COMMONWEALTH OF VIRGINIA

Medicaid Enterprise System (MES)
Encounters Processing Solution (EPS)

Encounters Technical Manual

for

Cardinal Care Managed Care
FFS Non-Emergency Medical Transportation
FFS Dental

April 16, 2024
Document Version 3.2

Department of Medical Assistance Services (DMAS)

Document Version Control

Date	Document Version	Updated By	Description
8/18/21	3.0	DRH	Version 3.0 is a major update to the manual. The description of prior version updates has been removed. Prior version updates are available upon request, if needed.
8/18/21	3.0	DRH	**Section 1: Introduction and Purpose** Removed statement that the manual is applicable to all encounter that are processed in the MES/EPS. Added statement regarding examples that are included in the document. Added list of encounter uses.
8/18/21	3.0	DRH	**Section 2: Encounter Processing Solution (EPS) in the MES System** Enhanced verbiage to accompany EPS diagram. Renamed & reorganized section by adding subsections (see below)
8/18/21	3.0	DRH	**Section 2.1: Overview** Enhanced verbiage to provide description of EPS process flow
8/18/21	3.0	DRH	**Section 2.2: EPS Production Environment** Added new section
8/18/21	3.0	DRH	**Section 2.3: EPS Test Environment** Added new section
8/18/21	3.0	DRH	**Section 2.4: DMAS Support** Added new section. Subsection 2.4.3 now contains DMAS Contact Information which was relocated from top of document. NEMT added to Contact chart.
8/18/21	3.0	DRH	**Section 3.1.4: Test File Submission** Section removed
8/18/21	3.0	DRH	**Section 3.1.5: Production File Submission** Section removed
8/18/21	3.0	DRH	**Section 3.2.2: Service Center and Subcontractor Identifiers** Clarified verbiage
8/18/21	3.0	DRH	**Section 3.2.3: Paid & Denied Encounters** Enhanced verbiage
8/18/21	3.0	DRH	**Section 3.2.5: Payer Claim Identifier** Added further detail to include that unique Payer Claim ID is within Subcontractor ID.
8/18/21	3.0	DRH	**Section 3.2.6: National Provider Identifier (NPI) / Atypical Provider Identifier (API)** Removed "Atypical Provider Identifier (API)" from section label. Removed reference to PSF-113 file.
8/18/21	3.0	DRH	**Section 3.2.7: Provider Taxonomy** Added further detail with reference to PSF-113
8/18/21	3.0	DRH	**Section 3.2.8: Duplicate Encounter Transactions** Split duplicate check into 3 levels for clarification. Added that level 1 duplicate check constitutes subcontractor ID + Payer Claim ID, instead of Payer Claim ID alone. Added Fill Number as part of the NCPDP duplicate key.
8/18/21	3.0	DRH	**Section 3.2.9: Transportation Services** This section has been reorganized and enhanced. Updates have been made to clarify details and to add transportation requirements that have been previously communicated via email but not reflected in the prior version of the manual. Section 3.2.9 should be reviewed in its entirety.
8/18/21	3.0	DRH	**Section 3.2.10.1: Adjudication/Payment Info - Additional Dates & Payment Status** Updated Document & Line Level Payment Status (PYMS) definition

Date	Document Version	Updated By	Description
8/18/21	3.0	DRH	**Section 3.2.10.2: Adjudication/Payment Info – Payment Amount & Date** Clarified verbiage concerning zero-paid claims. Updated verbiage for Service Line Adjudication/Payment Info requirements for Medicaid and TPL payers. Enhanced documentation to include NCPDP transactions.
8/18/21	3.0	DRH	**Section 3.2.10.2.1: Adjudication/Payment Info - Single Payer** Service line adjudication/payment info must always be reported for Medicaid payers. Added NCPDP example.
8/18/21	3.0	DRH	**Section 3.2.10.2.2: Adjudication/Payment Info - Third-Party Liability (TPL)** Service line adjudication/payment info for third-party payers must be reported when available. Added NCPDP example.
8/18/21	3.0	DRH	**Section 3.2.12.2: Drug Services – 340B Drugs** Removed Basis of Cost requirement for identifying 340B drugs. Also, removed Submission Clarification Code occurrence restriction of 1.
8/18/21	3.0	DRH	**Section 3.2.13.3: Consumer Directed Attendants - Reporting Attendant Overtime** Added new section
8/18/21	3.0	DRH	**Section 3.2.13.4: Consumer Directed Attendants - EVV Requirement Exemption** Added new section
8/18/21	3.0	DRH	**Section 3.2.15: Dental Services** Added new section
8/18/21	3.0	DRH	**Section 3.2.16: Enhanced Benefit Services** Added new section
8/18/21	3.0	DRH	**Section 3.2.17: Supplemental Encounter Data for Reporting** Added new section
8/18/21	3.0	DRH	**Section 3.3: Encounter Testing Requirements** Added new section
8/18/21	3.0	DRH	**Section 4.1.1 : EPS-assigned File Identifier** Corrected EPS File ID layout
8/18/21	3.0	DRH	**Section 5.2: Correcting Encounter Data in EPS – Using the RESUBMISSION method** Added restrictions for updating claim frequency when using the EPS RESUBMISSION method.
8/18/21	3.0	DRH	**Section 7: EPS Cache Code Sets** Added new section
5/19/23	3.1	DRH	**Section 2.1: Overview** Updated reference to provider services in MES
5/19/23	3.1	DRH	**Section 3.2.7: Provider Taxonomy** Changed reference from PSF-113 file to PRSS
5/19/23	3.1	DRH	**Updated the manual for FFS Dental in the sections below.** Section 1: Introduction and Purpose Section 2.4.3: FFS Dental (new section) Section 2.4.4: DMAS Contact Information Section 3.2.1: EDI Transactions Section 3.2.15: Dental Services Section 4.1.1: EPS-assigned File Identifier Section 4.1.2: EPS-assigned Transaction Control Number (TCN) Section 6: Business Rules

Date	Document Version	Updated By	Description
4/16/24	3.2	DRH	Updated contract references to reflect Cardinal Care Managed Care in place of CCC Plus and Medallion 4. Changes made in the sections below. **Section 1: Introduction and Purpose** **Section 2.4: DMAS Support** **Section 3.2.17.1: Supplemental Encounter Data Requirements** **Section 6: EPS Business Rules**
4/16/24	3.2	DRH	**Section 3.2.13 Consumer-Directed, Agency-Directed, & Home Health Services** Section has been renamed and rewritten to include Electronic Visit Verification (EVV) requirements for Consumer-Directed, Agency-Directed, and Home Health services.
4/16/24	3.2	DRH	**Section 3.2.18 Reporting Allowed Amount** New section added
4/16/24	3.2	DRH	**Section 3.3: Cardinal Care Managed Care Encounter Testing – Expectations & Timeline** Section has been renamed and rewritten to include new subsections and updated requirements.

Version Effective Dates

Document Version	Effective Date
3.0	08/18/2021
3.1	05/19/2023
3.2	04/16/2024

Table of Contents

1 Introduction and Purpose

This document provides information and guidance for external contractors submitting encounter data for Virginia Medicaid. The information in this document applies to all managed care organizations for the Cardinal Care Managed Care program, the Commonwealth's fee-for-service (FFS) non-emergency transportation broker (NEMT), and the Commonwealth's FFS dental administrator. Additional information and requirements are documented in the Virginia Medicaid Encounters Companion Guides and the Data Quality Scorecard evaluation guide, when applicable.

The encounter data is used for administrative and analytic purposes such as those specified below. It is essential that the encounter data be complete, accurate and timely to provide for the effective utilization of the data.

- Evaluate health care quality
- Rate setting - Capitation & FFS
- Determine Disproportionate Share (DSH), Behavioral Health risk adjustments, Chronic Illness and Disability Payment System risk adjustments
- Supplemental payments, Value-based payments, Quality withhold payments, Performance withhold incentive payments
- Financial forecasting
- Drug rebates
- Data analysis for decision making
- Virginia General Assembly reporting
- CMS reporting
- Evaluate contractor performance

In general, unless otherwise specified in the Companion Guides or this document, the encounter data should match the claims data.

For purpose and clarity of this document, please refer to the definitions below:

- The term "Contractor" refers to any entity that contracts with DMAS, under the State Plan and in return for a payment, to process claims, to pay for or provide medical services, or to enhance DMAS' capability for effective administration of the program.
- The term "Subcontractor" refers to an individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under its contract with DMAS.
- The term "Payer" refers to an entity that adjudicates and/or provides payment of the claim to the provider. The Payer and the Contractor may be the same entity. Or, the Payer and the Subcontractor may be the same entity.
- The term "Contract" refers to a specific contract or managed care program, such as Cardinal Care Managed Care services, FFS Non-emergency Transportation services, or FFS Dental services.
- The term "MCO" refers to a Managed Care Organization.

This manual provides examples on various topics. It should be noted that examples may not be provided on all topics and for all transaction types. This does not mean that the encounter requirement is not applicable in those instances where an example is not provided.

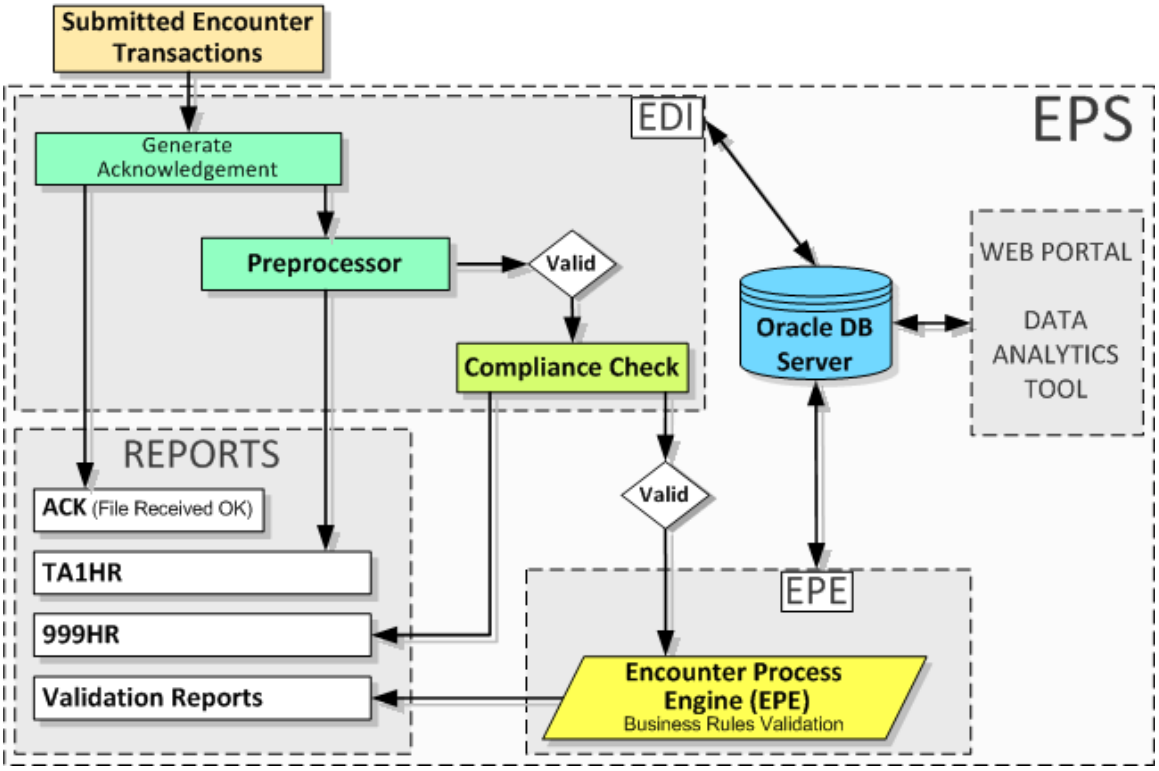
2 Encounter Processing Solution (EPS) in the MES system

2.1 Overview

The Encounter Processing Solution (EPS) is a primary component of Virginia's new Medicaid Enterprise System (MES). The Virginia MES is an integrated set of functional and operational processes that complies with the CMS Medicaid Information Technology Architecture (MITA) initiative. This initiative is intended to foster integrated business and IT transformation across the Medicaid enterprise (including all external vendors) to improve the administration of the Medicaid program. The key MES components that interface with the EPS are as follows:

- Member demographics, eligibility, and enrollment
- Provider Services Solution (PRSS) for provider demographics, taxonomy, and enrollment
- Reference data for validation and lookup
- Enterprise Data Warehouse Solution (EDWS) for data quality assessment and reporting
- Medicaid Pharmacy Benefit Manager (PBM) Contractor for collection of pharmacy rebates

As shown in the diagram below, the EPS process flow includes: intake of encounter files from external submitters, EDI compliance check, EPS business rule validation, and generation of response reports (processing results) for the submitter. Encounter transactions are stored in EPS and later extracted for other MES components and downstream systems, including a data warehouse where encounter data is available for detailed analysis.



2.2 EPS Production Environment

The EPS production environment is available for the intake of encounter files 24 hours a day, 7 days a week with the exception of the **EPS system maintenance window on Friday at 7pm until Saturday at 2am, ET**. **Encounter files should not be submitted during the EPS system maintenance window.** Most EPS software deployments and system changes, including updates to the EPS business rules, occur during this window.

2.3 EPS Test Environment

The EPS trading partner test (TPT) environment is available 24 hours a day, 7 days a week for the submission of test encounter files. As a general rule, production implementations are deployed to the TPT environment several days after the production environment is updated. This approach may be project-dependent as there are situations where Contractors will want to test the compatibility of changes on their side against the new encounter requirements in EPS. When this is the case, the DMAS encounter teams will communicate this approach along with the new requirements for the project.

The encounter data content in the TPT environment will not always mirror the encounter data content on the EPS production side. Periodic refreshes are made in the TPT environment to load production member and provider files. Typically, encounter transactions are only refreshed from production when necessary for specific projects. Because the TPT environment is not refreshed as regularly as production, member and provider edits are set as informational edits in the TPT environment. Informational edits are not displayed on the response reports that are returned to the submitter.

The TPT environment should not to be used for routine submission of production files with the intent to preview EPS processing results. Production encounter files may be submitted to the TPT environment on a limited basis when Contractors are testing specific implementations.

2.4 DMAS Support

2.4.1 Cardinal Care Managed Care (CCMC) Encounters

The Cardinal Care Managed Care contract is managed across two divisions within the DMAS organizational structure. Each division has encounter team members thereby constituting a dedicated team and encounter mailbox for support for both Acute and MLTSS encounters.

As part of the ongoing support, the CCMC encounter team conducts a monthly encounter review meeting to review the status of encounter projects, correction of encounter failures, and general oversight of encounter submissions. While the attendance of this meeting is open to all MCO staff, subcontractors and third-party administrators are not included routinely without special permission from DMAS. Subcontractors and third-party administrators may attend the meeting without DMAS approval when specific projects or issues necessitate their attendance.

The CCMC encounter team also facilitates ad hoc meetings when needed. These meetings may be requested by the MCO or the DMAS encounter teams to cover such topics as encounter requirement clarification, encounter correction guidance, and other daily operation support topics.

2.4.2 FFS Non-Emergency Medical Transportation Encounters

The DMAS FFS Transportation team supports and manages the intake and processing of encounters that are submitted by the DMAS transportation broker. They work closely with the broker to communicate encounter requirements and expectations. The team is available to provide guidance and answer questions when needed.

In addition, the DMAS FFS Transportation team is a major resource to the CCMC encounter team in providing support for defining encounter requirements, EPS business rules, and analyzing managed care transportation encounters. The teams work closely together to promote encounter data consistency for fee-for-service and managed care transportation encounters.

2.4.3 FFS Dental Encounters

The DMAS FFS Dental team supports and manages the intake and processing of encounters that are submitted by the DMAS dental administrator. They work closely with the dental administrator to communicate encounter requirements and expectations. The team is available to provide guidance and answer questions when needed.

2.4.4 DMAS Contact Information

DMAS Encounter Support	DMAS Contact
Cardinal Care Managed Care: General Encounter Support EPS Business Rules Encounter Data Quality Scorecard Encounter File Certifications EPS/Payment Cycle Reconciliation Encounter Technical Manual MES/EPS Companion Guides Trading Partner Testing EDI Compliance Check	Primary Contact: CCMCEncounters@dmas.virginia.gov Copy: Please copy each CCMC encounter team member
FFS NEMT: General Encounter Support EPS Business Rules Encounter Data Quality Scorecard Encounter File Certifications EPS/Payment Cycle Reconciliation Encounter Technical Manual MES/EPS Companion Guides Trading Partner Testing EDI Compliance Check	Primary Contact: Transportation@dmas.virginia.gov
FFS Dental: General Encounter Support EPS Business Rules Encounter File Certifications EPS/Payment Cycle Reconciliation Encounter Technical Manual MES/EPS Companion Guides Trading Partner Testing EDI Compliance Check	Primary Contact: michele.anderson@dmas.virginia.gov Copy: lisa.bilik@dmas.virginia.gov
DMAS EDI Support: EDI Enrollment Forms/Registration Package Trading Partner Agreements MFT GoAnywhere Access (FTP) /Availability/Issues EDI File Submission EPS Response Files EPS Portal Access/Availability/Issues	Primary Contact: DMASEDISupport@dmas.virginia.gov For CCMC items, copy: CCMCEncounters@dmas.virginia.gov For FFS NEMT items, copy: Transportation@dmas.virginia.gov For FFS Dental items, copy: michele.anderson@dmas.virginia.gov
Note	
Group mailboxes are to be used by DMAS contracted entities and their designees only	

3 Encounter Requirements

This section covers EPS file and data requirements for all types of encounters.

3.1 Encounter Files

3.1.1 File Requirements

FILE REQUIREMENTS	REQUIREMENT DETAILS
Each encounter file must contain 5,000 transactions or less.	Transaction count is based on the following: 837 = CLM segment count NCPDP = G1 segment count
Subcontractor encounters must be submitted to DMAS by the Contractor.	Subcontractors may not submit encounter files directly to DMAS.
The Contractor must submit subcontractor encounters in separate files to DMAS. Each subcontractor file(s) should be mutually exclusive (i.e. separate file(s) for Pharmacy, separate file(s) for Vision, separate file(s) for Transportation, etc.).	Subcontractor encounters must not be included in the same file as the Contractor's encounter data or with another subcontractor's encounter data.
Only one EDI Interchange is allowed per 837 file.	EDI Interchange = All segments between and including the ISA segment and the IEA segment
File-naming convention for encounter files is unrestricted.	Files may be named in any manner. It is recommended that a standard file extension be used. (Example: .837, .TXT, .EDI, etc.)
EDI file delimiters are restricted.	For 837 files, the following delimiters must be used: Data element separator = asterisk (*) Component element separator = colon (:) Repetition separator = caret (^) Segment terminator = tilde (~)

3.1.2 File Submission Guidelines

Please see the *COV EDI Procedure Manual* for instructions on how to submit Encounter files. Encounter files should follow the submission guidelines below.

FILE SUBMISSION GUIDELINES	GUIDELINE DETAILS
The number of files that may be posted for routine file submission is unlimited.	There is no limit to the number of files that may be submitted per day or week for routine file postings. (Routine = approximately one payment cycle plus corrections to encounters from the prior payment cycle).
File submission frequency is unlimited.	Files may be submitted daily. Corrections to encounter data may be submitted same-day as original posting. Corrections may be posted multiple times per day. Files may be submitted 24/7.
Large encounter backlogs must be discussed with DMAS prior to submission.	DMAS will work with the Contractor to create a backlog submission schedule for large backlogs.

3.1.3 Duplicate Encounter Files

The EDI Preprocessor will evaluate the preexistence of EDI files with same contents that were previously submitted using a hash value calculated using the SHA-256 algorithm. By comparing hash values, the preprocessor ensures that a duplicate file is not created. Duplicate encounter files are not allowed. The discovery of an exact duplicate will halt further processing and a TA1 response will be created. For X12 files, the ISA, GS, ST, BHT, SE, GE, and IEA segments are not included in the hash total.

EPS also checks for duplicates at the transaction level. See section 3.2.8.

3.2 Encounter Data

3.2.1 EDI Transactions

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all covered entities must use standard transaction sets when exchanging certain information. In accordance with the law, DMAS uses HIPAA transaction sets as the standard for Virginia Medicaid encounter data submission.

The ANSI X12 Technical Report Type 3 (TR3) and the National Council for Prescription Drug Programs (NCPDP) are the official standard for electronic submission of health care encounter data. Nothing in this documentation is intended to conflict or contradict the ANSI X12 TR3 or NCPDP Implementation Guide.

HIPAA adopted national code sets for use in all transaction sets. These code sets include most of the information currently codified in the UB92 and CMS 1500 paper claims and their electronic counterparts. DMAS will only allow valid procedure codes that are adopted for national use and will not accept local codes.

DMAS currently requires use of a variation of the Provider-to-Payer-to-Payer COB model of the 837 transaction sets, Version 5010, Addendum 2 for facility and professional services. For prescription drugs, the mandated transaction set is the NCPDP Batch Version D.0 Telecommunication Standard. As new versions of the transaction sets are adopted by HIPAA, DMAS will use the newer versions in accordance with HIPAA requirements.

All EDI transactions should pass an EDI compliance check (SNIP Levels 1, 2, 3, 4) before the Contractor submits the encounter data to DMAS.

The matrix below, based on billing entity, should be used to determine which EDI transaction type is appropriate for the reporting the encounter.

Billing Entity	Transaction
Inpatient Urgent Care Facility	837 Institutional
Outpatient Urgent Care Facility	837 Institutional
Inpatient Mental Health Facility	837 Institutional
Outpatient Mental Health Facility	837 Institutional
Federally Qualified Health Center	837 Professional
Long Term Care Facility	837 Institutional
Skilled Nursing Facility	837 Institutional
Home Health Provider	Either 837 Institutional or 837 Professional, depending on contract between the MCO and the provider.
Pharmacy Benefit Manager	NCPDP
Retail Pharmacy	NCPDP
Hospital Pharmacy	837 Institutional
Independent Laboratory	837 Professional
Hospital-based Laboratory	837 Institutional
Non-Emergency Medical Transportation	837 Professional
Emergency Transportation	837 Professional
Hospital-based Clinic	837 Institutional
Free-standing Clinic	837 Professional
Physicians	837 Professional
Other medical professionals	837 Professional
Dentist/Dental Clinic	837 Dental

3.2.2 Service Center and Subcontractor Identifiers

During the registration process, the Contractor will be assigned a Service Center ID and a default Subcontractor ID for non-subcontracted data. If the Contractor will be submitting subcontracted encounter data, a Subcontractor ID will be assigned for each subcontractor. The Subcontractor ID will consist of the Contractor's Service Center ID followed by three characters. The default Subcontractor ID will end in "000". These values will be used to identify the MCO and subcontracted data and non-subcontracted data in the EPS.

SERVICE CENTER AND SUBCONTRACTOR ID					
Trans Type	**Element Name**	**Loop**	**Segment**	**Element**	**Value**
837	**Security Information Qualifier**		ISA	02	Use 4-character Service Center ID assigned by DMAS.
	Interchange Sender ID		ISA	06	If Contractor is submitting non-subcontracted encounter data, use: Service Center ID + Subcontractor ID default "000" If Contractor is submitting subcontracted encounter data, use: Service Center ID + Subcontractor ID
	Application Sender's Code		GS	02	
NCPDP	**Transaction Header**		ØØ-File Control	K1	

837 Example
Example 1: Non-subcontracted data
Sample data: Service Center = CP14 **S**ubcontractor ID default = 000 **ISA/GS segments:** ISA*03***CP14** *00* *ZZ***CP14000** *ZZ*VAMES EPS *160805*0509*^*00501*000020498*1*P*:~ GS*HC***CP14000***VAMES EPS*20170522*0708*20498*X*005010X222A1~
Example 2: Subcontracted data
Sample data: Service Center = CP14 Subcontractor ID = 001 **ISA/GS segments:** ISA*03***CP14** *00* *ZZ***CP14001** *ZZ*VAMES EPS *160805*0509*^*00501*000020498*1*P*:~ GS*HC***CP14001***VAMES EPS*20170522*0708*20498*X*005010X222A1~

NCPDP Example
Example 1: Non-subcontracted data
Sample data: Service Center = CP14 **S**ubcontractor ID default = 000 **NCPDP Transaction Header:** STX00TCP14000 00665462017040603 59P125148010900 ETX
Example 2: Subcontracted data
Sample data: Service Center = CP14 Subcontractor ID = 001 **NCPDP Transaction Header:** STX00TCP14001 00665462017040603 59P125148010900 ETX

3.2.3 Paid & Denied Encounters

The contractor is responsible for submitting encounters for all transaction types (837 and NCPDP), which fall into the following categories:

- Paid
- Denied
- Zero Medicaid payment due to full reimbursement by another payer or bundling of services

For NCPDP transactions, the contractor should submit denied encounters only for those claims that were denied for reasons other than missing information.

The EPS will use the PYMS Payment Status value that is populated by the Payer on the inbound encounter transaction (K3 segment) to determine if the encounter is paid or denied. See section 3.2.10.1 for further details.

3.2.4 Subcontractor Encounters

Subcontractor encounters must be submitted to DMAS by the Contractor. The subcontracting entity may not post encounter transactions directly to DMAS. All subcontractor encounters should be EDI compliance-checked through SNIP Levels 1, 2, 3, and 4 prior to submission.

3.2.5 Payer Claim Identifier

The EPS requires a unique Payer Claim ID (i.e., Submitter Claim ID) for each encounter within each Subcontractor ID. Because this ID will be used for claims research and for audit purposes, the Contractor must be able to identify the source claim with the ID submitted in the encounter. It is the Contractor's responsibility to ensure that subcontractor encounter transactions also contain a unique Payer Claim Identifier. Please see section 3.2.8 for details regarding the duplicate encounter transaction validation in EPS.

RESEND and RESUBMISSION transactions are an exception as these transactions must contain the Payer Claim ID of the transaction that is being corrected. See section 5 for further detail.

PAYER CLAIM IDENTIFIER						
Name	**Trans Type**	**Loop**	**Segment**	**Element**	**Value**	**Requirements**
Payer Claim ID	837P 837I 837D	2300	CLM	01	Payer Claim ID	Must be unique for original, replacement, and void transactions. Exception: RESEND & RESUBMISSION (See section 5)
	NCPDP		AM01	CX	99	Patient ID Qualifier
				CY	Payer Claim ID	Must be unique for B1 transactions (new billings). Exception: RESEND & RESUBMISSION (See section 5)

3.2.6 National Provider Identifier (NPI)

The NPPES-registered NPI must be included when reporting provider information on the Encounter.

3.2.7 Provider Taxonomy

A valid taxonomy code is required for each provider NPI that is present on the encounter at the loops shown below. To be considered valid, the taxonomy code must be present in the TAXONOMY EPS Cache Code Set, which can be viewed in the EPS Portal. In addition, the provider taxonomy code should be associated with the provider in PRSS.

Please see section 3.2.9.1 for special considerations regarding taxonomy for Transportation encounters.

PROVIDER TAXONOMY						
Trans Type	**Doc/Line Level**	**Loop**	**Segment**	**Element**	**Value**	**Requirements**
837P	Document	2000A	PRV	03	Taxonomy code	• Taxonomy code must be present for each provider NPI on the encounter. • Taxonomy code must be found on the EPS Cache Code set. • For transportation services, the taxonomy code must be associated with a "transportation" taxonomy code on the EPS Cache Code set. • Taxonomy code associated with the provider on the encounter should also be associated with the provider in PRSS.
		2310B				
	Line	2420A				
837I	Document	2000A				
		2310A				
837D	Document	2000A				
		2310A				
		2310B				
		2310D				
	Line	2420A				
		2420B				
NCPDP	NCPDP does not support taxonomy code					

3.2.8 Duplicate Encounter Transactions

Duplicate encounter transactions should not be submitted to EPS. The logic below is used to identify duplicate encounter transactions in EPS. Please note that **RESEND** and **RESUBMISSION** transactions are excluded from duplicate encounter transaction editing as these transactions must contain the Payer Claim ID of the transaction that is being corrected. See Section 5 for further detail.

Level 1

For 837 and NCPDP transactions, the combination of Subcontractor ID + Payer Claim ID must be unique. If two transactions are received with the same Subcontractor ID and Payer Claim ID, the second transaction will fail as a duplicate Payer Claim ID, regardless of the payment status, *since a unique Payer Claim ID is expected* on all 837 and NCPDP transactions. When the second transaction is processed, its status will be set automatically to FAIL and INACTIVE. It will not appear on the EPS Failure Log report or be included in the Data Quality Scorecard "encounter completeness" measure.

Level 2

NCPDP transactions are validated at an additional level for uniqueness. The second check is based on matching Servicing Provider NPI + DOS + Rx No. + NDC + Fill Number. *Encounters with a denied payment status are excluded from this matching logic.* If a second paid B1 transaction matching all five key fields is received and the first B1 transaction has not been reversed by a B2 transaction, it will fail as a duplicate. Its status will be automatically set to FAIL and INACTIVE. It will not appear on the EPS Failure Log report or be included in the Data Quality Scorecard "encounter completeness" measure.

Level 3

837I encounters are flagged as possible duplicates for post-processing review by DMAS when they match to another active institutional encounter on the combination of Service Center + Member ID + DOS + Billing Provider + Total Charge + Bill Type. DMAS will request research and remediation by the Contractor periodically. Similar informational edits will be implemented in the future to identify duplicate 837P encounters.

EPS Duplicate Transaction Check Data Elements - Level 1				
TRANS TYPE	**NAME**	**LOOP**	**SEGMENT**	**ELEMENT / FIELD**
837P 837I 837D	Payer Claim ID	2300	CLM	01
NCPDP	Payer Claim ID		AM01	CY

EPS Duplicate Transaction Check Data Elements - Level 2			
TRANS TYPE	**NAME**	**SEGMENT**	**FIELD**
NCPDP	Servicing Provider NPI	Transaction Header	201-B1
	Date of Service (DOS)		401-D1
	Prescription No.	AM07	402-D2
	National Drug Code (NDC)		407-D7
	Fill Number		403-D3

3.2.9 Transportation Services

The 837P (professional) transaction must be used for submitting all transportation services. This includes emergency and non-emergency transportation services as there are no exceptions to this requirement. See section 3.2.1 for further documentation regarding EDI transactions.

3.2.9.1 Identifying Transportation Encounters in EPS

Each transportation encounter must contain a taxonomy code from the EPS Cache Code set TRANSPTAXONOMY at the BILLING provider level. The EPS will use the billing provider taxonomy code to identify the encounter as containing transportation services. Once identified as a "transportation" encounter, the transaction will be subject to all EPS transportation business rules/edits.

Only taxonomy codes in the EPS TRANSPTAXONOMY Cache Code set may be used for transportation providers. The Cache Code set can be viewed in the EPS Portal. DMAS will consider additions to the code set upon request.

TRANSPORTATION Identifying Transportation Encounters in EPS					
Trans Type	**Loop**	**Segment**	**Element**	**Value**	**Requirement**
837P	2000A	PRV	01	BI	• Billing provider taxonomy is required. • For an encounter to be identified as a "transportation" encounter, a transportation taxonomy code must be present at the BILLING provider level.
			02	PXC	
			03	Value from EPS Cache Code Set TRANSPTAXONOMY	

3.2.9.2 Ambulance Services

Ambulance services are categorized in EPS as emergency or non-emergency by procedure (a.k.a. service) code. The category can be determined by reviewing the cache code sets in the EPS Portal. All ambulance service codes are listed in AMBUPROCCODES. Emergency ambulance service codes are listed in the EMERAMBUPROCS. The non-emergency ambulance service codes are those that are in AMBUPROCCODES but not EMERAMBUPROCS. The EPS data requirements are different for each category. Please see the transportation data requirements grid in section 3.2.9.10 for further information.

3.2.9.2.1 Emergency and Non-Emergency Services must be reported separately

Non-emergency and emergency services must be reported on separate encounters. These services must not be mixed on the same encounter transaction.

3.2.9.2.2 Emergency and Non-Emergency Ambulance Services - Mileage Reporting

The trip mileage for all ambulance services (non-emergency and emergency) must be reported under a designated mileage procedure code at the service line level in loop 2400 SV104. The Transport Distance field in loop 2300 CR106 and loop 2400 CR106, when present, must be populated with zero.

The mileage code must be submitted on the same encounter as the ambulance service code and must either immediately precede or follow the service code line. For example, an encounter for a multi-leg trip with two ambulance service code lines followed by two mileage code lines will fail validation because only one service code line is adjacent to a mileage code line. The chart below provides the service code and mileage code association. This information is also available in the EPS SERVICE-MILEAGE and MILEAGE-SERVICE cache code sets, which can be viewed in the EPS Portal.

TRANSPORTATION Ambulance Services - Service & Mileage Code Reporting		
Transportation Mode	**Procedure Code**	
	Service Code	**Mileage Code**
Land	A0225 A0428 A0433 A0426 A0429 A0434 A0427 A0432 A0999	A0425
Air Fixed Wing	A0430	A0435
Air Rotor Wing	A0431	A0436

3.2.9.2.3 Emergency and Non-Emergency Ambulance Services – Place of Origin/Destination Modifiers

Each ambulance service code line must include a two-letter modifier that will identify the place of origin and destination of the ambulance trip. The first letter will describe the origin of the transport and the second letter will describe the destination. For example, when a patient is picked up at his/her residence and transported to the hospital, the modifier to describe the origin and destination would be "RH". The valid values for the ambulance origin and destination modifiers are available in the AMBUMODIFIERS cache code set in the EPS Portal.

The origin/destination modifier should be sent only on the ambulance transport service codes that are listed in the AMBUPROCCODES cache code set in the EPS Portal.

TRANSPORTATION Ambulance Services – Place of Origin/Destination						
Trans Type	**Document/ Line Level**	**Loop**	**Segment**	**Element**	**Value**	**Requirements**
837P	Line	2400	SV1	01-3	Procedure Code Modifier	• Ambulance services must contain procedure code modifiers to identify place of origin and destination. • The procedure code modifiers must be on the EPS AMBUMODIFERS Cache Code set.

3.2.9.2.4 Non-Emergency Ambulance Services – Medicare Affirmed/Non-affirmed Number

Medicare affirmed/Non-affirmed numbers for ambulance services should be reported on the encounter when applicable.

TRANSPORTATION Ambulance Services - Crossover Claims						
Trans Type	**Document/ Line Level**	**Loop**	**Segment**	**Element**	**Value**	**Requirements**
837P	Document	2330B	REF	01	G1 (Prior Authorization)	Mandatory when applicable
				02	Affirmed / Non-affirmed number	Mandatory when applicable

3.2.9.3 Pick-up/Drop-off Location Name and Address

The pick-up location name and address is required for all transportation services except emergency ambulance services, third party liability/crossover claims and claims submitted directly to the plan (e.g., CMS-1500 paper claims).

The drop-off location name and address is required for all transportation encounters except when the modifier QL or SH accompanies an ambulance service code. For claims submitted on the CMS-1500, the drop-off location should be recorded in Block 32 "Service Facility Location Information". When a CMS-1500 is used, each leg of a round trip should be reported on a separate claim.

The pick-up and drop-off location name and address are required at both the Document level (loops 2310E/2310F) and the Line level (loops 2420G/2420H). In cases where there are multiple trip legs included in the encounter, the Document level pick-up and drop-off location should reflect the information for the first leg of the trip reported on the first service line (LX*1), regardless of the number of trip legs.

TRANSPORTATION Pick-up / Drop-off Location						
Trans Type	**Doc/Line Level**	**Loop**	**Segment**	**Element**	**Value**	**Requirement**
837P	**Pick-up Location**					
	Document	2310E	NM1	01	PW=Pick-up location	Mandatory for most transactions Exceptions: • Emergency ambulance services (EPS EMERAMBUPROCS Cache Code set) • Third party liability/crossover claims • Claims submitted directly to Plan (typically paper claims) Please see the transportation data requirements grid in section 3.2.9.10 for further information.
				02	2=Non-person entity	
			N3	01	Address	
			N4	01	City	
				02	State	
				03	Postal Code	
	Line	2420G	NM1	01	PW=Pick-up location	
				02	2=Non-person entity	
			N3	01	Address	
			N4	01	City	
				02	State	
				03	Postal Code	
	Drop-off Location					
	Document	2310F	NM1	01	45=Drop-off location	Mandatory for most transactions Exceptions: • When QL or SH modifier is present Please see the transportation data requirements grid in section 3.2.9.10 for further information.
				02	2=Non-person entity	
			N3	01	Address	
			N4	01	City	
				02	Statue	
				03	Postal Code	
	Line	2420H	NM1	01	45=Drop-off location	
				02	2=Non-person entity	
			N3	01	Address	
			N4	01	City	
				02	State	
				03	Postal Code	

3.2.9.4 Non-ambulance Transport Services – Mileage Reporting

This section is applicable to non-emergency transportation service codes that are not included in the EPS AMBUPROCCODES cache code set. Refer to Section 3.2.9.2 for Emergency and Non-Emergency Ambulance mileage reporting requirements.

3.2.9.4.1 Reporting Mileage for Non-Ambulance Transport Services Other than Stretcher Van T2005

The trip mileage for non-ambulance transportation services must be reported at the service line level in loop 2400 SV104 on the transportation service code line. The mileage should not be submitted under a separate mileage code, with the exception of T2005. The Transport Distance field in loop 2300 CR106 and loop 2400 CR106, when present, must be populated with zero.

3.2.9.4.2 Reporting Mileage for Stretcher Van T2005

The trip mileage for the T2005 Stretcher Van service must be reported under mileage procedure code T2049 at the service line level in loop 2400 SV104. The Transport Distance field in loop 2300 CR106 and loop 2400 CR106, when present, must be populated with zero.

The mileage code must be submitted on the same encounter as the T2005 service code and must either immediately precede or follow the service code line. For example, an encounter for a multi-leg trip with two transport service code lines followed by two mileage code lines will fail validation because only one service code line is adjacent to a mileage code line. The chart below provides the service code and mileage code association. This information is also available in the EPS SERVICE-MILEAGE and MILEAGE-SERVICE cache code sets, which can be viewed in the EPS Portal.

TRANSPORTATION **Stretcher Van –T2005 - Service & Mileage Code Reporting**		
Transportation Mode	**Procedure Code**	
	Service Code	**Mileage Code**
Stretcher Van (non-emergency)	T2005	T2049

3.2.9.4.3 Reporting Deadhead Mileage When Paid as a Separate Line Item

Deadhead miles are miles driven by a transportation provider without a member on-board.

When the deadhead miles are paid as a separate line item, the "TP" modifier must be used along with the appropriate transportation CPT/mileage procedure code (e.g. S0215).

837P Example
TRANSPORTATION
Deadhead Miles – When Paid as a Separate Line Item

Loop 2400 – Service Line

```
LX*1~
SV1*HC:A0100*20*UN*14***1~
CR1****A*DH*0***TRIPTYPE-I TRIPLEG-1 PUTIME-0900 PULOC-RE DOLOC-AD DOTIME-0934 SP-0900 SD-0930~
DTP*472*D8*20171101~
K3*PYMS-P~
NM1*PW*2~
N3*123 ANYWHERE BLVD~
N4*RICHMOND*VA*23222~
NM1*45*2~
N3*987 ANYSTREET RD~
N4*HENRICO*VA*23294~
SVD*CPXX*20*HC:A0100**14~
DTP*573*D8*20171115~
LX*2~
SV1*HC:S0215:TP*25*UN*99***1~
DTP*472*D8*20171101~
K3*PYMS-P~
NM1*PW*2~
N3*123 ANYWHERE BLVD~
N4*RICHMOND*VA*23222~
NM1*45*2~
N3*987 ANYSTREET RD~
N4*HENRICO*VA*23294~
SVD*CPXX*25*HC:S0215:TP**99~
DTP*573*D8*20171115~
```

TP *Modifier must be used when deadhead mileage is paid as a separate line item*

3.2.9.5 Supplemental Trip Information

Transportation encounters for all categories of transport other than emergency ambulance must contain supplemental trip information. The transportation data requirements grid in section 3.2.9.10 specifies the supplemental data requirements by category.

The 837P CR1 segment in loops 2300 and/or 2400 is used to capture the supplemental information. Fields CR104, CR105 and CR106 are required by the EDI standard. CR104 and CR105 should be populated as specified by the standard. CR104 may be populated with 'A' as the default when the other values do not apply. The value for the CR106 Transport Distance element must always be populated with zero for all types of transportation, including emergency/non-emergency ambulance. The supplemental trip data must be reported in the CR109 element using a defined field label ("Field" column in chart below), a hyphen immediately following, and the field value. The field label must appear exactly as shown in the chart. Field/value pairs may be in any order. There must be at least one space as a delimiter between the pairs. See the 837P examples below.

3.2.9.5.1 Trip Number

The trip number is reported at the header level in Loop 2300 CR109 with the field name TRIPNUM. The trip number must be nine digits in length. If the payer's internal trip number is less than nine digits, the trip number on the encounter record must be right-justified and zero-filled to equal nine digits (e.g., 23 is reported as 000000023).

3.2.9.5.2 Trip Type

The trip type is reported at the line level in Loop 2400 CR109 with the field name TRIPTYPE. The trip type identifies the trip as being a round, initial one-way, return one-way or transfer trip. The valid values for this field are specified in the TRIPTYPECODE cache code set in the EPS Portal.

3.2.9.5.3 Trip Legs

Each leg of a trip must be reported as a separate service line in the encounter. The trip leg is identified at the line level in Loop 2400 CR109 with the field name TRIPLEG. The valid values for this field are specified in the TRIPLEG cache code set in the EPS Portal.

3.2.9.5.4 Pick-up and Drop-off Location Codes

The pick-up and drop-off location codes are reported at the line level in Loop 2400 CR109 with the field names PULOC and DOLOC, respectively. These codes identify the purpose of the trip (e.g., residence to doctor's office) and should not be confused with the pick-up and drop-off location name and address. The valid values for these fields are specified in the PICKUPDROPOFFLOC cache code set in the EPS Portal.

3.2.9.5.5 Pick-up and Drop-off Times (Actual)

The actual pick-up and drop-off times are reported at the line level in Loop 2400 CR109 with the field names PUTIME and DOTIME, respectively. The times must be expressed in a HHMM 24-hour format (e.g., 1530).

3.2.9.5.6 Scheduled Pick-up Time and Scheduled Appointment/Drop-off Time

The scheduled pick-up and scheduled appointment/drop-off times are reported at the line level in Loop 2400 CR109 with the field names SP and SD, respectively. The times must be expressed in a HHMM 24-hour format (e.g., 1530).

There are three exceptions to the standard reporting requirements for this data.

- Trips with no scheduled appointment time (e.g., trip to grocery store)
  When there is no scheduled appointment time, the scheduled appointment/drop-off time must be set to the actual drop-off time.

- Will Call
  When a scheduled pick-up and/or scheduled appointment/drop-off time is unknown because the member has arranged to call for pick-up, the SP or SD field must be set to midnight (example: SP-0000 and/or SD-0000).

- Hospital Discharge
  Below is a suggested approach for populating time values for a transportation trip that includes a hospital discharge. Other methods may be used but should be approved by DMAS. It should be noted that the use of a "will call" should not be used for a hospital discharge scenario.

  The hospital discharge trips are normally one-way trips. Therefore, the trips can be entered for encounters by using the following steps:
  1a. The transportation broker can enter the scheduled pick-up as the time it is called into reservations or time-stamped by the scheduling system.
  1b. Actual pick-up time is the time that the provider enters once the provider arrives at the hospital to pick up the member.

2a. Scheduled drop off time should be three (3) hours from the time the discharge is called into the NEMT Program's reservation call center.
2b. Actual drop-off time is the time the provider actually drops member off at address called to transport member to.

With this approach, DMAS will calculate the discharge three-hour requirement by using the time the discharge is called into the reservation line (1a or 2a) call center and the time the provider arrives at the hospital (1b).

Hospital discharges that are called in advance can be rescheduled as URGENT trips for the next day or same day if the hospital states what time the discharge is to take place.

TRANSPORTATION
Trip Information

Doc/Line Level	Trans Type	Loop	Seg	Elem	Description
Document Level	837P	2300	CR1	04	Ambulance Transport Reason Code - Populate per the X12 837P standard. Code A may be used as the default when the other codes do not apply
				05	Basis of Measurement - Populate with DH per the X12 837P standard
				06	Transport Distance/Mileage - Populate with a value of **ZERO always**
				09	

FIELD	DESCRIPTION	USAGE	FORMAT	SIZE	VALID VALUE
TRIPNUM	Trip Number*	See section 3.2.9.10	nnnnnnnnn	9	000000001-999999999

Doc/Line Level	Trans Type	Loop	Seg	Elem	Description
Line Level	837P	2400	CR1	04	Ambulance Transport Reason Code - Populate per the X12 837P standard. Code A may be used as the default when the other codes do not apply
				05	Basis of Measurement - Populate with DH per the X12 837P standard
				06	Transport Distance/Mileage - Populate with a value of **ZERO always**
				09	

FIELD	DESCRIPTION	USAGE	FORMAT	SIZE	VALID VALUE
TRIPTYPE	Trip Type	See section 3.2.9.10	XX	2	Value from TRIPTYPECODE Cache Code Set
TRIPLEG	Trip Leg	See section 3.2.9.10	X	1	Value from TRIPLEG Cache Code Set
PUTIME	Pick-up time (actual)	See section 3.2.9.10	HHMM	4	00-23{HH]00-59[MM]
DOTIME	Drop-off time (actual)	See section 3.2.9.10	HHMM	4	00-23[HH]00-59[MM]
PULOC	Pick-up location code	See section 3.2.9.10	XX	2	Value from PICKUPDROPOFFLOC Cache Code Set
DOLOC	Drop-off location code	See section 3.2.9.10	XX	2	Value from PICKUPDROPOFFLOC Cache Code Set
SP	Scheduled Pick-up time (A leg, B leg, C leg, etc.)	See section 3.2.9.10	HHMM	4	00-23[HH]00-59[MM]
SD	Scheduled appointment time or scheduled appointment/drop off time	See section 3.2.9.10	HHMM	4	00-23[HH]00-59[MM]

Notes:
- **There should be at least one space between the pair values.**
- **Each pair must have one hyphen (-) between the field and value.**
- **The pair values may be in any order.**
- ***Trip number must be 9 digits. If less than 9 digits, must be right-justified and zero-filled.**

Transportation Trip Information 837P – CR1 Segment – Examples	
Sample Data	Note: Sample data contains a provider internal trip number that is less than 9 digits. Trip Number=000023 Trip Type=I Trip Leg=A Pick-up Location Code=AD Pick-up Time (Actual) =1820 Drop-off Location Code=HO Drop-off Time (Actual)=1850 Scheduled Pickup Time=1820 Scheduled Appointment Time=1845
Document Level Example	Note: Trip number has been right-justified and zero-filled to create a 9-digit trip number CR1****A*DH*0***TRIPNUM-000000023~
Line Level Example	CR1****A*DH*0***TRIPTYPE-I TRIPLEG-A PUTIME-1820 PULOC-AD DOTIME-1850 DOLOC-HO SP-1825 SD-1845~

TRANSPORTATION Single-Leg Trip Example
837P

Example: One-leg trip ONLY

Header Level (Home to Doctor)

```
CR1****A*DH*0***TRIPNUM-000000001~
HI*ABK:A228~
NM1*DN*1*PROVIDER1*NANCY*U***XX*9999999999~
NM1*82*1*PROVIDER2*MARIA*A***XX*9999999988~
PRV*PE*PXC*3416A0800X~
NM1*77*2*CHKDOUTPATIENT DEPARTMENT*****XX*1164501581~
N3*601 CHILDRENS LN~
N4*NORFOLK*VA*89502~
NM1*PW*2~
N3*123 ANYWHERE DR~
N4*NORFOLK*VA*89505~
NM1*45*2~
N3*601 CHILDRENS LN~
N4*NORFOLK*VA*89505~
```

Line Level (Home to Doctor)

```
LX*1~
SV1*HC:T2003*50*UN*25***1~
CR1****A*DH*0***TRIPTYPE-X TRIPLEG-1 PUTIME-0900 PULOC-RE DOTIME-0934 DOLOC-DO SP-0900 SD-0930~
DTP*472*D8*20170321~
REF*6R*124109261~
K3*PYMS-P~
NM1*PW*2~
N3*123 ANYWHERE DR~
N4*NORFOLK*VA*89505~
NM1*45*2~
N3*601 CHILDRENS LN~
N4*NORFOLK*VA*89505~
```

TRANSPORTATION – Multi-Leg Trip Example
837P

Example: Two-leg trip

Header Level (Home to Doctor)

```
CR1****A*DH*0***TRIPNUM-000000001~
HI*ABK:A228~
```

```
NM1*DN*1*PROVIDER1*NANCY*U***XX*9999999999~
NM1*82*1*PROVIDER2*MARIA*A***XX*9999999988~
PRV*PE*PXC*3416A0800X~
NM1*77*2*CHKDOUTPATIENT DEPARTMENT*****XX*1164501581~
N3*601 CHILDRENS LN~
N4*NORFOLK*VA*89502~
NM1*PW*2~
N3*123 ANYWHERE DR~
N4*NORFOLK*VA*89505~
NM1*45*2~
N3*601 CHILDRENS LN~
N4*NORFOLK*VA*89505~
```

Line Level

Leg 1 or A: Home to Doctor

```
LX*1~
SV1*HC:T2003*50*UN*25***1~
CR1****A*DH*0***TRIPTYPE-X TRIPLEG-A PUTIME-0900 PULOC-RE DOLOC-AD DOTIME-0934 SP-0900 SD-0930~
DTP*472*D8*20170321~
REF*6R*124109261~
K3*PYMS-P~
NM1*PW*2~
N3*123 ANYWHERE DR~
N4*NORFOLK*VA*89505~
NM1*45*2~
N3*601 CHILDRENS LN~
N4*NORFOLK*VA*89505~
```

Leg 2 or B: Doctor to Home

```
LX*2~
SV1*HC:T2003*50*UN*25***1~
CR1****A*DH*0*** TRIPTYPE-X TRIPLEG-B PULOC-AD PUTIME-1600 DOLOC-RE DOTIME-1634 SP-1600 SD-1630~
DTP*472*D8*20170321~
REF*6R*124109262~
K3*PYMS-P~
NM1*PW*2~
N3*601 CHILDRENS LN~
N4*NORFOLK*VA*89505~
NM1*45*2~
N3*123 ANYWHERE DR~
N4*NORFOLK*VA*89505~
```

3.2.9.6 Third-Party Liability (TPL) / Crossover Transportation Claims

As a best practice for TPL and crossover claims, please send the accurate trip information in the CR1 segment if it is available. If not available, optional trip information should be omitted and default values should not be used. Most of the EPS trip information rules do not apply to encounters with other payers, but there are some exceptions. Please see the transportation data requirements grid in section 3.2.9.10 for further information.

3.2.9.7 Transportation-Related Services & Special Cases

Transportation-related services must be reported on an encounter. A list of the services that fall into this category is available in the TRANSREIMBPROCS cache code set in the EPS Portal. Only those codes with an active status are relevant. Please note that mass transit passes are addressed below in Section 3.2.9.8 and that taxi cabs do not fall into this category.

Transportation-related services require the use of the Supervising Provider Name fields in Loop 2310D, NM103 and 2420D, NM103 to document the name of the provider or payee. Please refer to the examples at the end of this section and refer to the transportation data requirements grid in section 3.2.9.10 for the additional data requirements.

TRANSPORTATION Transportation-related Services & Special Cases						
Trans Type	**Doc/Line Level**	**Loop**	**Segment**	**Element**	**Value**	**Requirements**
837P	Line	2420D	NM1	01	DQ	Mandatory at the Line Level
				02	1	
				03	Last Name	
				04	First Name (when applicable)	
			REF	01	LU	
				02	Trip Number	

3.2.9.7.1 Transportation Attendants

A transportation attendant is a person that is approved by the broker to accompany a member or a group of members during transport only.

Reimbursement for a transportation attendant(s) will be made to the transportation provider by the transportation broker or internal transportation service for monitoring a member or a group of members when it is necessary for the safety of the member(s) to ensure timeliness of the trip and to reduce behavioral problems in-route. The attendant is employed by the transportation provider.

Transportation attendant services should be reported under service code T2001. The unit of measure for the units reported in Loop 2400 SV104 should be 1 unit for every 30 minutes Please note that “transportation attendant” (CPT T2001) should not be confused with “attendant care services” (CPT S5125).

3.2.9.7.2 Services provided by a Transportation Network Company (TNC)

Transportation services provided by a TNC company must be reported with service code A0120 (*Non-emergency transportation: mini-bus or other transportation systems*). Multiple TNCs should not be reported on the same encounter.

The TNC company (e.g. Uber, Lyft, UZURV) could enroll to get an NPI number and taxonomy code. If the TNC does not have an NPI and taxonomy code, the broker/internal transportation’s NPI should be used with taxonomy code 172A00000X. Do not use an API. Specify the provider (payee) as “TNC– and the name of the TNC company" in Loops 2310D, NM103 and 2420D, NM103 as shown in the example below.

3.2.9.7.3 Other Transportation Related Services

Some examples of other types of services in this category are as follows:

- Gas reimbursement for transportation provided by family members, neighbors, case workers, etc.
- Parking fees, tolls, other (e.g., postage)
- Member and escort lodging
- Member and escort meals

An escort is defined as a family member, friend or facility employee who accompanies a Medicaid member (any age) for the entire trip and stays with the member at the destination.

The name of the person being reimbursed (payee) must be submitted in Loops 2310D, NM103 and 2420D, NM103 as shown in the example below.

837P - Example

Transportation-Related Services & Special Cases

Procedure Codes: A0090, A0110, A0120, A0140, A0160, A0170, A0180, A0190, A0200, A0210, T2001

Loop 2000B - Subscriber

```
SBR*S*18*******MC~
NM1*IL*1*SUBSCRIB LSTNM*SUBSCRIB FRSTNM*E***MI*999999999999~
N3*100 ANYSTREET LANE~
N4*AFTON*VA*229202834~
DMG*D8*19440817*F~
NM1*PR*2*VAMES EPS*****PI*DMAS MEDICAID~
```

Loop 2300 – Claim

```
CLM*709101003009*100***99:B:1*Y*A*Y*Y~
REF*D9*709101003009~
K3*DREC-20170920 DADJ-20170925 DPYM-20171006 PYMS-P~
K3*CN101-05~
CR1****A*DH*0***TRIPNUM-000100003~
HI*ABK:R99~
NM1*DQ*1*PROVIDER LSTNM*PROVIDER FRSTNM~
REF*LU*000100003~
```

Document Level - Trip Number - REQUIRED

Document Level - Supervising Provider Loop – OPTIONAL
Last Name - Transportation Escort, TNC Company Name, Hotel, etc.
First Name - Only when applicable (e.g., Transportation Escort)
ID - Trip Number (Must match 2300, CR109 TRIPNUM)

Loop 2310E – Ambulance Pick-up Location

Document Level - Pick-up Location - REQUIRED

```
NM1*PW*2~
N3*238 PICKUP ADDRESS~
N4*AFTON*VA*229202834~
```

Loop 2310F – Ambulance Drop-off Location

Document Level - Drop-off Location - REQUIRED

```
NM1*45*2*RONALD MCDONALD HOUSE~
N3*3727 14TH ST NE~
N4*WASHINGTON*DC*200173004~
SBR*P*18*******MC~
AMT*D*100~
OI***Y***Y~
NM1*IL*1*SUBSCRIB LSTNM*SUBSCRIB FRSTNM*E***MI*999999999999~
NM1*PR*2*DEPT OF MED ASSIST SVCS*****PI*NE01~
```

Loop 2420D – Supervising Provider Information

```
LX*1~
SV1*HC:A0180:RD*100*UN*1***1~
CR1****A*DH*0***TRIPTYPE-I TRIPLEG-A PULOC-RE PUTIME-1600 DOLOC-UN DOTIME-1700~
DTP*472*D8*20170910~
K3*PYMS-P~
K3*CN101-05~
NM1*DQ*1*PROV LSTNM*PROV FRSTNM~
REF*LU*000100003~
```

Line Level CR1 data OPTIONAL

Line Level - Supervising Provider Loop – REQUIRED
Last Name-Transportation Escort, TNC Company Name, Hotel, etc.
First Name-Only when applicable (e.g., Transportation Escort)
ID - Trip Number (Must match 2300, CR109 TRIPNUM)

Loop 2420G – Ambulance Pick-up Location

```
NM1*PW*2~
N3*238 PICKUP ADDRESS~
N4*AFTON*VA*229202834~
```

Line Level - Pick-up Location - REQUIRED

Loop 2420H – Ambulance Drop-off Location

Line Level - Drop-off Location - REQUIRED

```
NM1*45*2*RONALD MCDONALD HOUSE~
N3*3727 14TH ST NE~
N4*WASHINGTON*DC*200173004~
SVD*NE01*100*HC:A0180:RD**1~
DTP*573*D8*20171006~
```

3.2.9.8 Mass Transit Passes

Mass transit passes, such as bus or subway passes, must be reported to DMAS via encounter transactions using CPT code A0110. Please follow the procedures for special cases in section 3.2.9.6. The supervising provider in loop 2420D may vary based on how the pass is purchased which is listed in the chart below.

Please see the following sections for methods of reporting monthly, daily, and single-use passes. DMAS must receive encounter transactions as they appear in the vendor's claims processing system. For DMAS reconciliation purposes, EPS encounter transaction counts must match vendor claim counts.

Please see the transportation data requirements grid in section 3.2.9.10 for further information.

TRANSPORTATION Mass Transit Passes						
Trans Type	**Document / Line Level**	**Loop**	**Segment**	**Element**	**Value**	**Requirements**
837P	Document	2300	SV1	01-2	A0110	• CPT code A0110 must be used for mass transit passes
	Line	2400	NM1	01	DQ	• EDI qualifier to indicate Supervising Provider segment
				03	Last name	• If the member purchases the pass and is reimbursed, populate supervising provider last name with member last name • If the transportation vendor purchases the pass and sends it to the member, populate supervising provider last name with transit company name
				04	First name	• If the member purchases the pass and is reimbursed, populate supervising provider first name with member first name

3.2.9.8.1 Mass Transit - Additional Dates & Payment Status

For Mass Transit Passes, the following definitions will be used for the required additional date and payment status information that is reported on the K3 segment. Please note that these definitions override the descriptions listed in Section 3.2.10.1.

Document Level

- Date of Receipt (DREC) = Date of Service (mandatory)
- Date of Adjudication (DADJ) = Date of Service (mandatory)
- Date of Payment (DPYM) = Date of Service (mandatory)
- Payment Status (PYMS) = Payment status will always be paid (mandatory)

Line Level

- Payment Status (PYMS) = Payment status will always be paid (mandatory)

3.2.9.8.2 Mass Transit - Monthly Passes

Monthly mass transit passes may be reported via encounter transaction(s) in one of the two ways:

- Submit the first encounter transaction with the full price of the monthly pass on the first date of service. Subsequent encounter transactions should be submitted for each date of service with a $0 payment amount.
  Example: Monthly bus pass cost $35 with 10 dates of service.
  First encounter transaction will be submitted on the first date of service for the month with a payment amount of $35. Nine encounter transactions will follow for each date of service with a payment amount of $0.

OR

- Submit an encounter transaction for each date of service, dividing the cost of the monthly pass by the number of date of service trips for the monthly pass timeframe.
  Example: Monthly transit pass cost $35 with 10 dates of service.
  Ten encounter transactions will be submitted. Each encounter transaction for each date of service will have a payment amount of $3.50 and a unit of 1.

3.2.9.8.3 Mass Transit - Daily or Single-use Passes

Daily or single-use passes may be reported in one encounter transaction with the cost of the single pass as the payment amount on the date of service.

3.2.9.9 Transportation Enhanced Benefits

When a transportation service is an enhanced benefit (i.e., value-added service) offered by the MCO, the enhanced benefit indicator must be present at the service line. See Section 3.2.16 for technical instructions on how to identify a service as an enhanced benefit in an encounter.

The purpose of the trip must be documented with the use of the pick-up and drop-off location codes, which are addressed in Section 3.2.9.5.4. Examples include code “GS” (Grocery Store) or “BS” (Barber – Hair/Beauty Salon). In addition, transportation to and from an appointment for a value-added service such as vision care should also be designated as an enhanced benefit.

3.2.9.10 Transportation Data Requirements Grid

O= Optional R = Required S = Situational

DATA DESCRIPTION	EMERGENCY AMBULANCE *(Non-mileage codes in EMERAMBUPROCS)* WITH NO COB	TRANSPORTATION-RELATED SERVICES/SPECIAL CASES *(Codes in TRANSREIMBPROCS)* BUS PASSES *(A0110 only)* TNC SERVICES *(A0120 only)*	ANY ENCOUNTER WITH COB	NON-EMERGENCY AMBULANCE *(Non-mileage codes in AMBUPROCCODES that are not In EMERAMBUPROC)*	NON-EMERGENCY *(Codes in TRANSPROCCODES that are not in AMBUPROCCODES, TRANSREIMBPROCS or BYPASS_TRANS_OTHER_SERVICE_PROCS)*	NEMT CLAIMS SUBMITTED DIRECTLY TO THE PLAN *(Typically CMS-1500 Paper Claims) EXCLUDES SPECIAL CASES, EMERGENCY AMBULANCE & COB PLEASE REFER TO THOSE COLUMNS*
Claim Source	Any	Any	Any	Vendor/Broker/Internal Scheduler Subcontractor ID **NOT IN** TRANSBYPASS_SUBCONTRACTORS	Vendor/Broker/Internal Scheduler Subcontractor ID **NOT IN** TRANSBYPASS_SUBCONTRACTORS	Plan Subcontractor ID **IN** TRANSBYPASS_SUBCONTRACTORS
AMBULANCE ORIGIN/ DESTINATION MODIFIER	R	NA	S-Required for ambulance encounters	R	NA	S-Required for ambulance encounters
DROP-OFF LOCATION NAME, ADDR, CITY, STATE, ZIP	S – Required unless modifier is QL or SH	R	R	S – Required unless modifier is QL or SH	R	S – Required unless ambulance modifier is QL or SH
DROP-OFF LOCATION CODE	O	O	O	S – Required unless modifier is QL or SH	R	O
DROP-OFF TIME	O	O	O	S – Required unless modifier is QL or SH	R	O
SCHEDULED APPT/DEPARTURE TIME	O	O	O	S – Required unless modifier is QL or SH	R	O
PICK-UP LOCATION NAME, ADDR, CITY, STATE, ZIP	O	R	O	R	R	O
PICK-UP LOCATION CODE	O	O	O	R	R	O
PICK-UP TIME	O	O	O	R	R	O
SCHEDULED PICK-UP TIME	O	O	O	S – Required unless modifier is QL or SH	R	O
SERVICE MILEAGE CODE	S – Required unless modifier is QL or SH	O	S-Required for T2005	S – Required unless modifier is QL or SH	S - Required for T2005	S – Required for T2005 and ambulance encounters without QL or SH modifier
NAME OF TRANSPORTATION ESCORT, PURCHASER for BUS PASSES, TNC COMPANY	NA	R	NA	NA	NA	NA
TRIP NUMBER	O	R	O	R	R	O
TRIPLEG	O	O	O	R	R	O
TRIPTYPE	O	O	O	R	R	O

3.2.9.11 Transportation Cache Code Sets

Transportation Cache Code Set Name	Transportation Cache Code Set Description
AMBUMODIFERS	Origin and destination modifiers for ambulance encounters
AMBUPROCCODES	Service codes for emergency and non-emergency ambulance transportation
BYPASS_AMBUPROCCODES	Service codes that bypass the drop-off location address and drop-off time edits when a modifier in the PAT_DECEASED_MODS cache code set is present
BYPASS_TRANS_OTHER_SERVICE_PROCS	Non-transportation service codes (e.g., supplies, EKG) that may be present on a transportation encounter. The transportation edits do not set for these service codes.
EMERAMBUPROCS	Service and mileage codes for emergency ambulance transportation
MILEAGECODE	Mileage codes that require a specific transportation service code as indicated in the MILEAGE-SERVICE cache code set
MILEAGE-SERVICE	Required mileage and service code pairs. The mileage code must be submitted with the specified service code.
PAT_DECEASED_MODS	Ambulance modifiers that indicate a patient may not have been transported due to death.
PICKUPDROPOFFLOC	Pick-up and drop-off location codes
SERVICECODE	Service codes that require a specific mileage code as indicated in the SERVICE-MILEAGE cache code set
SERVICE-MILEAGE	Required service and mileage code pairs. The service code must be submitted with the specified mileage code.
TRANSBYPASS_SUBCONTRACTORS	The subcontractor ID that identifies encounters for non-emergency transportation claims that were submitted directly to the Plan. Some transportation edits are relaxed for paper claims that could not be submitted through the transportation broker/scheduling department.
TRANSBYPASSMODS	Modifiers to indicate deadhead miles. Some transportation edits are relaxed for deadhead mileage charges.
TRANSPROCCODES	CPT (service) codes that are accepted on a transportation encounter
TRANSPTAXONOMY	Taxonomy codes that indicate transportation providers
TRANSREIMBPROCS	Service codes for special case and transportation-related services such as gas reimbursement, hotel charges, meals, parking fees, tolls, bus passes and other transportation services.
TRIPLEG	Trip leg codes
TRIPTYPECODE	Trip type codes

3.2.10 Adjudication/Payment Information

3.2.10.1 Additional Dates & Payment Status

The Payer is required to provide additional dates and payment status information about the claim in the encounter as documented in the first example at the bottom of this section.

Please use the definitions below for encounters that originate from adjudication (original, replacement, void, etc.). For EPS corrections (RESEND or RESUBMISSION, see section 5 for further explanation), the date value should remain unchanged on the transaction unless the reason for the correction is to change/correct the date(s) or payment status.

The definitions below are applicable to all encounters except for services provided by Consumer-Directed Attendants (see section 3.2.13 for special instructions) and Transportation Mass Transit Passes (see section 3.2.9.8 for special instructions). The payment status is required at the document and service line level.

Document Level

- Date of Receipt (DREC) = Date that the Payer received the transaction from the provider (mandatory).
- Date of Adjudication (DADJ) = Date that the Payer adjudicated the transaction (mandatory).
- Date of Payment (DPYM) = Date that the Payer pays the claim (check date, remit date, or EFT date).
- Payment Status (PYMS) = The document level payment status will indicate whether an encounter is considered paid or denied. The document level payment status is based on the payment status of the service line(s). When all service lines are denied, the document level payment status is denied. If one or more service lines are paid ($0 or >$0), then the document level payment status must be set to paid.

For NCPDP transactions, the Date of Receipt, Date of Adjudication, and Date of Payment submitted in the 350-HN segment must be populated with the date for the time zone in which the transaction occurred. This requirement is to accommodate scenarios where there is a time zone difference between point-of-sale and adjudication.

Line Level

- Date of Payment = The line level payment date is reported in Loop 2430 DTP03 segment where DTP01 = 573. Please refer to Section 3.2.10.2 for additional information.
- Payment Status (PYMS) = The line level payment status will indicate whether the service line is considered paid or denied. The line level payment status is based on the Medicaid payment determination regardless of the payment amount. A service line with a Medicaid covered service and a $0 Medicaid payment due to reimbursement by another payer or bundling of services, for example, is considered paid.

<table>
<tr><th colspan="6">837 – Additional Payment Dates & Status</th></tr>
<tr><th>Doc/Line Level</th><th>Trans Type</th><th>Loop</th><th>Segment</th><th>Element</th><th>Description</th></tr>
<tr><td>Document Level</td><td>837P
837D
837I</td><td>2300</td><td>K3</td><td>01</td><td>
<table>
<tr><th>FIELD</th><th>DESCRIPTION</th><th>USAGE</th><th>FORMAT/VALUE</th></tr>
<tr><td>DREC</td><td>Date of Receipt</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>DADJ</td><td>Date of Adjudication</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>DPYM</td><td>Date of Payment</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>PYMS</td><td>Payment Status - Paid
Payment Status - Denied</td><td>Mandatory</td><td>P
D</td></tr>
</table>
Note:
• There should be at least one space between the pair values
• Each pair must have one hyphen(-) between the field and value
• The pair values may be in any order
</td></tr>
<tr><td rowspan="2">Line Level</td><td>837P
837D</td><td>2400</td><td>K3</td><td>01</td><td>
<table>
<tr><th>FIELD</th><th>DESCRIPTION</th><th>USAGE</th><th>FORMAT/VALUE</th></tr>
<tr><td>PYMS</td><td>Payment Status - Paid
Payment Status - Denied</td><td>Mandatory</td><td>P
D</td></tr>
</table>
</td></tr>
<tr><td>837I</td><td>2400</td><td>NTE</td><td>02</td><td>
<table>
<tr><th>FIELD</th><th>DESCRIPTION</th><th>USAGE</th><th>FORMAT/VALUE</th></tr>
<tr><td>PYMS</td><td>Payment Status - Paid
Payment Status - Denied</td><td>Mandatory</td><td>P
D</td></tr>
</table>
</td></tr>
</table>

837 Example	
Sample Format	DREC-CCYYMMDD DADJ-CCYYMMDD DPYM-CCYYMMDD PYMS-x

K3 Segment	`K3*DREC-20170223 DADJ-20170224 DPYM-20170225 PYMS-P`
	OR
	`K3*DREC-20170223 DADJ-20170224 DPYM-20170225 PYMS-D`

<table>
<tr><th colspan="6">NCPDP – Payment Date & Status</th></tr>
<tr><th>Doc/Line Level</th><th>Trans Type</th><th>Loop</th><th>Segment</th><th>Element</th><th>Description</th></tr>
<tr><td>Document Level</td><td>NCPDP</td><td>AM</td><td>AM01</td><td>HN</td><td>
<table>
<tr><th>FIELD</th><th>DESCRIPTION</th><th>USAGE</th><th>FORMAT/VALUE</th></tr>
<tr><td>DREC</td><td>Date of Receipt</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>DADJ</td><td>Date of Adjudication</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>DPYM</td><td>Date of Payment</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>PYMS</td><td>Payment Status - Paid
Payment Status - Denied</td><td>Mandatory</td><td>P
D</td></tr>
</table>
Note:
• There should be at least one space between the pair values
• Each pair must have one hyphen(-) between the field and value
• The pair values may be in any order
</td></tr>
</table>

NCPDP Example	
Sample Format	DREC-CCYYMMDD DADJ-CCYYMMDD DPYM-CCYYMMDD PYMS-x
HN Field	HNDREC-20170223 DADJ-20170224 DPYM-20170225 PYMS-P **OR** HNDREC-20170223 DADJ-20170224 DPYM-20170225 PYMS-D

3.2.10.2 Payment Amount & Date

All encounters require a Medicaid payment amount.

For paid encounters, the payment amount should reflect the amount paid to provide services to the member and should not reflect a capitated or salaried reimbursement arrangement.

In most cases, paid claims will contain at least one service line that has a payment amount greater than zero. However, there are instances when a zero-pay amount is appropriate for a paid encounter. For example, when a third-party payer makes a payment for a service and the payment covers the total billed amount or exceeds the Medicaid allowable amount, then a zero-pay by the Medicaid payer is appropriate. Another instance, the Medicaid payer could have an arrangement with a subcontractor whereby the subcontractor payment is capitated. In this case, it would be appropriate for the subcontractor to indicate a zero-pay for the service rendered.

Denied claims must always have a payment amount of zero.

On 837 transactions, Loop 2320 (Other Subscriber Information) is used to report Payment/Adjudication information. Loop 2320 should be repeated for each payer that is involved in the payment of the claim (MCO entities are considered payers). Loop 2330B identifies the Payer and coordinating loop 2430 will contain the detailed adjudication/payment information. Please note the usage of the following elements:

- SBR01 (Payer Responsibility Sequence Number) indicates the order in which the claim is adjudicated when multiple payers are involved. Medicaid is always the payer of last resort.
- SBR09 (Filing Indicator Code) must be populated with the appropriate indicator to specify the carrier type. For example, Medicare Part B would use “MB”. Medicaid (including MCOs) will use indicator “MC”.
- Loop 2430, SVD01 (Other Payer Primary Identifier) must match the appropriate value in loop 2330B, NM109 (Other Payer Primary Identifier) for adjudication information to be complete.

837 – Adjudication/Payment Information						
Trans Type	**Loop**	**Segment**	**Element**	**Value**	**Description**	**Requirement**
837P 837I 837D	2320	SBR	01	Most common: P=Primary S=Secondary T=Tertiary All TR3 values accepted	Payer responsibility sequence number code; When multiple payers, Medicaid is always last.	Mandatory
			09	Most common: MC=Medicaid/MCO	Claim Filing Indicator Code; Medicaid/MCO must use “MC”.	Mandatory

				MA=Medicare A MB=Medicare B CI=Commercial Insurance All TR3 values accepted		
		AMT	01	D	Payer Paid Amount	Mandatory
			02	Payment amount (COB)	COB Total Paid Amount	Mandatory when line amount not available
	2330B	NM1	09	Medicaid/MCO use Service Center Id	Other Payer Primary Identifier Must match 2430.SVD.01	Mandatory
	2430	SVD	01	Medicaid/MCO use Service Center Id	Other Payer Primary Identifier Must match 2320B.NM1.09	Medicaid-Mandatory TPL-Mandatory when available
			02	Payment amount (line)	Line payment amount must be present when possible. Otherwise, COB total paid amount must be present (2320.AMT.02).	
		DTP	01	573	Date Qualifier	
			02	D8	Date – CCYYMMDD format	
			03	Payment cycle date	Payment cycle in which the claim was paid or denied.	

On NCPDP transactions, the Coordination of Benefits/Other Payments segment (AM05) is used to report payment/adjudication information. The Coordination of Benefits/Other Payments Count (338-5C) will indicate the number of payers that are reported within the segment. Each payer that is involved in the payment of the claim (MCO entities are considered payers) should be reported in a separate COB/Other Payments occurrence within the Coordination of Benefits/Other Payments segment (AM05) in accordance with the NCPDP standard.

NCPDP - Adjudication/Payment Information						
Trans Type	**Loop**	**Segment**	**Element**	**Value**	**Description**	**Requirement**
NCPDP		AM05	4C	1-9	COB/Other Payments Count - EPS will accept a maximum of 9 occurrences (in accordance with the NCPDP standard)	Mandatory
			5C	01-09	Other Payer Coverage Type – Medicaid is always the last payer	Mandatory
			6C	03 or 99	Other Payer ID Qualifier 03 = BIN ID 99 = Other	Mandatory
			7C	Medicaid/MCO use 4-digit Service Center ID	Other Payer ID	Mandatory
			E8	Payment cycle date	Payment cycle in which the claim was paid or denied	Mandatory
			HB	1	Other Payer Amount Paid Count - Only 1 Amount Paid allowed	Mandatory
			HC	07	Other Payer Amount Paid Qualifier 07 = Drug Benefit	Mandatory
			DV	Payment amount	Other Payer Amount Paid	Mandatory

3.2.10.2.1 Single Payer

The example below shows an 837P encounter where only one payer (Medicaid) was involved in the payment of the claim. Service line adjudication/payment info must always be reported for Medicaid payers.

837I transactions will follow the same pattern.

PAYMENT INFORMATION **837P Example** **Single Payer**	
Example 1: **Single Payer with Payment > 0**	**Example 2:** **Single Payer with Payment = 0** **(Non-denied "zero-paid" claim)**
SBR*P*18*****MC~** ← *MC=Medicaid Primary* **AMT*D*130~** OI***Y***Y~ NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~ N3*1329 ANYSTREET DR~ N4*ANYCITY*VA*229024939~ NM1*PR*2*PAYER NAME*****PI***CP01~** LX*1~ SV1*HC:99232*150*UN*1*21**1****Y~ DTP*472*D8*20170315~ SVD***CP01***130*HC:99232**1~ ← *Medicaid detailed payment info* CAS*CO*45*20~ DTP*573*D8*20170405~	**SBR*P*18*******MC~** ← *MC=Medicaid Primary* **AMT*D*0~** OI***Y***Y~ NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~ N3*1329 ANYSTREET DR~ N4*ANYCITY*VA*229024939~ NM1*PR*2*PAYER NAME*****PI***CP01~** LX*1~ SV1*HC:99232*150*UN*1*21**1****Y~ DTP*472*D8*20170315~ SVD***CP01***0*HC:99232**1~ ← *Medicaid detailed payment info* CAS*CO*45*150~ DTP*573*D8*20170405~

The example below shows a NCPDP encounter where only one payer (Medicaid) was involved in the payment of the pharmacy claim.

PAYMENT INFORMATION **NCPDP Example** **Single Payer**
Example 1: **Single Payer with Payment > 0**
RSFSAM05FS4C1 FS5C01FS6C99FS7C**CP01**FSE820180805FSHB1FSHC07FSDV0000143{ ← *COB segment, count = 1 payer Medicaid – Primary, $143.00*
Example 2: **Single Payer with Payment = 0** **(Non-denied "zero-paid" claim)**
RSFSAM05FS4C1 FS5C01FS6C99FS7C**CP01**FSE820180214FSHB1FSHC07FSDV0000000{ ← *COB segment with 1 payer Medicaid – Primary, $0.00*

3.2.10.2.2 Third-Party Liability (TPL)

If there is third-party liability (TPL) involved in the payment of the claim, the Contractor is required to submit the TPL adjudication/payment information in addition to his own payment information. This includes crossover or commercial claims submitted to the Medicaid plan/MCO where there is no Medicaid/MCO payment required or TPL in which there was a "zero payment". TPL may originate from other payers such as Medicare and Commercial carriers.

When more than one third-party payment is involved, each third-party payer adjudication information must be reported separately via loop 2320 for 837 transactions. Service line adjudication/payment info for third-party payers must be reported when available. See example below.

PAYMENT INFORMATION
837P Example
TPL – Commercial Insurance

Example 1: Two Payers
Commercial Payment = 0 and Medicaid Payment > 0

```
SBR*P*18*******CI~                    <- Commercial Insurance Primary
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*COMMERCIAL PAYER*****PI*C2021333~
SBR*S*18*******MC~                    <- Medicaid Secondary
AMT*D*166~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*CP01~
LX*1~
SV1*HC:99232*190*UN*1*21**1****Y~
DTP*472*D8*20170315~
SVD*C2021333*0*HC:99232**1~           <- Commercial detailed payment info
CAS*CO*45*190~
DTP*573*D8*20170405~
SVD*CP01*166*HC:99232**1~             <- Medicaid detailed payment info
CAS*CO*45*24~
DTP*573*D8*20170411~
```

Example 2: Two Payers
Commercial Payment > 0 and Medicaid Payment = 0

```
SBR*P*18*******CI~                    <- Commercial Insurance Primary
AMT*D*50~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*COMMERCIAL PAYER*****PI*C2021333~
SBR*S*18*******MC~                    <- Medicaid Secondary
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*CP01~
LX*1~
SV1*HC:99232*70*UN*1*21**1****Y~
DTP*472*D8*20170315~
SVD*C2021333*50*HC:99232**1~          <- Commercial detailed payment info
CAS*CO*45*20~
DTP*573*D8*20170405~
SVD*CP01*0*HC:99232**1~               <- Medicaid detailed payment info
CAS*CO*45*70~
DTP*573*D8*20170411~
```

Example 3: Three Payers
Commercial Payment > 0, Medicare Payment > 0, and Medicaid Payment > 0

```
SBR*P*18*******CI~                    <- Commercial Insurance Primary
AMT*D*100~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*COMMERCIAL PAYER*****PI*C2021333~
SBR*S*18*******MB~                    <- Medicare Secondary
AMT*D*43~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*M553~
SBR*T*18*******MC~                    <- Medicaid Tertiary
AMT*D*95~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*CP01~
LX*1~
SV1*HC:99232*365*UN*1*21**1****Y~
DTP*472*D8*20170315~
SVD*C2021333*100*HC:99232**1~         <- Commercial detailed payment info
CAS*CO*45*265~
DTP*573*D8*20170401~
SVD*M553*43*HC:99232**1~              <- Medicare detailed payment info
CAS*CO*45*322~
DTP*573*D8*20170410~
SVD*CP01*95*HC:99232**1~              <- Medicaid detailed payment info
CAS*CO*45*270~
DTP*573*D8*20170421~
```

When more than one third-party payment is involved, each third-party payer adjudication information must be reported separately via an additional occurrence within the COB/Other Payments segment (AM05) for NCPDP transactions. See example below.

PAYMENT INFORMATION
NCPDP Example
TPL

Example 1: Two Payers
Payer1 Payment = 0 and Medicaid Payment > 0

```
RSFSAM05FS4C2
FS5C01FS6C99FS7CC2021333FSE820180805FSHB1FSHC07FSDV0000000{
FS5C02FS6C99FS7CCP01FSE820180815FSHB1FSHC07FSDV0000125H
```

COB segment, count = 2 payers
Payer1 – Primary, $0.00
Medicaid – Secondary, $12.58

Example 2: Two Payers
Payer1 Payment > 0, and Medicaid Payment = 0

```
RSFSAM05FS4C2
FS5C01FS6C99FS7CC2021333FSE820181016FSHB1FSHC07FSDV0000256E
FS5C02FS6C99FS7CCP01FSE820181025FSHB1FSHC07FSDV0000000{
```

COB segment, count = 2 payers
Payer1 – Primary, $25.65
Medicaid – Secondary, $0.00

Example 3: Three Payers
Payer1 Payment > 0, Payer2 Payment > 0, and Medicaid Payment > 0

```
RSFSAM05FS4C3
FS5C01FS6C99FS7CC2021333FSE820180903FSHB1FSHC07FSDV0000256{
FS5C02FS6C99FS7CM553FSE820180910FSHB1FSHC07FSDV0000106C
FS5C03FS6C99FS7CCP01FSE820180918FSHB1FSHC07FSDV0000032B
```

COB segment, count = 3 payers
Payer1 – Primary, $25.60
Payer2 – Secondary, $10.63
Medicaid – Tertiary, $3.22

3.2.10.2.3 Medicare

If there is Medicare payment involved with the claim, the Contractor is required to submit the Medicare adjudication/payment information in addition to his own payment information. This includes Medicare crossover claims submitted to the Medicaid plan/MCO for which there is no Medicaid/MCO payment required. Also included are claims in which there was a "zero payment" by Medicare. In addition, any claims for which the Medicaid plan/MCO was responsible for the Medicare covered services as a MA or D-SNP plan. The plans will calculate and separately record the Medicare and Medicaid liability for claim payment it makes to a provider as both the Medicare (MA or DSNP) and Medicaid payer. For 837 transactions, Medicare adjudication/payment information is reported in the same manner as TPL using loops 2320, 2330B, and 2430. Several 837P examples below show Medicare payment. 837I transactions will follow the same pattern.

ADJUDICATION/PAYMENT INFORMATION
837P Example
Medicare

Example 1:
Medicare Payment = 0 and Medicaid Payment > 0

```
SBR*P*18*******MB~
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*MEDICARE B*****PI*H3067~
SBR*S*18*******MC~
AMT*D*166~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*CP01~
LX*1~
SV1*HC:99232*190*UN*1*21**1****Y~
DTP*472*D8*20170315~
SVD*H3067*0*HC:99232**1~
CAS*CO*45*190~
DTP*573*D8*20170405~
SVD*CP01*166*HC:99232**1~
CAS*CO*45*24~
DTP*573*D8*20170411~
```

MB=Medicare B Primary

MC=Medicaid Secondary

Medicare B detailed payment info

Medicaid detailed payment info

Example 2:
Medicare Payment > 0 and Medicaid Payment = 0

```
SBR*P*18*******MB~
AMT*D*166~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*MEDICARE B*****PI*H3067~
SBR*S*18*******MC~
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*CP01~
LX*1~
SV1*HC:99232*190*UN*1*21**1****Y~
DTP*472*D8*20170315~
SVD*H3067*166*HC:99232**1~
CAS*CO*45*24~
DTP*573*D8*20170405~
SVD*CP01*0*HC:99232**1~
CAS*CO*45*190~
DTP*573*D8*20170411~
```

MB=Medicare B Primary

MC=Medicaid Secondary

Medicare B detailed payment info

Medicaid detailed payment info

Example 3:
Medicare Payment = 0 and Medicaid Payment = 0

```
SBR*P*18*******MB~
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*MEDICARE B*****PI*H3067~
SBR*S*18*******MC~
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*CP01~
LX*1~
SV1*HC:99232*190*UN*1*21**1****Y~
DTP*472*D8*20170315~
SVD*H3067*0*HC:99232**1~
CAS*CO*45*190~
DTP*573*D8*20170405~
SVD*CP01*0*HC:99232**1~
CAS*CO*45*190~
DTP*573*D8*20170411~
```

MB=Medicare B Primary

MC=Medicaid Secondary

Medicare B detailed payment info

Medicaid detailed payment info

Example 4:
Medicare Payment > 0 and Medicaid Payment > 0

```
SBR*P*18*******MB~
AMT*D*125~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*MEDICARE B*****PI*H3067~
SBR*S*18*******MC~
AMT*D*45~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*111222333444~
N3*1329 ANYSTREET DR~
N4*ANYCITY*VA*229024939~
NM1*PR*2*PAYER NAME*****PI*CP01~
LX*1~
SV1*HC:99232*190*UN*1*21**1****Y~
DTP*472*D8*20170315~
SVD*H3067*125*HC:99232**1~
CAS*CO*45*65~
DTP*573*D8*20170405~
SVD*CP01*45*HC:99232**1~
CAS*CO*45*145~
DTP*573*D8*20170411~
```

MB=Medicare B Primary

MC=Medicaid Secondary

Medicare B detailed payment info

Medicaid detailed payment info

3.2.11 Supplemental Contract Information

The EPS EDI compliance check will not allow the CN1 segment on 837 transaction sets. If an encounter is submitted with this segment present at the document or line level, the EDI compliance check will set an error. In place of the CN1 segment, contractual information must be reported in the K3 segment. All encounters should identify how the claim was paid using values from the CN1 segment, but sent in the document level K3 segment. NOTE: Show the payment arrangement between the Payer and the provider, not the arrangement between DMAS and the Contractor.

837 – Contract Information

Doc/Line Level	Trans Type	Loop	Segment	Element	Description
Document Level	837P 837D 837I	2300	K3	01	See below
Line Level	837P 837D	2400	K3	01	

FIELD	DESCRIPTION	USAGE	SIZE	FORMAT/VALUE
CN101	Contract Type Code	Mandatory	2	99
CN102	Contract Amount	Optional	10	9999999.99
CN103	Contract Percent	Optional	3	999
CN104	Contract Code	Optional	3	XXX
CN105	Discount Percent	Optional	3	999
CN106	Version ID	Optional	4	XXX

Notes:

- **The K3 segment containing CN1 data is mandatory.**
- **There should be at least one space between the pair values**
- **Each pair must have one hyphen (-) between the field and value**
- **The pair values may be in any order**
- **There is no CN1 segment in line level for 837I**

837 Example	
Sample Format	`CN101-99 CN102-9999999.99 CN103-999 CN104-xxx CN105-999 CN106-xxxx`

K3 Segment with CN1 data requirements	`K3*CN101-01 CN102-50.23 CN103-34 CN104-AB1 CN105-57 CN106-V01`
	`K3*CN101-01 CN102-50.23 CN103-34`
	`K3*CN101-01 CN102-50.23 CN103-34 CN104-AB2`
	`K3*CN101-01 CN102-50.23 CN104-AB1 CN105-57 CN106-V01`

3.2.12 Drug Services

3.2.12.1 Drug Rebates

DMAS is required by the Affordable Care Act to collect pharmacy rebates for drugs provided to Medicaid members in an outpatient setting who are enrolled in a managed care arrangement. For successful rebate collection, pharmacy/drug encounters must contain certain required fields, e.g., NDC, MCO payment date, MCO payment amount. Drugs may be submitted as pharmacy or medical for the following transaction types: Pharmacy (NCPDP), Professional (837P), and Institutional (837I).

The following data elements must be populated on the EDI transaction to DMAS for successful rebate collection from the manufacturer.

Data Element	EDI Reference		
	NCPDP Field	**837P Loop.Segment.Element**	**837I (outpatient only) Loop.Segment.Element**
MCO payment amount	431-DV	2430.SVD.02	Claim level: 2320.AMT.01=D 2320.AMT.02 OR Service level: 2430.SVD.02
MCO payment cycle date	443-E8	2430.DTP.01=573 2430.DTP.03	Claim level: 2330B.DTP01=573 2330B.DTP03 OR Service level: 2430.DTP.01=573 2430.DTP.03
Medicaid member ID	302-C2	2010BA.NM1.09	2010BA.NM1.09
NDC	407-D7	2410.LIN.02=N4 2410.LIN.03	2410.LIN.02=N4 2410.LIN.03
Drug unit of measure (837 only)	N/A	2410.CTP.05-1	2410.CTP.05-1
Drug unit/quantity	442-E7	2410.CTP.04	2410.CTP.04

3.2.12.2 340B Drugs

340B drugs are not eligible for rebate. The Contractor must have a process in place to identify 340B drugs so that the drug may be excluded from rebate collection. The technical requirements for 340B drug identification are shown below.

DRUG SERVICES Identifying 340B Drugs						
Trans Type	**Loop**	**Segment**	**Element/ Field**	**Element/Field Name**	**Value**	**Requirement**
NCPDP		AM07	420-DK	Submission Clarification Code	20	• Submission Clarification Code of 20 is used to identify a 340B drug for pharmacy transactions
837P	2400	SV1	01 (3-6)	Procedure Modifier	UD	• Each drug service line must contain modifier UD along with the procedure code and NDC
837I	2400	SV2	02 (3-6)	Procedure Modifier	UD	• If bill type is 13x or 83x, each drug revenue line must contain modifier UD along with the procedure code and NDC

3.2.12.3 NCPDP Pharmacy – Multiple Transaction Submission

The requirement below must be followed when submitting NCPDP pharmacy transactions to EPS. Please note that the requirement is for NCPDP pharmacy transactions only.

- When all NCPDP transactions related to one claim occur within the same adjudication cycle, only the final version of the claim (encounter) should be submitted to EPS unless the final version results in a reversal of the claim.
- When all NCPDP transactions related to one claim occur across multiple adjudication cycles, the final version of the claim (encounter) from each adjudication cycle should be submitted to EPS including a reversal that negates an original from a prior adjudication cycle. As noted above, if the final version of the claim results in a reversal of the original all within the same adjudication cycle, no submission to EPS is necessary.

3.2.13 Consumer-Directed (CD), Agency-Directed(AD), & Home Health (HH) Services

Consumer-Directed services are identified based on the procedure codes which are included in the EPS CDSERVPROCS Cache Code set. Agency-Directed services are identified based on the procedure codes included in the EPS ADSERVPROCS EPS Cache Code set.

3.2.13.1 Electronic Visit Verification (EVV)

DMAS requires Electronic Visit Verification (EVV) reporting for individuals receiving personal care, respite care, and home health services. The federal 21st Century CURES Act requires states to implement Electronic Visit Verification. The following data elements are required:

1. Type of service performed
2. Member receiving the service
3. Date of service
4. Service begin and end time
5. The location of service delivery at the beginning and end of the service
6. Employee providing the service

3.2.13.2 Reporting 837P Consumer-Directed and Agency-Directed – EVV

837P – EVV Reporting Consumer-Directed & Agency-Directed					
Trans Type	**Doc/line Level**	**Loop**	**Segment**	**Element**	**Requirements**
837P	Line	2400	SV1	01-7 Description	For CD and AD services, this field is required and is the time the services began and ended for EVV requirements. Format is HHMM-HHMM. HH will be 00 – 23 and MM will be 00 – 59. Example is 1130-1630 (11:30AM – 4:30PM)
		2420D	NM1	03 Attendant Last Name	This field is required for CD and AD services to identify the Last name of the Attendant associated to the service delivered for EVV requirements.
				04 Attendant First Name	This field is required for CD and AD services to identify the First name of the Attendant associated to the service delivered for EVV requirements.
			REF	01 Reference Identification Qualifier	This field is required for CD and AD services when attendant information is submitted in Loop 2420D Attendant Name associated to the service delivered for EVV requirements.
				02 Reference Identification	This field is required for CD and AD services to identify the unique Attendant ID (not SSN or FEIN) for the Attendant associated to the service delivered for EVV requirements.
		2420G	NM1		This segment is used and required for CD and AD services to identify the Begin Location of the service delivered for EVV.
			N3	01 Address Information	This segment is used and required for CD and AD services to identify the Begin Location Street Address of the service delivered for EVV.
			N4	01 City Name 02 State Code 03 Postal Code	This segment is required for CD and AD services to identify the Begin Location City, State, and ZIP Code of the service delivered for EVV.
		2420H	NM1		This segment is required for CD and AD services to identify the End Location of the service delivered for EVV.
			N3	01 Address Information	This segment is required for CD and AD services to identify the End Location Street Address of the service delivered for EVV.
			N4	N401 City Name N402 State Code N403 Postal Code	This segment is required for CD and AD services to identify the End Location City, State, and ZIP Code of the service delivered for EVV.

837P Example
Consumer-Directed - EVV

```
CLM*15465439*25.04***12:B:1*Y*A*Y*Y~
AMT*F5*0~
K3*DREC-20230719 DADJ-20230801 DPYM-20230811 PYMS-P~
K3*CN101-09~
HI*ABK:R6889~
SBR*P*18*******MC~
AMT*D*25.04~
OI***Y***I~
NM1*IL*1*NAME2*NAME1****MI*999999999999~
N3*225 ANYNAME RD~
N4*ANYTOWN*VA*229722730~
NM1*PR*2*BEST CONSUMER DIRECT CARE *****PI*CP01~
LX*1~
SV1*HC:S5126:::::0645-0830*25.04*UN*1.75*12**1~
DTP*472*D8*20230719~
REF*G1*CFR9999999~
REF*6R*15365409~
K3*PYMS-P~
K3*CN101-09~
NM1*DQ*1*LNAME*FNAME~
REF*LU*999999999~
NM1*PW*2~
N3*225 ANYNAME RD~
N4*ANYTOWN*VA*22972~
NM1*45*2~
N3*225 ANYNAME RD~
N4*ANYTOWN*VA*22972~
SVD*CP01*25.04*HC:S5126**1.75~
DTP*573*D8*20230811~
```

EVV Begin and End time

Attendant Last and First name

Attendant ID

EVV Beginning Location
Address, City, State, Zip Code

EVV Ending Location
Address, City, State, Zip Code

3.2.13.3 Reporting 837I Home Health - EVV

Home Health Care services are identified based on the Bill type which are included in the Cache Code set HHBILLTYPE and the revenue codes which are included in the EPS Cache Code set HHSERVREVCODES.

837I - EVV Reporting Home Health					
Trans Type	**Doc/line Level**	**Loop**	**Segment**	**Element**	**Description**
837I	Doc	2310E	NM1	03 Entity Identifier Code	For HH EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. Value must be ''HH EVV Service Location'. This will be used to indicate where the HH EVV services were performed.
			N3	01 Address Information	For HH EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. This will be used to indicate the street address where the HH EVV services were performed.
			N4	01 City Name 02 State Code 03 Postal Code	For HH EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. This will be used to indicate the City, State, and ZIP Code of the location where the HH EVV services were performed.
			REF	01 Reference Identification Qualifier	For HH EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. The value for this element will be 'LU'.
				02 Reference Identification	For HH EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. The value for this element will be '99999'.
	Line	2400	SV2	02-7 Description	For HH services (CLM05-1 Facility Type Code = 32 or 34). This field is required and is the time the services began and ended for EVV requirements. Format is HHMM-HHMM. HH will be 00 – 23 and MM will be 00 – 59.
		2420D	NM1	03 Name Last	For HH EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. This field is used to identify the Last Name of the HH Attendant delivering the services.
				04 Name First	For HH EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. This field is used to identify the First Name of the HH Attendant delivering the services.
			REF	01 Reference Identification Qualifier	For HH EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. The value for this element is G2 (Commercial ID). This field is used to identify the type of identifier for the REF02 value associated to the HH Attendant delivering the services.
				02 Reference Identification	For HH EVV services (CLM05-1 Facility Type Code = 32 or 34), this field is required. This field is used to identify the unique Attendant ID (not SSN or FEIN) for the HH Attendant delivering the services.

837I Example
Home Health - EVV

```
CLM*1227X60872*185***32:A:1**A*Y*Y~
DTP*434*RD8*20220504-20220504~
CL1*3*4*30~
REF*D9*999234608884~
K3*CN101-09~
HI*ABK:N390~
HI*APR:N390~
HI*ABF:B965*ABF:B952*ABF:Z466*ABF:L89154*ABF:G8221*ABF:E1122*ABF:N1830*ABF:G4700*ABF:M4640*ABF:
K8080*ABF:N210*ABF:Z7984~
NM1*71*1*LNAME*FNAME M****XX*9999999999~
HI*ABF:
B965*ABF:B952*ABF:Z466*ABF:L89154*ABF:G8221*ABF:E1122*ABF:N1830*ABF:G4700*ABF:M4640*ABF:K8080*A
BF:N210*ABF:Z7984~
NM1*71*1*LNAME*FNAME M****XX*1679472973~
NM1*77*1*SERVICE LOCATION NAME~
N3*123 MAIN STREET~
N4*ANY CITY*VA*225542456~
REF*LU*99999~
SBR*P*18**OHCC-SWWND*****MC~
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LASTNAME*FIRSTNAME*M***MI*999999999999~
NM1*PR*2*VAMES EPS*****PI*CP01~
LX*1~
SV2*0434*HC:G0152:::::0600-1600*185*UN*1**185~
DTP*472*RD8*20220504-20220504~
NM1*DN*1*BESTLNAME*BESTFNAME~
REF*G2*99999999~
SVD*CP01*0*HC:G0152*0434*1~
CAS*CO*16*185~
DTP*573*D8*20221003~
AMT*EAF*0~
```

HH EVV Service Location Name

HH EVV Service Location Address, City, State, Zip Code

HH EVV Service Location Qualifier and Reference ID

HH EVV Start and End time

HH EVV Attendant Last and First Name

HH EVV Attendant ID

3.2.13.4 Adjudication/Payment Information - Additional Dates & Payment Status

For adjudication/payment information on Consumer Directed Attendant encounters, the following definitions will be used for the required additional data and payment status. Please note that these definitions override the descriptions listed in Section 3.2.10.1.

Document Level

- Date of Receipt (DREC) = Payroll Start Date - date of the current pay cycle to which a timesheet has been submitted for a payment (mandatory).
- Date of Adjudication (DADJ) = Check Date – the date in the payroll cycle that the timesheet enters paid status (mandatory).
- Date of Payment (DPYM) = Date that the CD F/EA Agent is paid by the MCO (mandatory).
- Payment Status (PYMS) = Payment status will always be "P". The Contractor receives 100% voucher payment within specified payment term. As such, the 837 represents encounter data for paid claims (mandatory).

Line Level

- Payment Status (PYMS) = Payment status will always be "P". The Contractor receives 100% voucher payment within specified payment term. As such, the 837 represents encounter data for paid claims (mandatory).

837P – Consumer Directed Attendants
Adjudication/Payment Information
Additional Payment Dates & Status

<table>
<tr><th>Trans Type</th><th>Doc/Line Level</th><th>Loop</th><th>Segment</th><th>Element</th><th>Description</th></tr>
<tr><td rowspan="2">837P</td><td>Document Level</td><td>2300</td><td>K3</td><td>01</td><td>
<table>
<tr><th>FIELD</th><th>DESCRIPTION</th><th>USAGE</th><th>FORMAT/VALUE</th></tr>
<tr><td>DREC</td><td>Payroll Start Date</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>DADJ</td><td>Check Date</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>DPYM</td><td>Date CD F/EA Agent is paid by MCO</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>PYMS</td><td>Payment Status – Paid</td><td>Mandatory</td><td>P</td></tr>
</table>
Note:
• There should be at least one space between the pair values
• Each pair must have one hyphen (-) between the field and value
• The pair values may be in any order
</td></tr>
<tr><td>Line Level</td><td>2400</td><td>K3</td><td>01</td><td>
<table>
<tr><th>FIELD</th><th>DESCRIPTION</th><th>USAGE</th><th>FORMAT/VALUE</th></tr>
<tr><td>PYMS</td><td>Payment Status - Paid</td><td>Mandatory</td><td>P</td></tr>
</table>
</td></tr>
</table>

837P - Example	
Sample Format	DREC-CCYYMMDD DADJ-CCYYMMDD DPYM-CCYYMMDD PYMS-P
K3 Segment	K3*DREC-20170910 DADJ-20170915 DPYM-20170920 PYMS-P

3.2.13.5 Reporting Attendant Overtime

To report overtime for Consumer Directed attendants, procedure modifier "TU" must be present at the service line at loop 2400 in element SV101-3 or SV101-4 through SV101-6 if other modifiers are present on the line. Regular hours and overtime hours must be reported on separate service lines.

3.2.13.6 EVV Requirement Exemption

For situations where EVV requirements are exempt, the "UB" modifier must be present at the service line at loop 2400 in element SV101-3 or SV101-4 through SV101-6 if other modifiers are present on the line. The modifier will indicate the exemption and EPS business rules for EVV will be bypassed.

3.2.14 Newborns without Medicaid IDs

For newborns that do not have a Medicaid ID, the newborn encounter must contain a Medicaid ID that consists of the first 11-digits of the mother's Medicaid ID plus an alpha character in the 12th position. The alpha character is to be uppercase and in the range of "A" through "Z". Alpha characters should be used in succession, ascending to descending for each baby.

Example:

Mom's Medicaid ID = 111222333449
Baby #1 Medicaid ID = 11122233344A
Baby #2 Medicaid ID = 11122233344B
Baby #3 Medicaid ID = 11122233344C

Newborns without Medicaid IDs						
Name	**Trans Type**	**Loop**	**Segment**	**Element**	**Value**	**Requirements**
Medicaid Member ID	837P 837I 837D	2010BA	NM1	09	Mother's Medicaid ID + Alpha character	• Use first 11-digits of mother's Medicaid ID • Post-fix alpha character in the 12th position • Alpha character range "A-Z", used in succession, ascending to descending for each baby
	NCPDP		AM04	302-C2		

3.2.15 Dental Services

All dental-related services must be reported. There are instances where oral medical services are rendered along with or in addition to dental services. When services occur in a facility or hospital setting, the service is typically billed as a medical claim using a dental-related HCPCS procedure code. If there is no appropriate dental-related HCPCS procedure code available, the encounter must use an American Dental Association code (AD) and be submitted on an 837D transaction. AD codes are only allowed on 837D transactions and HCPCS dental-related medical codes are only allowed on 837P/837I transactions.

3.2.16 Enhanced Benefit Services

Some payers offer enhanced benefit services to their members. When these services are present on the encounter, the payer must identify the service as an enhanced benefit by using an indicator at the service line. The indicator consists of a field label ("Field" column in chart below), a hyphen immediately following, and the field value. The field label must appear exactly as shown in the chart below. Field/value pairs may be in any order when multiple field/value pairs are used (e.g. PYMS-P and EBIN-Y together). There must be at least one space to serve as a delimiter between the pairs. See 837P example below.

837 – Identifying Enhanced Benefits

Doc/Line Level	Trans Type	Loop	Segment	Element	Description
Line Level	837P	2400	K3	01	FIELD: **EBIN** — DESCRIPTION: Enhanced Benefit Indicator — USAGE: Required when enhanced services are present; Omitted on non-enhanced benefit services. — FORMAT/VALUE: Y **Note:** • **There should be at least one space between the pair values** • **Each pair must have one hyphen(-) between the field and value** • **The pair values may be in any order**
	837I	2400	NTE	02	FIELD: **EBIN** — DESCRIPTION: Enhanced Benefit Indicator — USAGE: Required when enhanced services are present; Omitted on non-enhanced benefit services. — FORMAT/VALUE: Y **Note:** • **There should be at least one space between the pair values** • **Each pair must have one hyphen(-) between the field and value** • **The pair values may be in any order**

837 Example	
Sample Format	**EXAMPLE 1:** PYMS-x EBIN-Y **EXAMPLE 2:** EBIN-Y PYMS-x
Line Level K3 Segment	**EXAMPLE 1:** `K3*PYMS-P EBIN-Y` **EXAMPLE 2:** `K3*EBIN-Y PYMS-D`

3.2.17 Supplemental Encounter Data for Reporting

3.2.17.1 Reporting Payment Reductions for ER Utilization & Hospital Readmissions

This data requirement is to support DMAS reporting of budget amendment payment reductions for emergency room utilization (313 #28C) and hospital readmissions (313 #29C). These requirements are applicable to ~~Medallion 4 and CCC Plus~~ Cardinal Care Managed Care medical encounters only. The MCO must identify an encounter for which payment was reduced in accordance with the budget amendment by including a K3 segment with the reduction amount as described below.

If available, all payment reduction amounts for this reporting requirement must be sent in the 2300 loop, K3 segment, data element K301. The K301 data element will contain a concatenated value of a label, a hyphen, and an associated dollar amount of zero or greater. If a reduction in payment occurred but the payment reduction amount is not available, the associated dollar amount will be zero. If a reduction in payment occurred and payment reduction amount is available, the associated amount (greater than zero) must be populated on the K301 segment.

837 – Reporting Payment Reductions - ER Utilization & Hospital Readmissions

Doc/Line Level	Trans Type	Loop	Segment	Element	Description
Document Level	837P 837I	2300	K3	01	

FIELD	DESCRIPTION	USAGE	FORMAT/VALUE
NONEMG	Indicates that a payment reduction occurred for a non-emergent service that occurred in the ER	Required when a payment reduction occurs .	9999999 or 9999999.99 See X12 837 TR3 Appendix B (Nomenclature) for decimal data element type definition
READMT	Indicates that a payment reduction occurred for an inpatient readmission	Required when a payment reduction occurs	9999999 or 9999999.99 See X12 837 TR3 Appendix B (Nomenclature) for decimal data element type definition

Notes:

- **One hyphen(-) is required between the field and value**
- **NONEMG and READMT labels are mutually exclusive**
- **When the NONEMG or READMT indicator is used, the field/label should not occur on a K3 segment with other K3 labels. It will be on a K3 segment occurrence alone.**
- **The value must be a dollar amount by which the payment amount was reduced. A value of zero indicates that a reduction in payment occurred but the dollar amount could not be determined.**

3.2.17.1.1 Reporting Payment Reductions for Emergency Room Utilization on Professional Encounters (837P)

For 837P, the label "NONEMG" will indicate a payment reduction for emergency room utilization. The payment amount will include the total of all payment reductions at the line level related to emergency room utilization on the claim. If a reduction in payment occurred but the amount cannot be determined, the payment reduction amount will be zero.

Reporting Payment Reductions – ER Utilization **837P – Examples**	
Example 1	Payment reduction amount: $486.10 Format: K3*NONEMG-9999999.99~ K3 segment: `K3*NONEMG-486.10~`
Example 2	Payment reduction amount: $467.00 Format: K3*NONEMG-9999999~ K3 segment: `K3*NONEMG-467~`
Example 3	Payment reduction occurred but the amount cannot be determined Format: K3*NONEMG-9999999~ K3 segment: `K3*NONEMG-0~`

3.2.17.1.2 Reporting Payment Reductions for Emergency Room Utilization on Institutional Encounters (837I)

For 837I, the label "NONEMG" will indicate a payment reduction for emergency room utilization. The payment amount will include the total of all payment reductions at the line level related to emergency room utilization on the claim. If a reduction in payment occurred but the amount cannot be determined, the payment reduction amount will be zero.

Reporting Payment Reductions – ER Utilization **837I – Examples**	
Example 1	Payment reduction amount: $5,843.40 Format: K3*NONEMG-9999999.99~ K3 segment: `K3*NONEMG-5843.40~`
Example 2	Payment reduction amount: $1,389.00 Format: K3*NONEMG-9999999~ K3 segment: `K3*NONEMG-1389~`
Example 3	Payment reduction occurred but the amount cannot be determined Format: K3*NONEMG-9999999~ K3 segment: `K3*NONEMG-0~`

3.2.17.1.3 Reporting Payment Reductions for Hospital Readmission on Institutional Encounters (837I)

The label "READMT" will indicate a payment reduction for hospital readmission. The payment amount will include the total of all payment reductions at the line level related to hospital readmission on the claim. If a reduction in payment occurred but the amount cannot be determined, the payment reduction amount will be zero.

Reporting Payment Reductions - Hospital Readmission **837I – Examples**	
Example 1	Payment reduction amount: $3,522.10 Format: K3*READMT-9999999.99~ K3 segment: `K3*READMT-3522.10~`
Example 2	Payment reduction amount: $2,199.00 Format: K3*READMT-9999999~ K3 segment: `K3*READMT-2199~`
Example 3	Payment reduction occurred but the amount cannot be determined Format: K3*READMT-9999999~ K3 segment: `K3*READMT-0~`

3.2.18 Reporting Allowed Amount

Per CMS requirement for encounters (CMS Rule §438.242(C)(3)), Allowed Amount must be reported on all services for all encounter types, including subcontracted data.

For 837 transactions, Allowed Amount is reported in the Claim Pricing/Repricing Information segment at the document and line levels, as outlined below.

Reporting Allowed Amount 837					
Trans Type	**Doc/line Level**	**Loop**	**Segment**	**Element**	**Requirements**
837P 837I 837D	Doc	2300	HCP	01	This is a required field. Populate the HCP01 Pricing Methodology field with a value of 03 (Priced at a Contractual Percentage)
				02	This is a required field. Populate the HCP02 Monetary Amount with the allowed amount in the standard monetary format.
	Line	2400		01	This is a required field. Populate the HCP01 Pricing Methodology field with a value of 03 (Priced at a Contractual Percentage)
				02	This is a required field. Populate the HCP02 Monetary Amount with the allowed amount in the standard monetary format.

Allowed Amount
837 Example

```
CLM*TAR999999999999999*105***31:B:1*Y*A*Y*Y*P~
DTP*435*D8*20230405~
AMT*F5*0~
K3*DREC-20230926 DADJ-20230926 DPYM-20230929 PYMS-P~
K3*CN101-04 CN102-54.57~
HI*ABK:G894*ABF:E639*ABF:G629*ABF:F419*ABF:F32A~
HCP*03*54.57~          <-- Pricing Methodology Qualifier and Amount (Document Level)
NM1*82*1*LNAME*FNAME****XX*9999999999~
PRV*PE*PXC*363A00000X~
NM1*77*2*BEST PRACTICE REHAB AND NURSING*****XX*9999999999~
N3*4142 ANYSTREET RD~
N4*ANYTOWN*VA*234521711~
SBR*P*18*******MC~
AMT*D*54.57~
OI***Y*P**Y~
NM1*IL*1*LASTNAME*FIRSTNAME****MI*999999999999~
N3*309  E MAIN STREET*APT 3~
N4*ANYCITY*NJ*078660000~
NM1*PR*2*MCO OF VA*****PI*CP01~
LX*1~
SV1*HC:99308*105*UN*1***1:2:3:4~
DTP*472*D8*20230919~
REF*6R*1~
K3*PYMS-P~
K3*CN101-04 CN102-54.57~
HCP*03*54.57~          <-- Pricing Methodology Qualifier and Amount (Line Level)
SVD*CP14*54.57*HC:99308**1~
CAS*CO*45*50.43~
DTP*573*D8*20230929~
```

For NCPDP transactions, Allowed Amount is calculated using the required fields below:

431-DV - Other Payer Amount Paid
352-NQ - Other Payer-Patient Responsibility Amount

Reporting Allowed Amount NCPDP			
Trans Type	**Segment**	**Element**	**Requirements**
NCPDP	AM05	341-HB Other Payer Amount Paid Count	This is a required field.
		342-HC Other Payer Amount Paid Qualifier	This is a required field when fields HB and DV are populated. Use EPS Cache Code set OTHPYRAMTPDQUAL for values.
		431-DV Other Payer Amount Paid	This field is required when Other Payer Amount Paid and Other Payer Amount Paid Qualifier are used. Is mandatory for MCO Medicaid payment. Value in field must be zero or greater than zero. Negative amounts are not valid.
		353-NR Other Payer-Patient Responsibility Amount Count	This is a required field when fields NP and NQ are populated
		351-NP Other Payer-Patient Responsibility Amount Qualifier	This field is required if fields NR and NQ are populated. Use EPS Cache Code set OTHPYRPATRESAMTQUAL for values.
		352-NQ Other Payer-Patient Responsibility Amount	This field is required when Other Payer-Patient Responsibility Amount Paid and Other Payer-Patient Responsibility Amount Qualifier are used. Is mandatory for Paid Medicaid encounters. Value in field must be zero or greater than zero. Negative amounts are not valid.

Allowed Amount NCPDP Example
RSFSAM05FS4C1 FS5C01FS6C99FS7CCP01FSE820181016FSHB2FSHC03FSDV0000256EFSHC07FSDV0000256E FSNR2FSNP03FSNQ000000567{FSNP06FSNQ0000000967{FSA7259829999

3.3 Cardinal Care Managed Care Encounter Testing - Expectations & Timeline

3.3.1 Contractor System Implementations or Changes

The Contractor is required to submit test files for any event on their side that will impact the submission and/or the content of the encounter data before submitting encounter transactions to the EPS production environment. Examples of an event include: new internal encounter processing system, outsourcing the processing of encounters to a vendor, change to the existing encounter system software, change in subcontractor, change in software by the subcontractor, a change to the subcontractor's system, etc. The DMAS encounter teams must be notified of such events as soon as possible so that they may work with the Contractor concerning EPS testing.

DMAS will issue a customized EPS test plan to the Contractor which will contain scenarios that are designed to test encounter requirements that are applicable to the event, including parallel testing if deemed necessary by DMAS. DMAS will review the results of the test plan and approve production submission once all scenarios are successfully executed. The Contractor/ should make every effort to use production data, when available, for test plan execution. Test data may be used during the early stages of testing to expedite the process. Within 14 calendar days of system implementation, the Contractor must submit the first volume test file (using production data) to the EPS test environment while continuing to complete the individual test scenarios, if needed. Subsequent volume tests may be requested. Further details will be indicated in the DMAS-issued test plan, including the required minimum size of the volume test file(s).

The Contractor will be required to successfully complete all testing and submit the final version of the test plan results for review by DMAS no later than 90 calendar days from the "go live" date of the system implementation. Submission of production encounter files must begin no later than 10 calendar days and any backlog occurring during this test period and must be completed within 30 calendar days after DMAS approval of the test results.

3.3.2 New Subcontractors

The DMAS encounter teams should be notified as soon as possible when there is an upcoming change in subcontracted member services. When there is a new subcontractor, the Contractor must submit the appropriate EPS registration documents to obtain a new EPS subcontractor ID. Immediately following setup, it is recommended that a test transaction be submitted to confirm functionality.

DMAS will provide an EPS test plan to the Contractor to ensure that all encounter file and data requirements are met by the Contractor/Subcontractor. The Contractor/Subcontractor should make every effort to use production data, when available, for test plan execution. Test data may be used during the early stages of testing to expedite the process. Within two weeks of the new subcontractor's first payment cycle, the Contractor must submit the first volume test file (using production data) to the EPS test environment while continuing to complete the individual test scenarios, if needed. Subsequent volume tests may be requested. Further details will be indicated in the DMAS-issued test plan, including the required minimum size of the volume test file(s).

The Contractor will be required to successfully complete all testing and submit the final version of the test plan results for review by DMAS no later than 60 calendar days from the "go live" date of the subcontractor implementation. Submission of production encounter files must begin no later than 10 calendar days and any backlog occurring during this test period and must be completed within 30 calendar days after DMAS approval of the test results.

3.3.3 DMAS Required System Implementations or Changes

The Contractor is required to submit test files when the DMAS encounter teams announce new encounter requirements, add or update EPS business rules, or when other events necessitate changes to the encounter data, such as new requirements required by CMS, General Assembly, etc.

DMAS will issue a customized EPS test plan to the Contractor which will contain scenarios that are designed to test encounter requirements that are applicable to the event. DMAS will review the results of the test plan and provide production submission approval once all scenarios are successfully executed. The Contractor/ should make every effort to use production data, when available, for test plan execution. Test data may be used during the early stages of testing to expedite the process. Subsequent volume tests may be requested. Further details will be indicated in the DMAS-issued test plan, including the required minimum size of the volume test file(s).

The Contractor will be required to successfully complete all testing and submit the final version of the test plan results for review by DMAS no later than 14 calendar days from the "go live" date established by DMAS and submission of production encounter files must begin on this date.

4 EPS Processing

The purpose of this section is to provide an overall understanding of how EPS will track and create a status on each encounter transaction. There is also discussion concerning Claim Frequency types and EPS requirements for Replacement and Void transactions.

4.1 Understanding EPS Encounter Tracking & Status

4.1.1 EPS-assigned File Identifier

Each EDI file that is submitted to DMAS will be assigned a unique File Identifier and returned to the Contractor via the Acknowledgement (ACK) file. Please see the *COV EDI Procedure Manual* for further details about the Acknowledgement file. The File Identifier is an important number that is used by DMAS to track the file and is used for file identification when communicating with the Contractor. The layout below displays the structure of the File ID along with an example: F17050100005CPCP01EP.

FILE IDENTIFER						
	File Identifier	**Submission Date**	**Numeric Counter**	**Service Center**	**Transaction Indicator**	**Transaction Type**
Position	1	2-7	8-14	15-18	19	20
Format/ Value(s)	F=File	YY [17-99] MM [01-12] DD [01-31]	9999999	CPxx NExx M4xx DExx	E=Encounter F=FFS	P=837P I=837I D=837D N=NCPDP
Example	F	170501	0000600	CP01	E	P

4.1.2 EPS-assigned Transaction Control Number (TCN)

EPS assigns a Transaction Control Number (TCN) for every encounter transaction that is submitted to DMAS. The TCN is unique and is used for tracking the transaction through EPS processing. The layout below displays the structure of the TCN along with an example: T1705010000023BCPEPO.

Transaction Control Number (TCN)								
	Trans ID	**Submission Date**	**Trans Count Per Day**	**Submission Source**	**Program Identifier**	**Encounter / FFS**	**Trans Type**	**Claim Frequency**
Position	1	2-7	8-14	15	16-17	18	19	20
Format/ Value(s)	T = Trans ID	YY [17-99] MM [01-12] DD [01-31]	0000001-9999999	B=Batch R=Reprocess	CP=CCC Plus NE=FFS NEMT M4=Medallion DE=FFS Dental	E=Encounter	P=837P I=837I D=837D N=NCPDP	O=Original R=Replacement V=Void
Example	T	170501	0000023	B	CP	E	P	O

4.1.3 EPS-assigned Status

Once an Encounter is processed, the EPS will set the following statuses to define the state of the encounter: Validation Status, Active/Inactive Status, and Paid/Denied Status.

A Validation Status is set on the Encounter after all EPS business rules have been applied to the Encounter. The Validation Status for the Encounter will be set to either PASS or FAIL after processing is complete. DMAS may override the Validation Status from FAIL to PASS, HOLD, or EXCLUDE if deemed necessary.

EPS maintains a versioning method for processed transactions. The current transaction will be flagged as ACTIVE (Validation status may be PASS or FAIL). For example, once a replacement transaction is processed by the EPS, the original transaction status is set to INACTIVE and the replacement transaction becomes ACTIVE. Inactive transactions are considered to be historical.

An EPS Paid/Denied status is set based on whether the Payer considers the claim to be paid or denied. The Payer will provide a Paid /Denied status on the inbound record (see section 3.2.10.1 PYMS Payment Status provided on the K3 segment).

EPS Status	Value	EPS Status Description
Validation Status	PASS	Transaction has passed all EPS business rules.
	FAIL	Transaction has failed one or more EPS business rules.
	HOLD	Transaction has been manually set to a HOLD status because it falsely failed an EPS business rule (transaction should have passed). Transaction will be reprocessed once the EPS business rule is functioning properly. Validation Status is assumed to be PASS for reporting purposes and for the Data Quality Scorecard.
	EXCLUDE	Transaction has been manually set to an EXCLUDE status to allow the transaction to be excluded and suppressed from all reporting. This status represents transactions that should have not been submitted to EPS. Active/Inactive Status is set to INACTIVE.
Active/Inactive Status	ACTIVE	The most recent transaction received for an encounter in EPS is considered the ACTIVE version. All prior transactions in the EPS, if any, are considered INACTIVE.
	INACTIVE	
Paid/Denied Status	PAID	The EPS Paid/Denied Status is set from the PYMS Payment Status value that is populated by the Payer on the inbound encounter transaction (K3 segment).
	DENIED	

4.2 Transaction Frequency

The EPS will accept a variety of Claim Frequency Type Codes (837) and Transaction Codes (NCPDP). The chart below shows the values that EPS will accept.

837 Claim Frequency Type Code - EPS Acceptable Values					
Transaction Type	**Element Name**	**Loop**	**Segment**	**Element**	**Acceptable Values**
837P	Claim Frequency Type Code	2300	CLM	05-3	1, 7, 8
837I	Claim Frequency Type Code	2300	CLM	05-3	1, 2, 3, 4, 5, 7, 8, 9
837D	Claim Frequency Type Code	2300	CLM	05-3	1, 7, 8

NCPDP Transaction Code - EPS Acceptable Values					
Transaction Type	**Element Name**	**Segment**	**Element**	**Acceptable Values**	**Notes**
NCPDP	Transaction Code	Transaction Header	103-A3	B1, B2	EPS will not accept B3 (rebills).

4.2.1 Replacement Transactions

4.2.1.1 Professional and Institutional (837) Encounters

A professional or institutional (837) encounter with a Claim Frequency Code of "7" indicates a Replacement encounter transaction. The Replacement transaction must contain a "pointer" to the encounter that is to be replaced in the EPS (original or replacement). For the Replacement transaction to process successfully in the EPS, the following rules apply:

- The "pointer" value on the Replacement transaction must equal the Payer Claim ID of the encounter in EPS that is to be replaced
- Using the "pointer" value on the Replacement transaction, EPS must be able to locate the encounter in EPS that is to be replaced
- The encounter that is to be replaced must have a Validation status of PASS in order for the replacement to process successfully without DMAS intervention
- The encounter that is to be replaced must have an ACTIVE status
- An encounter with a PAID or DENIED status may be replaced
- Replacement of a previously replaced transaction is allowed
- Replacement transactions should not be "manufactured" by the Payer with the sole intent to correct EPS encounter failures. See section 5 for Correcting Encounter data in EPS.

837 Replacement Transaction						
Trans Type	**Element Name**	**Loop**	**Segment**	**Element**	**Value**	**Notes**
837P 837D 837I	Patient Control Number	2300	CLM	01	Unique Payer Claim ID	Must be unique
	Claim Frequency Code	2300	CLM	05-3	7	Indicates replacement
	REF – Payer Claim Control Number	2300	REF	01 02	F8 Payer Claim ID of encounter that is to be replaced (Original or Replacement)	"Points" to encounter that is to be replaced

4.2.1.2 Pharmacy (NCPDP) Encounters

For Pharmacy Encounters (NCPDP), the EPS does not accept Rebill (B3) transactions. In place of the rebill, the Payer should submit a Void/Reversal (B2) transaction, confirm that the Void/Reversal (B2) transaction has a PASS status, and then submit a New Billing/Original (B1) transaction with the replacement data.

4.2.2 Void Transactions

4.2.2.1 Professional and Institutional (837) Encounters

A professional or institutional (837) Encounter with a Claim Frequency Code of "8" indicates a Void encounter transaction. The Void transaction must contain a "pointer" to the encounter that is to be voided in the EPS.

For the Void transaction to process successfully in the EPS, the following rules apply:

- The "pointer" value on the Void transaction must equal the Payer Claim ID of the encounter in EPS that is to be voided
- Using the "pointer" value on the Void transaction, the EPS must be able to locate the encounter in EPS that is to be voided
- The encounter that is to be voided must have a Validation status of PASS in order for the void to process successfully without DMAS intervention
- The encounter that is to be voided must have an ACTIVE status
- An original or replaced encounter may be voided
- An encounter with a PAID or DENIED status may be voided
- Once voided, no subsequent transactions (replacement or void) are allowed
- Void transactions should not be "manufactured" by the Payer with the sole intent to correct EPS encounter failures. See section 5 for Correcting Encounter data in EPS

837 Void Transaction						
Trans Type	**Element Name**	**Loop**	**Segment**	**Element**	**Value**	**Notes**
837P 837D 837I	Patient Control Number	2300	CLM	01	Unique Payer Claim ID	Must be unique
	Claim Frequency Code	2300	CLM	05-3	8	Indicates Void
	REF – Payer Claim Control Number	2300	REF	01 02	F8 Payer Claim ID of encounter that is to be voided (Original or Replacement)	"Points" to encounter that should be voided.

4.2.2.2 Pharmacy (NCPDP) Encounters

For Pharmacy encounters (NCPDP), a reversal transaction (B2) must be used to reverse/void the Original Encounter. The reversal transaction must contain a set of keys that will be used as a "pointer" to the encounter that is to be reversed. Only a New Billing/Original may be voided.

For the Reversal transaction to process successfully in the EPS, the following rules apply:

- Using the "pointer" keys, the EPS must be able to locate the original of the encounter that is to be reversed
- The encounter that is to be reversed/voided must have a Validation status of PASS
- The encounter that is to be reversed/voided must have an ACTIVE status
- Only a new billing/original may be voided
- Once voided, no subsequent reversals are allowed

NCPDP Reversal (B2) Transaction					
Trans Type	**Element Name**	**Segment**	**Element**	**Value**	**Notes**
NCPDP	Service Provider ID (Pharmacy NPI)	Transaction Header	201-B1	Pharmacy NPI of claim that is to be reversed	"Pointer" key values used to locate the encounter that is to be reversed
	Date of Service	Transaction Header	401-D1	Date of Service of the encounter that is to be reversed	
	Prescription No.	Claim	402-D2	Prescription No. of the encounter that is to be reversed	
	NDC	Claim	407-D7	NDC on the encounter that is to be reversed	

4.2.3 "Best Practices" for Replacement and Void Transactions

To ensure success of replacement and void/reversal transactions in the EPS, a best practice is to confirm that the companion transaction (original or prior replacement) has a Validation status of PASS in the EPS before submitting the replacement or void transaction to DMAS.

When EPS receives a replacement or void transaction originating from the Payer's Claim Adjudication/Processing system, the encounter transaction that resides in EPS must have a Validation status of PASS for EPS to allow the update. If the EPS transaction to be updated has a status of FAIL, all subsequent replacement or void transactions will also result in a FAIL status. The DMAS Encounter teams will work with the Payer in processing these transactions.

5 Correcting Encounter Data in EPS

The Payer must correct all EPS Validation errors ("E" errors). Encounter data correction must occur with a RESEND or RESUBMISSION transaction when the data will not be corrected from transactions processed by the Payer's Claim Adjudication/Processing system. Replacement or Void transactions that are processed by the Payer's Claim Adjudication/Processing system and result in the correction of an EPS encounter error do not require a RESEND or RESUBMISSION transaction. Replacement or Void transactions should not be "manufactured" by the Payer with the sole intent to correct EPS encounter failures.

It is important to note that DMAS will reconcile EPS Encounter transaction counts with transaction counts from the Payer's Claim Adjudication/Processing system to determine "Encounter Completeness". It is essential that the EPS encounter transaction counts match Payer's claim transaction counts.

There are several methods available in EPS that can be used for correcting Encounter data when the correction will not occur via Replacement/Void transactions originating from the Payer's Claim Adjudication/Processing system. The method selected will depend on the EPS Validation status (PASS/FAIL) of the erroneous encounter transaction. EPS will only allow corrections to encounter transactions with an ACTIVE status. Corrections to transactions with an INACTIVE status are not allowed.

- Use the EPS **RESEND** method when the encounter transaction has a Validation status of **FAIL**
- Use EPS **RESUBMISSION** method when the encounter transaction has a Validation status of **PASS**

5.1 Using the RESEND method

An EPS RESEND is to be used when the EPS encounter transaction has a Validation status of FAIL and the data will not be corrected from transactions processed by the Payer's Claim Adjudication/Processing system. An EPS Validation status of FAIL indicates that one or more "E" errors have been flagged on the encounter transaction.

Instructions for creating a RESEND transaction:

- Update/correct the data that was flagged as an EPS "E" error on the erroneous transaction
- Using the same Payer Claim ID, submit the corrected encounter transaction to EPS
- Note: There is no "resend indicator" on the transaction. EPS will recognize the transaction as a RESEND when an encounter with the matching Payer Claim ID is found in EPS and the Validation status is FAIL. If an encounter with the matching Payer Claim ID is found in EPS and the Validation status is PASS, EPS will flag the RESEND transaction as a duplicate.

For the RESEND transaction to process successfully in the EPS, the following rules apply:

- The same Payer Claim ID as the erroneous transaction must be used on the RESEND transaction
- EPS must be able to locate the erroneous encounter
- The erroneous encounter in EPS must have a Validation status of FAIL
- The erroneous encounter in EPS must have an ACTIVE status. Encounters in EPS that have an INACTIVE status may not be corrected

837 - Resend						
Trans Type	**Element Name**	**Loop**	**Segment**	**Element**	**Value**	**Notes**
837P 837D 837I	Patient Control Number	2300	CLM	01	Payer Claim ID	Must match the Payer Claim ID of the encounter that needs to be corrected

NCPDP – Resend						
Trans Type	**Element Name**	**Loop**	**Segment**	**Element**	**Value**	**Notes**
NCPDP	Payer Claim ID		AM01	CX	99	Must match the Payer Claim ID of the encounter that needs to be corrected
				CY	Payer Claim ID	

5.2 Using the RESUBMISSION method

An EPS RESUBMSSION is to be used when the EPS encounter transaction has a Validation status of PASS and the data will not be updated from transactions processed by the Payer's Claim Adjudication/Processing system. Most likely, this method will be used infrequently as the encounter transaction in EPS has met all data requirements. However, there can be rare situations where the Payer needs to update the EPS encounter transaction due to an issue within their internal systems. Example: An encounter transaction is submitted to EPS. EPS does not flag any errors on the transaction resulting in an EPS Validation of PASS. The Payer realizes that a mapping error occurred during the encounter extraction process and a corrected version of the encounter transaction needs to be submitted to EPS. The RESUBMISSION method must be used to submit the updated transaction to EPS.

Instructions for creating a RESUBMISSION transaction:

- The encounter must contain the "Date of Resubmission" as shown below. The "Date of Resubmission" should be the date that the encounter is resubmitted to DMAS.
- Resubmit the corrected encounter transaction to EPS using the same Payer Claim ID and including the "Date of Resubmission".

For the RESUBMISSION transaction to process successfully in the EPS, the following rules apply:

- The encounter must contain the "Date of Resubmission" as this will inform EPS that the transaction is being resubmitted. Otherwise, EPS will flag the transaction as a duplicate.
- The same Payer Claim ID as the encounter that needs to be updated must be used on the resubmitted transaction
- EPS must be able to locate the encounter that needs to be updated
- The encounter in EPS that needs to be updated must have a Validation status of PASS
- The encounter in EPS that needs to be updated must have an ACTIVE status. Encounters in EPS that have an INACTIVE status may not be updated.
- Please note the following restrictions for the claim frequency element (CLM05-3) on 837 transactions.
    - When the encounter in EPS (target) that is being updated by the resubmission has a claim frequency of replacement (7) or void (8), the resubmission encounter must have the same claim frequency as the EPS target encounter.
    - When the encounter in EPS (target) that is being updated by the resubmission has a claim frequency other than replacement (7) or void (8), the claim frequency may be updated with a claim frequency other than 7 or 8.
    - See Section 4.2 for further details regarding claim frequency.

<table>
<tr><th colspan="6">837 - Resubmission</th></tr>
<tr><th>Doc/Line Level</th><th>Trans Type</th><th>Loop</th><th>Segment</th><th>Element</th><th>Description</th></tr>
<tr><td rowspan="2">Document Level</td><td rowspan="2">837P
837D
837I</td><td rowspan="2">2300</td><td>CLM</td><td>01</td><td>Must match the Payer Claim ID of the encounter that needs to be modified.</td></tr>
<tr><td>K3</td><td>01</td><td>
<table>
<tr><th>FIELD</th><th>DESCRIPTION</th><th>USAGE</th><th>FORMAT/VALUE</th></tr>
<tr><td>DREC</td><td>Date of Receipt</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>DADJ</td><td>Date of Adjudication</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>DPYM</td><td>Date of Payment</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>DRES</td><td>Date of Resubmission</td><td>Mandatory for Resubmission</td><td>CCYYMMDD</td></tr>
<tr><td>PYMS</td><td>Payment Status - Paid
Payment Status - Denied</td><td>Mandatory</td><td>P
D</td></tr>
<tr><td colspan="4">Note:
• There should be at least one space between the pair values
• Each pair must have one hyphen(-) between the field and value
• The pair values may be in any order</td></tr>
</table>
</td></tr>
</table>

837 Example	
Sample Format	DREC-CCYYMMDD DADJ-CCYYMMDD DPYM-CCYYMMDD DRES-CCYYMMDD PYMS-x
K3 Segment	K3*DREC-20170223 DADJ-20170224 DPYM-20170225 PYMS-P K3*DREC-20170223 DADJ-20170224 DPYM-20170225 PYMS-D K3*DREC-20170223 DADJ-20170224 DPYM-20170225 DRES-20170227 PYMS-P K3*DREC-20170223 DADJ-20170224 DPYM-20170225 DRES-20170227 PYMS-D

<table>
<tr><th colspan="6">NCPDP – Resubmission</th></tr>
<tr><th>Doc/Line Level</th><th>Trans Type</th><th>Loop</th><th>Segment</th><th>Element</th><th>Description</th></tr>
<tr><td rowspan="3">Document Level</td><td rowspan="3">NCPDP</td><td rowspan="3">AM</td><td rowspan="3">AM01</td><td>CX</td><td>Value must be 99</td></tr>
<tr><td>CY</td><td>Must match the Payer Claim ID of the encounter that needs to be modified.</td></tr>
<tr><td>HN</td><td>
<table>
<tr><th>FIELD</th><th>DESCRIPTION</th><th>USAGE</th><th>FORMAT/VALUE</th></tr>
<tr><td>DREC</td><td>Date of Receipt</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>DADJ</td><td>Date of Adjudication</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>DPYM</td><td>Date of Payment</td><td>Mandatory</td><td>CCYYMMDD</td></tr>
<tr><td>DRES</td><td>Date of Resubmission</td><td>Mandatory for resubmission</td><td>CCYYMMDD</td></tr>
<tr><td>PYMS</td><td>Payment Status - Paid
Payment Status - Denied</td><td>Mandatory</td><td>P
D</td></tr>
<tr><td colspan="4">Note:
• There should be at least one space between the pair values
• Each pair must have one hyphen(-) between the field and value
• The pair values may be in any order</td></tr>
</table>
</td></tr>
</table>

NCPDP Example	
Sample Format	DREC-CCYYMMDD DADJ-CCYYMMDD DPYM-CCYYMMDD DRES-CCYYMMDD PYMS-x
HN Field	HNDREC-20170223 DADJ-20170224 DPYM-20170225 DRES-20170227 PYMS-P HNDREC-20170223 DADJ-20170224 DPYM-20170225 DRES-20170227 PYMS-D

6 EPS Business Rules

One of the features of EPS is that business rules are defined, packaged, and applied by ~~Contract~~ encounter program. This means that the DMAS business teams have the ability to create and apply business requirements differently for Cardinal Care Managed Care, FFS NEMT, and FFS Dental encounters. Although separate, most of the business rules are commonly defined across all programs to ensure that DMAS receives encounter data that is as consistent as possible. Differences in business rules may be related to the specific population served by the program.

The EPS business rules for each program may be found on the EPS portal. The portal provides details about each business rule including the applicability of the rule to the transaction type, claim frequency, and paid vs. denied status. In addition, supporting EDI elements used in the business rule logic are defined. Periodically, DMAS will issue a consolidated EPS Business rule list via email that also shows the same detailed information.

7 EPS Cache Code Sets

The EPS Cache Code Sets are a collection of codes or values that are referenced by the EPS business rules when an encounter transaction is processed. The code sets are used primarily to validate data submitted in the encounter, to determine if a rule applies to the encounter and to determine if the encounter is exempt form a rule. All EPS Cache Code sets may be viewed on the EPS Portal.

The EPS Cache Code Sets are a collection of codes or values that are used by EPS when processing an encounter transaction. The code sets are primarily used for validating elements on the encounter but some have other purposes as well. The values may be used to bypass or provide an exception to applying an EPS business rule or they may simply be a subset of values that are accepted by EPS. All EPS Cache Code sets may be viewed on the EPS Portal.

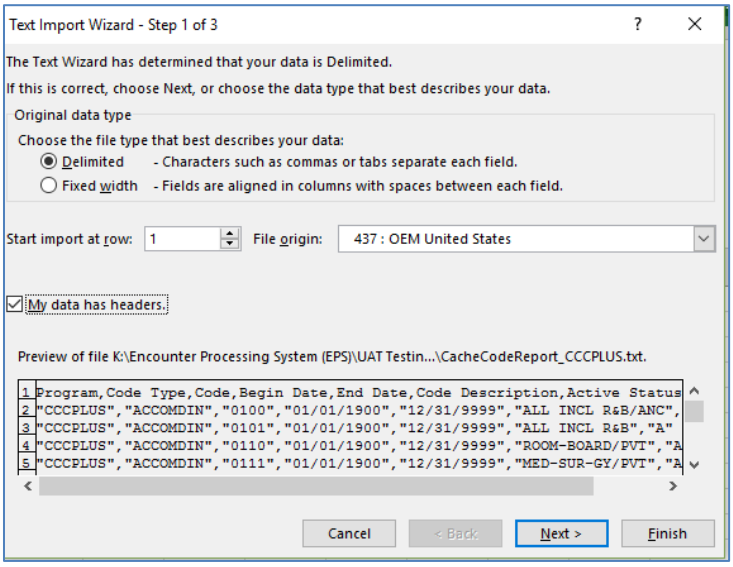
7.1 EPS Cache Code Set Values – Download Available

The EPS Cache Code Sets file is available for download from the EPS Portal under the Reports - Other Reports menu option.

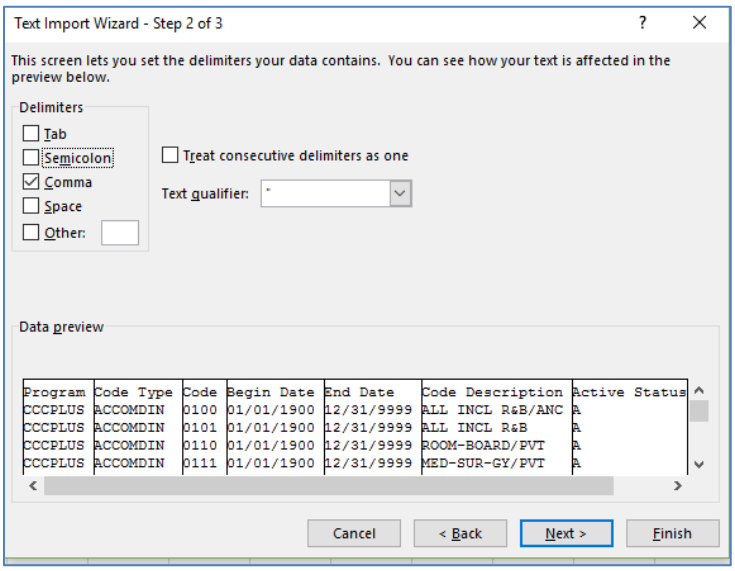
Instructions to Import the DMAS EPS Cache Code Set File into Excel

To view the Cache Code Set Values file in Excel, import the txt file into Excel as documented below. Do not open the file in Excel by changing the extension to csv. This method will cause leading zeros to be dropped from the values.

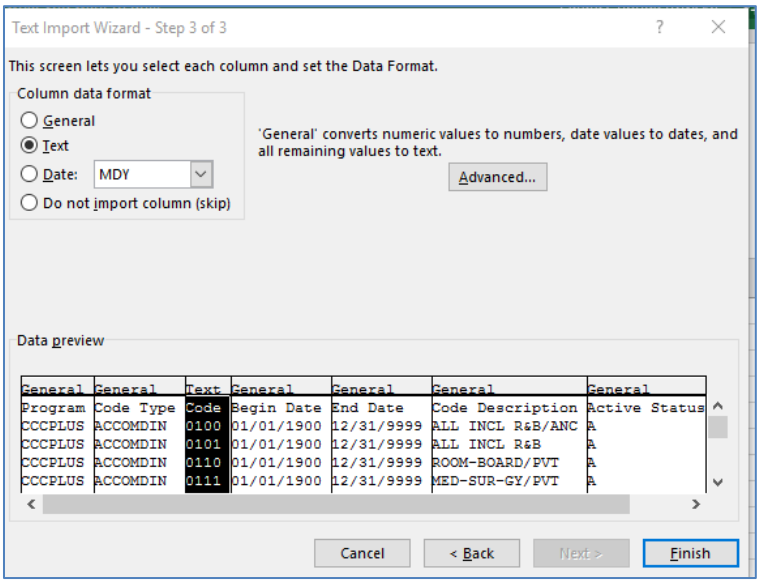
1. Download the Cache Code Set Values text file from the EPS Portal Reports- Other Reports.
2. Open an Excel workbook.
3. Select Data -> Get External Data -> From Text.
4. Select the file to be imported and click Import.
5. For Step 1 of the Text Import Wizard, check Delimited and My data has headers and click Next.



6. For Step 2 of the Text Import Wizard, select Comma and click Next.



7. For part 1 of Step 3 of the Text Import Wizard, select the Code column in the Data Preview Pane and select the Text column data format.



8. For part 2 of Step 3 of the Text Import Wizard, select the Begin and End Data columns in the Data Preview Pane, select the Date column data format and then select Finish.