Utah Specific Transaction Instructions

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

The Health Insurance Portability and Accountability Act (HIPAA) require all health insurance payers in the United States to 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 is the standard of compliance -- available at www.wpc-edi.com. The following supplemental information is specific to Utah Medicaid and serves as a companion guide to the implementation guide. Utah Medicaid Provider Manuals are available at http://www.health.utah.gov/medicaid/manuals/directory.php?p=Medicaid%20Provider%20Manuals/.

Electronic Claims:

1. Telephone number for Medicaid EDI Customer Support is 801-538-6155 or 800-662-9651 option 3, option 5, option 2. Hours of operation are Monday through Friday 8 am to noon and 1 pm to 5 pm, with the exception of Thursday when Medicaid will begin taking calls from 11 am to noon and 1 pm to 5 pm.

2. AccessNow, telephone automated system for member eligibility, is available from 6 am to 12 midnight Monday through Saturday and 12 noon to 12 midnight on Sundays.

3. Medicaid companion guides are available at https://health.utah.gov/hipaa/guides.htm.

4. All EDI must pass through the Utah Health Information Network (UHIN), an independent, not-for-profit, value added network serving all payers in Utah. Contact UHIN at www.uhin.org or call 801-466-7705 x200. UHIN will assign a Trading Partner Number (TPN) for EDI.

5. Use your TPN and your National Provider Identifier (NPI) to complete the online EDI Enrollment Form at https://mmcs.health.utah.gov/hcfenroll2/index.jsp. The TPN in the 835 field of the EDI Enrollment will receive the 835 electronic remittance advice.

6. The NPI and Tax ID (or SSN) must match to a single Medicaid contract. If a provider affiliates their NPI to more than one Medicaid Contract, a unique Taxonomy Code or unique address must be affiliated to their Contract. Update contract information with the Medicaid Provider Enrollment team at 801-538-6155 or 800-662-9651, menu 3, menu 4, or fax to 801-536-0471.

7. Transmit claims anytime 24 hours a day, 7 days a week. Medicaid's cut-off for claims acceptance is before the end of business on Thursday. Transactions received after the end of business on Thursday may miss the adjudication cycle and will process the following weekend.

8. A 997 Functional Acknowledgment will be available for pickup (download) within two hours of transmission for all 837 transactions. If you find no 997, contact OS&D.

9. A 277FE Health Care Claim Status Notification - Front End Acknowledgment will usually be available for pickup (download) the next business day after the transmission of the 837. If you find no 277FE, contact OS&D. This transmission assigns a 17-digit Transaction Control Number (TCN) to any claim that is accepted into the Medicaid Management Information System (MMIS). The lack of a TCN indicates a claim was rejected. Use the Claim Status Codes http://www.wpc-edi.com/content/view/715/1 to determine why the claim was rejected. Make corrections and resubmit.

10. Medicaid Customer Service agents are **unable** to see claims that have 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 transaction for claim status.

11. Utah Medicaid cannot accept a line with a negative submitted charge (method used by Medicare for adjusting claims). A negative amount will generate the 484 error code (Business Application Currently Not Available). For adjustments, Medicaid requests submission of a void or replace claim (see instructions below).

12. 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.

13. Transmit claims for all the Medicaid programs (Non-Traditional Medicaid, Primary Care Network, Select Access, Baby Your Baby, etc.) to Medicaid Fee-For-Service (FFS), HT000004-001 or to Medicaid Crossovers, HT000004-005.

14. Providers should submit their own corrections by submitting either a replacement or void claim. If the original claim was denied, submit claim as an original claim. Medicaid will allow for submission of electronic corrections or voids to a previously paid claim. Acceptable Values: “7” – Replacement “8” – Void. The TCN of the claim to be replaced or voided must be reported. Do not submit hyphens or spaces.
The following is information about replacement/void claims:
   - The provider number on the original claim must match the provider number being submitted on the replacement claim, or the claim will reject.
   - If the TCN of the original claim cannot be identified in the Medicaid system, or the claim has already been reprocessed, the replacement/void claim will be rejected.
   - Replacement claim(s) void the original claim. The replacement claim is then processed in the Medicaid system as an original claim.
   - If there is a line item that did not pay on the original claim, it is not necessary to submit a replacement claim. You may submit a new claim for only the services not paid on the original claim. However, if additional units are being added to an already paid procedure code, or you are changing procedure codes, a replacement claim must

be submitted.

- If wanting to replace an original claim that was split by Medicaid for processing, it is necessary to submit a void claim for each of the split claims. A new original claim would then be submitted for processing.
- If a claim was paid under the wrong provider number, submit a void claim with the provider number of the original claim and a new original claim with the correct provider number.
- If the original claim was denied, do not submit a replacement claim. Make the necessary correction(s) and resubmit the claim as an original claim.

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"
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	Identification Code Qualifier	"XX" – NPI
78	2010AA	NM109	Identification Code	NPI
80	2010AA	N301	Billing Provider Address Line	Address that coordinates with Medicaid Contract Service Location
81	2010AA	N401	Billing Provider City Name	City that coordinates with Medicaid Contract Service Location
82	2010AA	N402	Billing Provider State	State that coordinates with Medicaid Contract Service Location
82	2010AA	N403	Billing Provider's Zip Code	Zip Code + 4 Do not submit hyphens or spaces.
84	2010AA	NM108	Identification Code Qualifier	"EI" – Tax ID or "SY" – Social Security Number or "TJ" – Federal Taxpayer's ID
84	2010AA	NM109	Identification Code	Use the 9-digit identifier. Do not submit hyphens or spaces.
97	2000B	HL04	Hierarchical Child Code	"0" – The subscriber is always the patient; there are no dependents in Medicaid.

Page	Loop	Segment	Data Element	Values / Comments
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.
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 TCN assigned to the claim voiding or replacing must be reported in REF02.
155	2300	CLM19	Predetermination of Benefits Code	Utah Medicaid does not process a predetermination of benefits request. Claim will be rejected.
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.

Page	Loop	Segment	Data Element	Values / Comments
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. Report Patient Responsibility in Loop 2320 AMT Segment
216	2320	CAS02	Claim Adjustment Reason Code	As reported by other payer.
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.
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	Begins with 1 and is incremented by one for each additional line.
267	2400	SV301-3 to SV301-6	Procedure Modifier	Medicaid does not utilize modifiers for dental claims processing.

Page	Loop	Segment	Data Element	Values / Comments
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.
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.