01” not “1”). Alphabetic type of service codes must be left justified and blank filled. Valid values are:

01, 02, 03, 04, 05, 06, 07, 08, 09, C, E, F, G, I, J, L, P, R, S, T.

Refer to Exhibit 1 for definitions of each.

*CLAIM REJECT - MESSAGE D60*

**FA0-09.0 HCPCS PROCEDURE CODE**

Must be from the following coding structures.

CPT-4, HCPCS or locally assigned Medicare carrier or Medicaid codes

**FA0-10.0 HCPCS MODIFIER 1**

**FA0-11.0 HCPCS MODIFIER 2**

Used to modify payment of a procedure or to assist in determining appropriate coverage.

Valid values are: 20, 21, 22, 23, 24, 25, 26, 32, 47, 50, 51, 52, 54, 55, 56, 57, 58, 62, 66, 76, 77, 78, 79, 80, 81, 82, 90, 99, A5, A6, A7, A8, AA, AD, C5, C6, C7, C8, D5, D6, D7, D8, E5, E6, E7, E8, H5, H6, H7, H8,I5, I6, I7, I8, J5, J6, J7, J8, K5, K6, K7, K8, L5, L6, L7, L8, M5, M6, M7, M8, N5, N6, N7, N8, O5, O6, O7, O8, P1, P2, P3, P4, P5, P6, R5, R6, R7, R8, S5, S6, S7, S8, TC, U5, U6, U7, U8, V5, V6, V7, V8, W5, W6, W7, W8.

Refer to Exhibit 3 for a definition of each.

**FA0-13.0 LINE CHARGES**

Required. Must be greater than zero.

*CLAIM MESSAGE - D07*

**FA0-14.0 DIAGNOSIS CODE POINTER 1**

Required.

*CLAIM REJECT - MESSAGE D40*

**FA0-18.0 UNITS OF SVC**

Must be equal to or greater than 001.0. Must be equal to or less than 999.0. This field should equal 0010 when anesthesia minutes are submitted in FA0-19.0.

*CLAIM REJECT - MESSAGE D06*

**FA0-19.0 ANESTHESIA/OXYGEN MINUTES**

This field is required when the type of service is 7. Required when modifiers are AA, QJ, Q0, QQ, QX or QZ.

*CLAIM REJECT - MESSAGE 467*

- FA0-20.0 EMERGENCY INDICATOR**  
Required if CA0-24.0 = D. Valid values are:  
Y - Yes  
N - No
- FA0-23.0 PERFORMING PROVIDER NUMBER**  
Required if the billing provider is a group or MCO. Must be nine bytes, alphanumeric.
- FB0-22.0 EPSDT INDICATOR**  
Required. Valid values are:  
Y - Yes  
N - No
- FB0-23.0 FAMILY PLANNING INDICATOR**  
Valid values:  
Y - Yes  
N - No
- GA0-07.0 TYPE OF TRANSPORT**  
Valid values:  
I - Initial trip  
R - Return trip  
T - Transfer trip  
X - Round trip
- GA0-08.0 BED CONFINED BEFORE**  
Valid values:  
Y - Yes  
N - No
- GA0-09.0 BED CONFINED AFTER**  
Valid values:  
Y - Yes  
N - No
- GA0-10.0 MOVED BY STRETCHER**  
Valid values:  
Y - Yes  
N - No
- GA0-11.0 UNCONSCIOUS/SHOCK**  
Valid values:  
Y - Yes  
N - No
- GA0-12.0 EMERGENCY SITUATION**  
Valid values:  
Y - Yes  
N - No

**GA0-13.0 PHYSICAL RESTRAINTS**

Valid values:

Y - Yes

N - No

**GA0-14.0 VISIBLE HEMORRHAGING**

Valid values:

Y - Yes

N - No

**GA0-16.0 MEDICALLY**

Valid values:

Y - Yes

N - No

**GA0-18.0 ORIGIN INFO**

Required. Enter the address information regarding the origin of the ambulance trip.

**GA019.0 DESTINATION INFO**

Required. Enter the address information regarding the destination of the ambulance trip.

**GA0-20.0 PURPOSE OF ROUND TRIP**

If GA0-07.0 = "X", description must be given.

**GA0-21.0 PURPOSE OF STRETCHER**

If GA0-10.0 = "Y", description must be given.

**GA0-22.0 PATIENT DISCHARGED**

Required when the patient is transported from one facility to another. Valid values are:

Y - Yes

N - No

**GA0-23.0 PATIENT ADMITTED**

Required when the patient is transported from one facility to another. Valid values are:

Y - Yes

N - No

**GA0-24.0 SERVICES AVAILABLE**

Required when the patient is transported from one facility to another. Valid values are:

Y - Yes

N - No

**HA0-05.0 EXTRA NARRATIVE DATA**

Used for general comments about the claim.

**DATE****ALL DATE FIELDS**

If submitted, must be valid dates in CCYYMMDD format.

*CLAIM REJECT - MESSAGE 337*

**STATE****ALL STATE FIELDS**

If submitted, must be valid two-digit state postal abbreviation.

**ZIP****ALL ZIP CODE FIELDS**

If submitted, must be five (5) numerics or nine (9) numerics. May not contain hyphens. The first characters of the zip code must be within the range for the state according to the U. S. Postal Service.

For a complete list of reject messages, refer to Exhibit 5.

## **HMO Blue Medicaid - GENERAL INFORMATION**

- **DIAGNOSIS CODE REQUIREMENTS**

All claims require a diagnosis code.

Diagnosis codes in the External Causes of Injury and Poisoning range (E800 - E999) are not payable as a primary diagnosis.

Diagnosis codes in the Morphology of Neoplasms range (M8000 - M9970) are not acceptable.

Chiropractors must indicate the exact level of subluxation.

- **EMC BILLING LIMITATIONS**

There are no claim types that are not accepted in National Standard Format. If you have questions regarding specific services/claim types, please contact your EMC Marketing Representative.

- **ANESTHESIA SERVICES**

Must use CPT-4 anesthesia procedure codes (00100 to 01999).

## HMO Blue Medicaid - TEST DATA

Section 3 of this Implementation Guide describes the testing process. We recommend that new EDI System Vendors and Submitters include the following claim situations when testing HMO Blue Medicaid. Testing each of these situations, will ensure that all possible claims processing situations have been tested.

### **General Claims -**

- Multiple Place of Services (11, 12, 21, 22, 32...)
- Blue Shield Secondary Insurance to Commercial Narratives
- Assistant Surgery
- Multiple Surgery's
- Solo Practice
- Group Practice (with Performing Provider Id #'s)
- 27 Detail lines

### **Specialty Claim Types -**

- Anesthesia/CRNA (with modifiers, minutes)