Utah Specific Transaction Instructions

837 Health Care Claim: **Dental**
ASCX12N 837 (004010X097A1)

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, and all health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for healthcare as established by the Secretary of Health and Human Services. The ANSI ASC X12N 837D Version 4010 implementation guide has been established as the standard of compliance. The implementation guide is available electronically at www.wpc-edi.com. The following supplemental requirements are specific to Utah Medicaid and are intended to serve as a companion guide to the HIPAA ANSI X12N implementation guide. For clarification regarding submission of encounter records, refer to the encounter provider manual. Further billing instructions and policy are published in the Utah Medicaid Provider Manual.

Requirements:

1. For questions or suggestions about this companion guide, call (800) 662-9651 or (801) 538-6155 option 3, option 5, Operational Support and Development (OS&D). Go to http://health.utah.gov/hipaa/guides.htm to obtain the latest version of this guide. OS&D can help resolve issues on electronic transmissions.

2. All electronic data must pass through the Utah Health Information Network (UHIN), an independent, not-for-profit, value added network. Contact UHIN at www.UHIN.com or (801) 466-7705 x200. UHIN will assign a Trading Partner Number (TPN) for electronic data interchange.

3. Use your TPN and your Utah Medicaid Provider number to complete the Online Utah Medicaid EDI Enrollment Form at http://health.utah.gov/hcfenroll (do not mail or fax, simply click on submit). Without a successfully completed EDI enrollment, the Medicaid computer system cannot process or even acknowledge any transmission (e.g. no 997, no 277FE, etc).

4. Beginning October 1, 2006, register your National Provider Identifier (NPI) with Medicaid, 538-6155, option 3, option 4, or fax your NPI (include 12-digit provider number, taxonomy code, and zip code +4) to 536-0471. The 12-digit Medicaid Provider number will not be allowed on or after May 23, 2007, unless you are a provider type not eligible for the NPI. Submit both the NPI and 12-digit Medicaid Provider number on claims from October 1, 2006 to May 22, 2007. The Provider Taxonomy Code is required if there are multiple provider types/services under the same NPI. Zip Code + 4 is required if you are no longer using the 12 digit provider number.

5. Transmit dental claims anytime 24 hours a day, 7 days a week. Electronic claims received before the End of Business on Thursday usually adjudicate on that weekend. Transactions received after the End of Business on Thursday will miss the adjudication cycle and will process the following weekend.

6. Medicaid Customer Service agents are NOT able to see any claim that has not processed through at least one weekend adjudication cycle. Use the 997 and 277FE reports to determine status of electronic submissions prior to a weekend adjudication cycle. After an adjudication cycle use the 276 for claim status; include the 17-digit Transaction Control Number (TCN) assigned to the claim by Medicaid

7. Utah Medicaid recommends submitting 15 or fewer service lines for each Dental claim. Claims submitted with more than 15 service lines will be split and may encounter processing delays.

8. A 997 Functional Acknowledgment will be created for all 837 transactions.

9. A 277FE Health Care Claim Status Notification - Front End Acknowledgment will be created for all 837 transactions.

10. EDI processing does not distinguish between the different Medicaid programs supported by Health Care Financing (HCF), e.g., Non-Traditional Medicaid, Primary Care Network, Select Access, Baby Your Baby, etc. Transmit claims for Medicaid programs to the Medicaid Fee-For-Service (FFS) TPN, HT000004-001.

Page	Loop	Segment	Data Element	Values / Comments
56		BHT06	Claim or Encounter Identifier	"CH" – Used for claims with at least one chargeable item.
60	1000A	NM108	Identification Code Qualifier	"46" – Established by Trading Partner Agreement
61	1000A	NM109	Submitter Identifier	Submitter's TPN
67	1000B	NM103	Receiver Name	"Medicaid FFS"
67	1000B	NM108	Information Receiver Identification Number	"46" – Electronic Transmitter Identification Number (ETIN)
67	1000B	NM109	Receiver Primary Identifier	"HT000004-001"
72	2000A	PRV02	Reference Identification Qualifier	"ZZ" – Taxonomy Code
72	2000A	PRV03	Reference Identification	Provider Taxonomy Code required if multiple provider types/specialties under same NPI.
78	2010AA	NM108	Code Qualifier	"XX" – NPI
78	2010AA	NM109	National Provider Identification	NPI

Page	Loop	Segment	Data Element	Values / Comments
81	2010AA	N403	Billing Provider's Zip Code	Zip Code + 4 required if not using 12-digit provider number in REF02 below. Do not submit hyphens or spaces.
84	2010AA	REF01	Reference Identification Qualifier	"1D" – Medicaid Provider Number Not allowed on or after May 23, 2007.
84	2010AA	REF02	Billing Provider Additional Identifier	Use the 12-digit identifier assigned by Medicaid.
97	2000B	HL04	Hierarchical Child Code	"0" – The subscriber is always the patient, there are no dependents in Medicaid.
101	2000B	SBR09	Claim Filing Indicator Code	"MC" – Medicaid
104	2010BA	NM102	Entity Type Qualifier	"1" – Person
104	2010BA	NM103	Subscriber Last Name	Patient's last name. Match the name on the Medicaid Card.
104	2010BA	NM104	Subscriber First Name	Patient's first name is required. Match the name on the Medicaid Card. See UHIN Standard #37 for additional guidance.
105	2010BA	NM108	Identification Code Qualifier	"MI" – Member Identification Number
106	2010BA	NM109	Subscriber Primary Identifier	Use the 10-digit identifier assigned by Medicaid. Do not submit hyphens or spaces.
118	2010BB	NM103	Payer Name	"Medicaid FFS"
118	2010BB	NM108	Payer Identifier	"PI" – Payer Identification
118	2010BB	NM109	Payer Identifier	"HT000004-001"
132	2000C	HL	Patient Level	The subscriber is always the patient in Utah Medicaid. Do NOT use this loop.
150	2300	CLM01	Patient Account Number	Provider assigned number unique to this particular claim.
151	2300	CLM05-3	Claim Frequency Code	For original submission (or re-submission of denied claims) use value: "1" – Original Medicaid will allow for submission of electronic corrections or voids to a previously paid claim. Acceptable Values: "7" – Replacement "8" – Void The Provider Number must match. To correct a Provider Number, void out the paid claim, then submit an original claim using the correct Provider Number.
155	2300	CLM19	Predetermination of Benefits Code	Utah Medicaid will not process a predetermination of benefits request.

Page	Loop	Segment	Data Element	Values / Comments
171	2300	PWK01	Attachment Report Type Code	Required if documentation is needed to support the claim. Claim may deny, however once documentation is received the claim is re-processed.
171	2300	PWK02	Attachment Transmission Code	"BM" – by mail "FX" – by fax "EM" – by e-mail
172	2300	PWK06	Identification Code	Provider assigned number unique to this attachment. Each attachment associated with the claim must display the same unique number and the Provider ID.
180	2300	REF01	Reference Identification Qualifier	"F8" – Original Reference Number
180	2300	REF02	Claim Original Reference Number	When codes "7" or "8" are submitted in Loop 2300 CLM05-3, the TCN assigned to the original claim must be reported. Do not submit hyphens or spaces. Do not submit replacement/void claims until the original TCN processes through a weekend cycle.
182	2300	REF01	Reference Identification Qualifier	"G1" – Prior Authorization Medicaid does not utilize referral numbers.
182	2300	REF02	Reference Identification	Use the 7-digit Prior Authorization number assigned by Medicaid.
209	2320	SBR	Other Subscriber Information	If the patient has other coverage, repeat this loop for each payer. Do not put information about Medicaid coverage/payment in this loop.
216	2320	CAS01	Claim Adjustment Group Code	As reported by other payer. If other payer reported claim level patient responsibility, but did not provide a group code, use "PR" to report patient responsibility.
216	2320	CAS02	Claim Adjustment Reason Code	As reported by other payer. If other payer reported claim level patient responsibility, but did not provide a reason code, use: "1" - deductible amount "2" - coinsurance amount
216	2320	CAS03	Adjustment Amount – Claim Level	As reported by other payer.
220	2320	AMT01	Amount Qualifier Code	"D" – Payer Amount Paid
220	2320	AMT02	Payer Paid Amount	As reported by other payer.

Page	Loop	Segment	Data Element	Values / Comments
222	2320	AMT01	Amount Qualifier Code	"B6" – Allowed - Actual
222	2320	AMT02	Allowed Amount	As reported by other payer.
223	2320	AMT01	Amount Qualifier Code	"F2" – Patient Responsibility - Actual
223	2320	AMT02	Patient Responsibility Amount	As reported by other payer.
246	2330B	DTP03	Adjudication or Payment Date	As reported by other payer.
247	2330B	REF01	Other Payer Identification Number	"F8" – Original Reference Number
248	2330B	REF02	Other Payer Secondary Identifier	Output the other payer claim number if known.
265	2400	LX	Line Counter	Medicaid recommends submitting 15 or fewer service lines for each Dental claim. Claims submitted with more than 15 service lines will be split and may encounter processing delays.
267	2400	SV301-3 to SV301-6	Procedure Modifier	Medicaid will not utilize modifiers for dental claims processing.
268	2400	SV304-1	Oral Cavity Designation Code	Report the code identifying the area of the oral cavity in which serviced is rendered.
270	2400	SV306	Procedure Count	Report number of times a procedure is performed. Multiple units (quantity) are limited to x-ray procedure codes.
272	2400	TOO02	Tooth Number	Report tooth number associated with procedure requiring data.
272	2400	TOO03	Tooth Surface Code	Report tooth surface associated with procedure requiring data.
285	2400	REF01	Reference Identification Qualifier	"6R" – Provider Control Number
286	2400	REF02	Line Item Control Number	Provider assigned number unique to the line.
288	2400	NTE01	Note Reference Code	"ADD" – Additional Information
288	2400	NTE02	Note Text Line	Provide description of services rendered when utilizing an unspecified procedure code, e.g. D7999, etc.
301	2430	SVD	Line Adjudication Information	Use this loop if line level payment was received from another payer.
302	2430	SVD02	Service Line Paid Amount	As reported by other payer.

Page	Loop	Segment	Data Element	Values / Comments
307	2430	CAS01	Adjustment Group Code	As reported by other payer. If other payer reported line level patient responsibility, but did not provide a group code, use “PR” to report patient responsibility.
307	2430	CAS02	Adjustment Reason Code	As reported by other payer. If other payer reported line level patient responsibility, but did not provide a reason code, use: “1" – deductible amount “2" – coinsurance amount
307	2430	CAS03	Adjustment Amount - Line Level	As reported by other payer.
312	2430	DTP03	Adjudication or Payment Date	Report date received on EOB.