Ohio Administrative Code

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

Effective: January 1, 2020

(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, 2018).

(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 defined as follows:

(a) "American national standards institute (ANSI) X12 820 premium payment" is a transaction used to make a payment or send a remittance advice.

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

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

(d) "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.

(e) "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.

(f) "ANSI X12 271 eligibility, coverage, or benefit information response" is a transaction used to

communicate information about, or changes to, eligibility, benefits, or coverage.

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

(h) "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.

(i) "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.

(3) "Trading partner" is a covered entity 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) Trading partners submitting EDI transactions.

(1) Trading partners must meet the definition of a covered entity as defined in paragraph (A)(1) of this rule.

(2) To enroll as a medicaid 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 must complete and submit to ODM the following:

(a) The electronic "Medicaid Trading Partner Form" available at https://medicaid.ohio.gov.

(b) The ODM 06306 "Designation of an 835 or 834-820 Trading Partner" form (rev. 4/2017). This form is required 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 must be signed by an authorized representative of the trading partner.

(3) Once the medicaid trading partner number is assigned, the trading partner is eligible to submit claims, claim status inquiries, or eligibility inquiries for the testing process in accordance with paragraph (C) of this rule.

(C) Testing requirements.

(1) To become an active trading partner with ODM, all trading partners must abide by all ODM testing requirements as outlined in paragraph (C)(2) and in the "Electronic Data Interchange Trading Partner Information Guide" (6/27/2017). The "Electronic Data Interchange Trading Partner Information Guide" is available at https://medicaid.ohio.gov.

(2) The testing requirements that must be met in addition to the requirements listed in the "Electronic Data Interchange Trading Partner Information Guide" are as follows:

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

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

(c) Each file must contain a minimum of fifty claims, claim status inquiries, or eligibility inquiries.

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

(e) During testing, trading partners may submit one claim file per day, per 837 transaction (one professional, one institutional, and one dental) and one eligibility inquiry and one claim status inquiry per day.

(f) Test files are considered passing when ninety per cent of the claims submitted pass the test

adjudication process. A ninety per cent pass rate must be reached for each transaction type tested.

(D) 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 must 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.

(E) Trading partners shall be responsible for any breach of information and be held fully liable for any and all costs relating to such a breach.