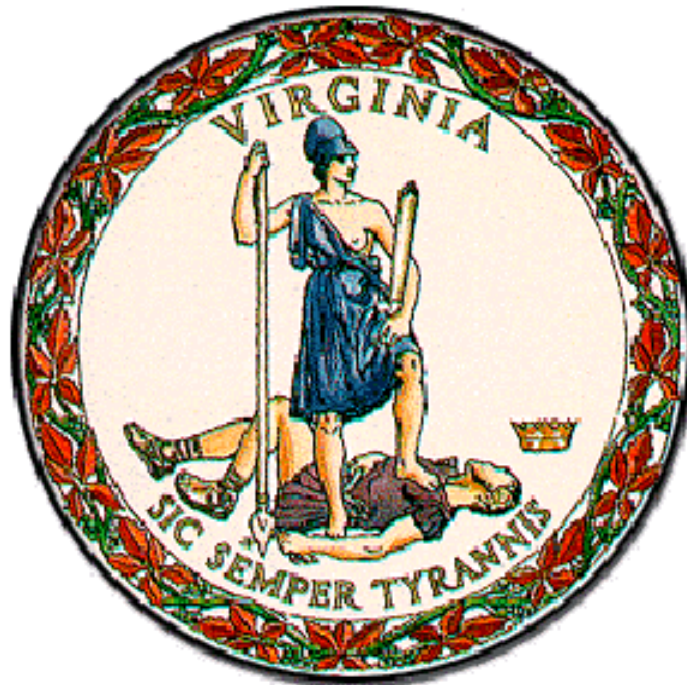


COMMONWEALTH OF VIRGINIA



Encounter Processing Solution (EPS)

Medicaid Enterprise System (MES)
Companion Guide

**For 837 Dental Health Care Encounter
Transactions**

ASC X12N 837
VERSION 005010X224A2

February 28, 2020
Document Version 2.2

Department of Medical Assistance Services (DMAS)



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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. Page 9 – Updated TOO02 Tooth Number for values that are valid to be submitted Page 9 – Updated TOO03 to include all 5 data elements	DMAS
2.0	06APRIL2018	Revised for Medallion 4.0 Implementation: Page 3 - Added additional comments to ISA02 – Authorization Information pertaining to Medallion 4. Page 3 - Added additional comments to ISA06 – Interchange Sender ID pertaining to Medallion 4. Page 4 - Added additional comments to GS02 – Application Sender’s Code pertaining to Medallion 4. 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 Changes effective 4/17/2020	Revised for Enhanced Benefits Identification and COB Changes Page 5 - Added new 2000B Loop information for COB. Page 10 – Revised and added additional comments for first K301-Fixed Format Information	DMAS



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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/admsimp/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.



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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: CP14 – CP19 for CCC Plus 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: CP14000 (Service Center CP14 that has no associated Subcontractor for this transmission) or CP14001 (Service Center CP14 and associated Subcontractor 001). M444000 (Service Center M444 that has no associated Subcontractor for this transmission) or 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



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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. Examples are: CP14000 indicates Service Center, CP14001 indicates a subcontractor for Service Center CP14. 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: CP14 – CP19 for CCC Plus 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. Note: Post Office Box or Lock Box addresses are not accepted



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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 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. 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.



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Page	Loop	Segment	Data Element	Comments
178	2300 – Claim Information	K3-File Information	K301-Fixed Format Information	<p>This K3 segment/field is used to convey the date encounter was received by the MCO, the date adjudicated by the MCO, the date paid by the MCO, the date for resubmissions from the MCO (if appropriate), and the payment status (Paid/Denied) of the encounter. The format for K301 is: K3*DREC-CCYYMMDD DADJ-CCYYMMDD DPYM-CCYYMMDD DRES-CCYYMMDD PYMS-P~ (Paid) or PYMS-D~ (Denied) Examples are as follows: For a paid encounter: K3*DREC-20170101 DADJ-20170105 DPYM-20170111 PYMS-P~ For a denied encounter: K3*DREC-20170101 DADJ-20170105 DPYM-20170111 PYMS-D~ For resubmission of a paid encounter: K3*DREC-20170101 DADJ-20170105 DPYM-20170111 DRES-20170115 PYMS-P~ For resubmission denied encounter: K3*DREC-20170101 DADJ-20170105 DPYM-20170111 DRES-20170115 PYMS-D~</p>



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Page	Loop	Segment	Data Element	Comments
178	2300 – Claim Information	K3-File Information	K301-Fixed Format Information	<p>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:</p> <p>K3*CN101-99 CN102-9999999.99 CN103-999 CN104-xxx CN105-999 CN106-xxxx.</p> <p>The CN101 field for this K3 segment is required and the remaining fields are optional.</p> <p>Note: The data values needed for all supplied fields are described in the 837D 5010 TR3 Guide on Pages 162-163.</p> <p>Examples are as follows: K3*CN101-01 CN102-50.23 CN103-34 CN104-AB1 CN105-57 CN106-V01 (all 6 fields supplied) or K3*CN101-09 CN106-V01 (2 fields supplied) or K3*CN101-04 (required field only)</p> <p>Note:</p> <ul style="list-style-type: none"> • There should be at least one space between each field • Each pair must have one hyphen between field and value • Fields can be in any order • No hyphen (-) allowed in the value
192	2310A-Referring Provider Name	NM1	NM109-Referring Provider Identifier	Submit the Referring Provider's NPI in this field.
199	2310B - Rendering Provider Name	PRV	PRV03-Provider Taxonomy Code	Required when Rendering Provider NPI is submitted.
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.



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Page	Loop	Segment	Data Element	Comments
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: MA to indicate Medicare A as payer MB to indicate Medicare B as payer MC to indicate Medicaid as payer (required) OF to indicate Medicare D as payer 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: 01 – 32 or 1 – 9 and 10 – 32 for Permanent Teeth, 51 – 82 for Supernumerary Permanent Teeth A – T for Primary Teeth 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



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Pages 300 - 399 - Table

Page	Loop	Segment	Data Element	Comments
309	2400-Service Line	K3-File Information	K301-Fixed Format Information	<p>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:</p> <p>Paid Service not an Enhanced Benefit K3*PYMS-P Paid Service is an Enhanced Benefit K3*PYMS-P EBIN-Y Denied Service not an Enhanced Benefit K3*PYMS-D Denied Service is an Enhanced Benefit K3*PYMS-D EBIN-Y</p> <p>Examples are as follows: K3*PYMS-P~ K3*PYMS-D~ K3*PYMS-P EBIN-Y~ K3*PYMS-D EBIN-Y~</p>
309	2400-Service Line	K3-File Information	K301-Fixed Format Information	<p>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.</p> <p>Note: This should reflect the payment arrangement between the MCO and the provider that rendered the service.</p>
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)
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.



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Page	Loop	Segment	Data Element	Comments
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.