# COMMONWEALTH OF VIRGINIA


## Encounter Processing Solution (EPS)

## Medicaid Enterprise System (MES)

## *Companion Guide*

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# For 837 Dental Health Care Encounter Transactions

**ASC X12N 837**

**VERSION 005010X224A2**

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**September 21, 2023**

**Document Version 2.3 (Effective 11/01/2023)**

**Department of Medical Assistance Services (DMAS)**

## CONTACT INFORMATION

Mail Original to: **Virginia Medicaid**
**EDI Coordinator**
**P.O. Box 26228**
**Richmond, VA 23260-6228**

Via Fax: **1-888-335-8460**

Via Email: DMASEDISupport@dmas.virginia.gov

Voice Contact: **1-866-352-0766**

## Publication Version Change Summary

| Version | Date | Revision Description | Prepared By: |
|---|---|---|---|
| 1.0 | 15DEC2017 | DMAS MES 5010 Original Implementation | DMAS |
| 1.1 | 11JAN2018 | Page 5 – Added additional information for Segment DTP Service Date as Segment is required for EPS encounters.<br>Page 9 – Updated TOO02 Tooth Number for values that are valid to be submitted<br>Page 9 – Updated TOO03 to include all 5 data elements | DMAS |
| 2.0 | 06APRIL2018 | Revised for Medallion 4.0 Implementation:<br>Page 3 - Added additional comments to ISA02 – Authorization Information pertaining to Medallion 4.<br>Page 3 - Added additional comments to ISA06 – Interchange Sender ID pertaining to Medallion 4.<br>Page 4 - Added additional comments to GS02 – Application Sender's Code pertaining to Medallion 4.<br>Page 4 - Added additional comments to NM109- Submitter Identifier pertaining to Medallion 4. | DMAS |
| 2.1 | 04MAY2018 | Page 5 – Removed length restriction in Comments for REF02-Reference Number. | DMAS |
| 2.2 | 28FEB2020<br>**Changes effective**<br>**4/17/2020** | Revised for Enhanced Benefits Identification and COB Changes<br>Page 5 - Added new 2000B Loop information for COB.<br>Page 10 – Revised and added additional comments for first<br>K301-Fixed Format Information | DMAS |
| 2.3 | 08JUN2023 | Revised to include new HCP Segments for submission of Allowed Amount. This will be included in both the Claim (2300 Loop) and the service line (2400 Loop).<br>Page 6 – Added new HCP Segment for the 2300 Loop for information required for allowed amount information for the claim.<br>Page 9 – Added new HCP Segment for the 2400 Loop for information required for allowed amount information for each service line. | DMAS |

# TABLE OF CONTENTS

# 1 INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N implementation guides. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

# 2 PURPOSE

This guide is concerned with the processing of batch requests and responses submitted to DMAS for Virginia Medicaid. DMAS adheres to all HIPAA standards and this guide contains clarifications and requirements that are specific to transactions and data elements contained in various segments. This guide is associated with the submission of 837D encounters by contracted MCOs and the DMAS dental program administrator, which are required to submit encounters.

# 3 SPECIAL NOTES

837 Encounters may be sent at any time 24 hours a day, 7 days a week; however, encounters should be submitted on their scheduled submission date based on the agreement established with DMAS. Contact the MCO/Contract Encounter Analyst or the Dental Contract Monitor if a scheduled submission is delayed and needs to be rescheduled.

The TA1, TA1HR, ACK, and the X12ERROR response files will normally be available for pickup 1 hour after file submission unless there are unforeseen technical difficulties. The 999, 999HR, and 277CA response files will be available immediately after the file submission is processed. Refer to the EDI Procedures Manual for more information about the outputs produced during EDI processing.

All references to Medicaid are used for simplicity, but other programs supported by DMAS are also included, such as FAMIS and TDO.

All encounters received will be processed using the NPI.

DMAS uses a Managed File Transfer (MFT) application to transmit batch EDI data into the Virginia Medicaid system. All Service Centers must have applied and been authorized by the Virginia EDI Coordinators office before using MFT to transmit files.

EDI Submitters can upload and retrieve batch files via the MFT application. Please refer to the EDI Procedures Manual for additional information related to using Managed File Transfer.

# 4 DATA ELEMENT DESCRIPTIONS

**Pages A – 99 - Table**

| Page | Loop | Segment | Data Element | Comments |
|---|---|---|---|---|
| C.4 | N/A | ISA | ISA01 - Authorization Information Qualifier | Use “03” - Additional Data Identification |
| C.4 | N/A | ISA | ISA02 – Authorization Information | Use 4-character Service Center ID assigned by DMAS Virginia Medicaid. Values currently in use:<br>CP14 – CP19 for CCC Plus<br>M444 – M449 for Medallion 4 |
| C.4 | N/A | ISA | ISA03 – Security Information Qualifier | Use “00” - No Security Information Present |
| C.4 | N/A | ISA | ISA05 – Interchange ID Qualifier | Use “ZZ” - Mutually defined |
| C.4 | N/A | ISA | ISA06 – Interchange Sender ID | Use to denote Service Center/Service Center Subcontractor relationship as follows in example:<br>CP14000 (Service Center CP14 that has no associated Subcontractor for this transmission)<br>or<br>CP14001 (Service Center CP14 and associated Subcontractor 001).<br>M444000 (Service Center M444 that has no associated Subcontractor for this transmission)<br>or<br>M444001 (Service Center M444 and associated Subcontractor 001) |
| C.5 | N/A | ISA | ISA07 – Interchange ID Qualifier | Use “ZZ” – Mutually defined |
| C.5 | N/A | ISA | ISA08 – Interchange Receiver ID | “VAMES EPS” |
| C.5 | N/A | ISA | ISA11 – Repetition Separator | Use “^” – Carat Separator |
| C.6 | N/A | ISA | ISA14 - Acknowledgment Requested | Use “1” - Interchange Acknowledgement Requested |
| C.6 | N/A | ISA | ISA16 - Component Element Separator | Use “:” – Colon Separator |

| Page | Loop | Segment | Data Element | Comments |
|---|---|---|---|---|
| C.6 | N/A | ISA | Segment Terminator | Use "~" – Tilde Terminator |
| | | | | |
| C.7 | N/A | GS | GS02 – Application Sender's Code | Use 7-character Service Center ID/Service Center Subcontractor ID assigned by DMAS Virginia Medicaid. Use '000' in last 3 characters for Service Center.<br>Examples are:<br>CP14000 indicates Service Center, CP14001 indicates a subcontractor for Service Center CP14.<br>M444000 indicates Service Center, M444001 indicates a subcontractor for Service Center M444 |
| C.7 | N/A | GS | GS03 – Application Receiver's Code | "VAMES EPS" |
| C.8 | N/A | GS | GS08 - Version/Release Industry ID Code | "005010X224A2" |
| | | | | |
| 67 | Beginning of Hierarchical Transaction | BHT | BHT06-Claim or Encounter Identifier | Use RP (Reporting) |
| | | | | |
| 70 | 1000A-Submitter Name | NM1 | NM109- Submitter Identifier | Use 4-character Service Center ID assigned by DMAS Virginia Medicaid. Values currently in use:<br>CP14 – CP19 for CCC Plus<br>M444 – M449 for Medallion 4 |
| 75 | 1000B-Receiver Name | NM1 | NM103-Name Last or Organization Name | Use "Dept of Medical Assistance Services" |
| 75 | 1000B-Receiver Name | NM1 | NM109-ID Code | Use "VAMES EPS" |
| | | | | |
| 78 | 2000A-Billing Provider Specialty Information | PRV | PRV03-Provider Taxonomy Code | Required for Billing Provider NPI submitted. |
| | | | | |
| 84 | 2010AA-Billing Provider Name | NM1 | NM108-Identification Code Qualifier | "XX"- NPI |
| 86 | 2010AA-Billing Provider Name | N3 | N301-Billing Provider Address Line | The Billing Provider Address must be a physical address.<br>Note: Post Office Box or Lock Box addresses are not accepted |

| Page | Loop | Segment | Data Element | Comments |
|---|---|---|---|---|
| 88 | 2010AA-Billing Provider Name | N4 | N403-Billing Provider Postal Zone or Zip Code | The billing provider 9-digit zip code (along with the address information in the 2010AA N3 segment) is required. |
| 89 | 2010AA-Billing Provider Name | REF | REF01-Reference Identification Qualifier | EI-Employer's Identification Number<br>SY-Social Security Number |
| 89 | 2010AA-Billing Provider Name | REF | REF02-Billing Provider Tax Identification Number | When sending the EI qualifier, use the Employer Identification Number.<br><br>When sending the SY qualifier, use the SSN. |

**Pages 100 - 199 - Table**

| Page | Loop | Segment | Data Element | Comments |
|---|---|---|---|---|
| 111 | 2000B-Subscriber Hierarchical Level | SBR | SBR01- Payer Responsibility Sequence Number Code | Must indicate Medicaid responsibility sequence (matching 2320 SBR01 Other Subscriber Information for Medicaid). |
| 113 | 2000B-Subscriber Hierarchical Level | SBR | SBR09- Claim Filing Indicator Code | Must indicate "MC" Medicaid. |
| 115 | 2010BA-Subscriber Name | NM1 | NM108-Identification Code Qualifier | Use "MI". |
| 116 | 2010BA-Subscriber Name | NM1 | NM109-Subscriber Primary Identifier | Use the 12-digit Member ID Number assigned by Virginia Medicaid. |
| | | | | |
| 125 | 2010BB-Payer Name | NM1 | NM103- Payer Name | Use "VAMES EPS". |
| 125 | 2010BB-Payer Name | NM1 | NM108-Identification Code Qualifier | Use "PI". |
| 125 | 2010BB-Payer Name | NM1 | NM109- Payer Identifier | Use "DMAS MEDICAID". |
| | | | | |
| 146 | 2300-Claim Information | CLM | CLM01-Claim Submitter's ID | For encounters, this should be the submitter's claim number ID. |
| 154 | 2300-Claim Information | DTP-Service Date | DTP03-Service Date | For encounters, this segment is required and must be submitted. This is the date of services for all services performed. |
| 168 | 2300-Claim Information | REF-Payer Claim Control Number | REF02-Reference Identification | For encounters, use the submitter's original claim number ID. |

| Page | Loop | Segment | Data Element | Comments |
|---|---|---|---|---|
| 178 | 2300 – Claim Information | K3-File Information | K301-Fixed Format Information | This K3 segment/field is used to submit the data required for encounters needed by DMAS for rate setting. The information supplied will be in the exact format as the CN1 Segment fields CN101 – CN106. This information is being requested to be used with the K3 Segment as the CN1 Segment is not HIPAA compliant. The format for K301 is:<br>K3*CN101-99 CN102-9999999.99 CN103-999 CN104-xxx CN105-999 CN106-xxxx.<br>The CN101 field for this K3 segment is required and the remaining fields are optional.<br>Note: The data values needed for all supplied fields are described in the 837D 5010 TR3 Guide on Pages 162-163.<br>Examples are as follows:<br>K3*CN101-01 CN102-50.23 CN103-34 CN104-AB1 CN105-57 CN106-V01 (all 6 fields supplied) or<br>K3*CN101-09 CN106-V01 (2 fields supplied) or<br>K3*CN101-04 (required field only)<br>Note:<br>• There should be at least one space between each field<br>• Each pair must have one hyphen between field and value<br>• Fields can be in any order<br>• No hyphen (-) allowed in the value |
| 186 | 2300 – Claim Information | HCP | HCP01-Pricing Methodology | This element is used for the claim header allowed amount information required for submission to DMAS. Value is 03 (Priced at Contractual Percentage) |
| 186 | 2300 – Claim Information | HCP | HCP02-Monetary Amount | This element is used for the claim header allowed amount information required for submission to DMAS. Value will be the amount allowed for the claim. |
| | | | | |
| 199 | 2310B - Rendering Provider Name | PRV | PRV03-Provider Taxonomy Code | Required when Rendering Provider NPI is submitted. |
| | | | | |

| Page | Loop | Segment | Data Element | Comments |
|---|---|---|---|---|
| 207 | 2310C - Service Facility Location | N4 | N403-Laboratory or Facility Zip code | The Service Facility zip code (along with the address information in the **2310C N3** segment) is required when the place of service is different than the billing zip code in 2010AA, N403. Providers are required to submit the 9- digit zip code. |
| | | | | |
| 221 | 2320 - Other Subscriber Information | SBR | | If the patient has Medicare or other coverage, repeat this loop for each payer with associated payment amounts. Additionally, one iteration of this loop must be used to represent the Medicaid coverage with the payment amount for any associated Medicaid expenditures. The EPS Service Center payer ID value is identified in Loop 1000A NM109 and must equal Loop 2330B NM109 value for Medicaid payments. |
| 222 | 2320- Other Subscriber Information | SBR | SBR01 - Payer Responsibility Sequence Number Code | Ensure that the MC (Medicaid) value is always the last payer in sequence |
| 224 | 2320-Other Subscriber Information | SBR | SBR09-Claim Filing Indicator Code | Use the following codes as applicable for this field:<br>MA to indicate Medicare A as payer<br>MB to indicate Medicare B as payer<br>MC to indicate Medicaid as payer (required)<br>OF to indicate Medicare D as payer<br>Other values as listed in the 837D TR3 Guide are acceptable. |
| 231 | 2320 - Other Subscriber Information | AMT - COB Payer Paid Amount | AMT02 - Payer Paid Amount | All payments associated for the encounter should be reported using this segment for the appropriate payer. The payment amount for any associated Medicaid expenditures must be reported. |

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|---|---|---|---|---|
| 247 | 2330B-Other Payer Name | NM1 | NM109-Other Payer Primary ID# | NM109 in Loop 2330B must match the value in SVD01 in Loop 2430. For EPS encounters, the 4-character Service Center ID assigned by Virginia Medicaid will be used. |
| | | | | |
| 285 | 2400-Service Line Counter | SV3 | SV304-1 thru SV304-5 - Oral Cavity Designation Code | If submitted, values are '00', '01', '02', 10', '20', '30' or '40'. |
| 288 | 2400-Service Line Counter | TOO | TOO02-Tooth Code | If submitted, values are:<br>01 – 32 or 1 – 9 and 10 – 32 for Permanent Teeth,<br>51 – 82 for Supernumerary Permanent Teeth<br>A – T for Primary Teeth<br>AS – TS for Supernumerary Primary Teeth |
| 289 | 2400-ServiceLine Number | TOO | TOO03-1 thru TOO03-5 – Tooth Surface Code | If submitted, values are B, D, F, I, L, M, or O |

**Pages 300 - 399 - Table**

| Page | Loop | Segment | Data Element | Comments |
|---|---|---|---|---|
| 309 | 2400-Service Line | K3-File Information | K301-Fixed Format Information | This K3 segment/field is used to convey if the service line was paid or denied and is a required for all service lines. Additionally, this K3 segment is used to identify if the paid or denied service line was an enhanced benefit based on the submitter's contract with DMAS. The format for this K301 field is:<br>Paid Service not an Enhanced Benefit<br>K3*PYMS-P<br>Paid Service is an Enhanced Benefit<br>K3*PYMS-P EBIN-Y<br>Denied Service not an Enhanced Benefit<br>K3*PYMS-D<br>Denied Service is an Enhanced Benefit<br>K3*PYMS-D EBIN-Y<br>Examples are as follows:<br>K3*PYMS-P~<br>K3*PYMS-D~<br>K3*PYMS-P EBIN-Y~<br>K3*PYMS-D EBIN-Y~ |
| 309 | 2400-Service Line | K3-File Information | K301-Fixed Format Information | This K3 segment/field is used to submit the data required for encounter service lines that may be different than the K3 Segment for CN1 information in Loop 2300 needed by DMAS for rate setting. The format for this segment is identical to the K3 Segment for the CN1 information in Loop 2300.<br>Note: This should reflect the payment arrangement between the MCO and the provider that rendered the service. |
| 312 | 2400-Service Line | HCP | HCP01-Pricing Methodology | This element is used for the service line allowed amount information required for submission to DMAS. Value is 03 (Priced at Contractual Percentage) |
| 312 | 2400-Service Line | HCP | HCP02-Monetary Amount | This element is used for the service line allowed amount information required for submission to DMAS. Value will be the amount allowed for the service line. |
| | | | | |
| 318 | 2420A-Rendering Provider Name | NM1 | NM108-Identification Code Qualifier | XX - NPI |
| 318 | 2420A-Rendering Provider Name | NM1 | NM109-Rendering Provider Identifier | Use National Provider Identification (NPI) |

| Page | Loop | Segment | Data Element | Comments |
|---|---|---|---|---|
| 319 | 2420A-Rendering Provider Name | PRV | PRV03-Provider Taxonomy Code | DMAS requires taxonomy codes on encounters when the provider has enumerated with separate NPIs based on the type of service being provided. |
| | | | | |
| 338 | 2420D-Service Facility Location | N4 | N403-Laboratory or Facility Postal Zone or Zip Code | The Service Facility zip code (along with the address information in the 2420C N3 segment) is required when the place of service is different than the billing zip code in 2010AA, N403 or 2310C, N403. Providers are required to submit the 9-digit zip code when available. |
| | | | | |
| 341 | 2430-Line Adjudication Information | SVD | SVD01-Other Payer Primary Identifier | For EPS encounters, SVD01 must match the value in NM109 in Loop 2330B. The 4-character Service Center ID assigned by Virginia Medicaid will be used. This element is mandatory. |
| 342 | 2430-Line Adjudication Information | SVD | SVD02-Service Line Paid Amount | The amount paid for each service line shall be reported in this field for associated payments, including Medicaid (MC) related payments. This element is mandatory |
| 347 | 2430-Line Adjudication Information | CAS | CAS02-Claim Adjustment Reason Code | For EPS encounters, use CAS02 Claim Adjustment Reason Code (Code Source 139) to indicate denial of payment reduction reason for the service line. |
| 351 | 2430-Line Adjudication Information | DTP | DTP03-Adjudication or Payment Date | This is the date the encounter (claim) line was paid to the provider in the CCYYMMDD format. This element is mandatory. |