

EDI Support Services

EDISS Trading Partner Agreement Companion Document For Iowa Dental Medicaid Providers 837 4010A1 Dental Claim

Last Updated 4/01/2010

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N 837 4010A1 Implementation Guides have been established as the standards of compliance for claim transactions. The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion document to the HIPAA ANSI X12N 837 4010A1 implementation guides. The use of this document is solely for the purpose of clarification.

The information describes specific requirements to be used for processing data in the Medicaid Management Information Systems (MMIS). The information in this document is subject to change. Changes will be communicated on the EDISS web site: www.edissweb.com and via the EDISS Email Listing. This companion document supplements, but does not contradict any requirements in the X12N 837 Dental 4010 Addenda implementation guide. Additional companion documents/trading partner agreements will be developed for use with other HIPAA standards, and will be posted as they become available.

Item No.	Loop ID - Loop Description	Element - Element Description	IG Page #	Medicaid Specifications
1	GENERAL - Compression	GENERAL	NA	Compression of files using PKZIP and WINZIP compression software is supported for transmissions between the submitter and EDISS.
2	Beginning of Hierarchical Transaction	REF02	66	For 4010A1 version of the 837P claims transaction, this value must equal 004010X097A1.
3	General - Interchange Control Number (997)	TA1 Segment, ISA13	B.11-B.13, B.3-B.6	EDISS claims translator generates the TA101 value in the Functional Acknowledgment Report (997). This value will not match the interchange control number of the originally submitted file (ISA13).
4	General - Case Conversion	GENERAL	NA	EDISS will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicaid processing system. Consequently, data later submitted for COB (Coordination of Benefits) will be submitted in upper case.
5	GENERAL - Sequencing of the HL segment	HL01 - Hierarchical ID Number, HL02 - Health Care Code Information, HL03 - Health Care Code Information, HL04 - Health Care Code Information	227 - 229	The subscriber hierarchical level (HL segment) must be in order from one, increased by one, and must be numeric. Medicaid will process only HL structures as described in the implementation guide front matter (Billing provider HL (parent) followed by the appropriate Subscriber HL (child)).

6	General - Provider Number 2010AA, 2010AB, 2310B, 2420A	REF Segment With a EI Qualifier	NA	The complete NPI must be submitted, and needs to be sent in the NM109 with NM108 = XX. Atypical providers need to send their atypical provider number (starting with X00...) in the REF segment with a G2 qualifier. After 5/22/08, any claim sent with a 1D qualifier will be rejected.
7	General - Provider Number 2310A	REF Segment With a EI Qualifier	NA	The complete Provider Employee Identification Number (EI) must used if submitting a REF segment. The complete NPI must be submitted, and needs to be sent in the NM109 with NM108 = XX.
8	GENERAL - Files Invalid in Syntax and Structure	ALL SEGMENTS AND ELEMENTS	NA	Only loops, segments, and data elements valid for the HIPAA Institutional Implementation (004010x096A1) Guide will be translated. Non-implementation guide data may be dropped or may not be sent for processing consideration.
9	GENERAL - Qualifiers to use for Medicaid	GENERAL	NA	Only valid qualifiers for Medicaid should be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicaid processing not defined for use in Medicaid billing may cause the claim or the transaction to be rejected.
10	GENERAL - Must pick up a 997	GENERAL	NA	We suggest retrieval of the ANSI 997 functional acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission.
11	GENERAL - 9999 Segments per Loop	GENERAL	NA	EDISS may reject an interchange (transmission) submitted with more than 9,999 segments per loop.
12	GENERAL - Delimiters Allowed	ISA16 - Component Element Separator	NA	The incoming 837 transactions utilize delimiters from the following list >, *, ~, ^, , and : Submitting delimiters not supported within this list may cause an interchange (transmission) to be rejected.
13	GENERAL - Extended character set	GENERAL	NA	You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Institutional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set will cause the interchange (transmission) to be rejected at the EDISS translator.
14	GENERAL - 9999 Loops per Transaction	GENERAL	NA	EDISS may reject an interchange (transmission) submitted with more than 9,999 loops.

15	Taxonomy Codes	PRV - Provider Specialty Information	71, 198	NPI billing requires the taxonomy code to be sent with the claim in the 2000A/PRV. When billing with an NPI that is associated with a Medipass number, Medicaid does not require taxonomy codes be submitted in order to adjudicate claims, but will accept the taxonomy code, if submitted. However, taxonomy codes that are submitted must be valid against the taxonomy code set published at www.wpc-edi.com/codes . Claims submitted with invalid taxonomy codes will be rejected.
16	General - Zip Codes 2010AA	N403	NA	The zip code that is billed should match the zip code that was verified with IME. If a five digit or nine digit zip code is on file with IME, that is what should be submitted on the claim.
17	ENVELOPES - Multiple Transactions within an Interchange	ISA - Interchange Control Header, GS - Functional Group Header, GE - Functional Group Trailer, IEA - Interchange Control Trailer	B.3 - B.10	EDISS will handle multiple GS-GE's within one ISA-IEA.
18	ENVELOPES - Group Control Number	GS06 - Group Control Number, GE02	B.8 - B.9	When multiple functional groups (GS-GE) are sent within one ISA-IEA the GS06 and GE02 values must be unique within each functional group.
19	ENVELOPES - Interchange Control Number	ISA13 - Interchange Control Number, IEA02	B.5, B.7	When multiple interchanges (ISA-IEA) are sent in one day, the ISA13 and IEA02 values must be unique within each Interchange.
20	ENVELOPES - Envelope Segments	ISA - Interchange Control Header, GS - Functional Group Header, ST - Transaction Set Header, SE - Transaction Set Trailer, GE - Functional Group Trailer, IEA - Interchange Control Trailer	B.3 - B.10, B.16 - B.18	EDISS will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Institutional Implementation Guide. An example of this is the GS03 edit in the following item.
21	ENVELOPES - Application Receiver's Code	GS03 - Application Receiver's Code	B.8	EDISS may reject an interchange (transmission) that is submitted with an invalid value in GS03 (Application Receivers Code) based on the receiver definition. The value for Iowa Medicaid is 0026.
22	ENVELOPES - Interchange Sender ID	ISA06 - Interchange Sender ID	B.4	EDISS may reject an interchange (transmission) that is submitted with a submitter identification number that is not authorized for electronic claim submission.
23	ENVELOPES - Unique ST02	ST02 - Transaction Set Control Number	B.17	If multiple transaction sets (ST-SE) are sent within a functional group (GS-GE), the Transaction Set Control Number in ST02 and the corresponding SE02 must be unique and increment within that functional group and interchange (ISA-IEA). An occurrence of an ST02/SE02 within a functional group cannot be less than or equal to that of a preceding ST02/SE02.
24	ENVELOPES - EDISS ID to use	ISA08 - Interchange Receiver ID	B.5	EDISS may reject an interchange (transmission) that is not submitted with a valid intermediary code. Each individual receiver determines this code. This value is '33477'.

25	ENVELOPES - Line of Business	ST - Transaction Set Header SE - Transaction Set Trailer	B.16 - B.18, B.30	EDISS will only accept claims for one line of business per transaction. Claims submitted for multiple lines of business within one ST-SE (Transaction Set) may cause the transaction to be rejected.
26	Envelopes - Transaction Type	GS - GE (Functional Group) ST - SE (Transaction Set)	B.3 - B.10	EDISS will only process one transaction per functional group.
27	ENVELOPE - GS08 value in 997	GS08 - Version / Release / Industry Identifier Code	B.9	EDISS will return 004010 as the version in GS08 (Version/Release/Industry Identifier Code) of the 997.
28	ENVELOPES - Transaction Set Purpose Code	BHT02 - Transaction Set Purpose Code	58	Transaction Set Purpose Code (BHT02) must equal '00' (ORIGINAL).
29	ENVELOPES - Claim or Encounter Indicator	BHT06 - Transaction Type Code	59	Claim or Encounter Indicator (BHT06) must equal 'CH' (CHARGEABLE).
30	ENVELOPES and 1000A	GS02 and NM109	B.8, 61	The values in the ISA06, GS02, and NM109 (1000A loop) are used by EDISS's front-end claim system to verify that each trading partner is authorized to send claims for each provider represented within the transaction. The values in the GS02 also aid in report delivery. When testing begins a unique number will be assigned by EDISS for each provider, clearinghouse, billing service, and billing group. If these numbers are not submitted in the correct elements it will cause the file to be rejected.
31	1000B - Receiver Name	NM109 - Identification Code	66	The receiver primary identifier is '18049'.
32	2010AB - Pay-To Provider Name	REF - Reference Identification	94 - 95	Only the first occurrence of the segment will be used.
33	2010BA - Subscriber Name	NM108 - Identification Code Qualifier	105	Qualifier of 'MI' needs to be submitted.
34	2010BA - Subscriber Name	NM109 - Identification Code	106	The 8 digit Iowa Medicaid recipient ID needs to be submitted.
35	2010AB - Pay-To Provider Name	REF - Reference Identification	113 - 114	Only the first occurrence of the segment will be used.
36	2010BB - Payer Name	NM109 - Identification Code	118	The payor primary identifier is '18049'.
37	2300, 2320 and 2400 - Reject Negative Values	CLM02 - Total Claim Charge, AMT02 - Patient Paid Amount, CR102 - Patient Weight, CR106 - Transport Distance, SV102 - Line Item Charge Amount, SV104 - Service Unit Count, PS102 - Purchased Service Charge Amount		Negative values submitted in the following fields may not be processed and may result in the claim being rejected: Total Claim Charge Amount (2300 Loop, CLM02), Patient Amount Paid (2300 Loop, AMT02), Payer Paid Amount (2320 Loop, AMT02), Allowed Amount (2320 Loop, AMT02), Line Item Charge Amount (2400 Loop, SV203), Service Unit Count (2400 Loop, SV207), Total Purchased Service Amount (2400 Loop, PS102).
38	2300 - Claim Information	CLM01 - Claim Submitter's Identifier	150	Only the first 13 bytes will be used.
39	2300 - Claim Information	PWK02 - Report of Transmission Code	171	The attachment code of 'BM' or 'FX' need to be submitted if a paper attachment is submitted for the electronic claim in order to be matched with the claim. If sending by mail, mail to PO Box 150001, Des Moines, IA 50315. If sending by fax, the fax number is 515-256-4626.

40	2300 - Claim Information	PWK06 - Identification Code	172	Only the first 20 bytes will be used. This number should be indicated on the paper attachment.
41	2300 - 5000 CLM Segments	CLM Segment	170-271	Iowa Medicaid may reject and interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.
42	2300 - Total Submitted Charges	CLM02	172	Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV302).
43	2300 - Claim Information	REF G1 Segment	16-17	Prior Authorization numbers should be submitted with a G1 qualifier.
44	2310A - Referring Provider Name	NM101 - Entity Identifier Code	188	The qualifier that needs to be submitted is 'P3'.
45	2310A - Referring Provider Name		187 - 194	Only 1st iteration of this loop will be used.
46	2310A - Referring Provider Name	NM101 - Entity Identifier Code	188	The qualifier that needs to be submitted is 'DN'.
47	2310A - Referring Provider Name	REF01 - Referring Provider Secondary Identifier	187 - 194	2nd iteration of this segment is required in cases where a MediPASS referral is involved.
48	2310A - Referring Provider Name	NM101 - Entity Identifier Code	188	The qualifier that needs to be submitted is 'P3'.
49	2310A - Referring Provider Name	NM109 - Identification Code	189	MediPASS NPI numbers should be used for MediPASS referrals.
50	2310A - Referring Provider Name	REF01 - Reference Identification Qualifier	193	The value that should be submitted in this segment is the referring Social Security Number with an SY qualifier in the REF01, or the Employer's Identification Number with a EI qualifier.
51	2400 - Monetary Amount	SV302		Receive claims of less than \$100,000.00. Any claims greater than this amount would be returned.
52	2400 - Line Counter	SV301-2 - Product/Service ID	267	Only the first 5 bytes will be used.
53	2400 - Line Counter	SV301-3 thru SV301-6 - Procedure Modifier	267	Only the first two modifiers will be used.
54	2400 - Line Counter	TOO - Tooth Identification	271 - 272	Only the first occurrence of the segment will be used.
55	2400 - Line Counter	REF02 - Line Item Control Number - Reference Identification	286	Only the last 2 bytes will be used.
56	2420A - Rendering Provider Name	REF - Rendering Provider Secondary Identification	295 - 296	Only the first occurrence of the segment will be used.