FLORIDA MEDICAID

837D FMMIS Batch Dental Health Care Claim and Encounter Claim Companion Guide 004010 X097A1

Version 1.3

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EDS

TABLE OF CONTENTS

1 Introduction ... 1
1.1 Purpose ... 1
1.2 Special Considerations for 837 Dental Transaction ... 1
2 Transmission and Data Retrieval Methods ... 3
3 Transmission Responses ... 4
4 EDI Support ... 5
5 Control Segment Definitions for Florida Medicaid 837 Dental Transaction ... 5
5.1 ISA - Interchange Control Header Segment ... 6
5.2 IEA - Interchange Control Trailer ... 7
5.3 GS – Functional Group Header ... 8
5.4 GE – Functional Group Trailer ... 8
5.5 ST – Transaction Set Header ... 9
5.6 SE – Transaction Set Trailer ... 9
5.7 TA1 – Interchange Acknowledgement ... 10
5.8 Valid Delimiters ... 11
6 Companion Guide for the 837D Transaction ... 11
7 Program Specific Required Information for Florida Medicaid Claims Processing ... 23

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1 INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid and all other health insurance payers in the United States comply with the EDI standards for health care as established by the Secretary of Health Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N implementation guides. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Additional information on the *Final Rule for Standards for Electronic Transactions* can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

1.1 Purpose

The 837 Dental transaction is used to submit health care claims and encounter data to a payer for payment. This transaction is the only acceptable format for electronic dental claim submissions to the Agency for Health Care Administration (AHCA). The intent is to expedite the goal of achieving a totally electronic data interchange environment for health care encounter/claims processing, payment, corrections, and reversals. This transaction will support the submission of dental claims and dental encounters.

The 837 Dental transaction is the electronic correspondent to the paper ADA claim forms; therefore, any claim types or encounter data submitted on the ADA forms correlate to the 837 Dental transaction, if data is submitted electronically.

All required segments within the 837 Dental transaction must always be sent by the submitter and received by the payer. Optional information will be sent when it is necessary for processing. Segments that are conditional are only sent when special criteria are met. Although required segments in the incoming transaction may not be used during claims processing, some of these data elements will be returned in other transactions such as the Unsolicited Claim Status (277 Transaction Set) and the Remittance Advice (835 Transaction Set).

1.2 Special Considerations for 837 Dental Transaction

1. **Subscriber, Insured = Recipient in the Florida Medicaid Eligibility Verification System:**

   The Florida Medicaid Eligibility Verification System does not allow for dependents to be enrolled under a primary subscriber, rather all enrollees/recipients are primary subscribers within each program or MCO (Managed Care Organization).

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2. **Provider Identification = Florida Medicaid ID or NPI:**

   The implementation date for National Provider Identifier (NPI) was May 23, 2007. The Agency for Health Care Administration has implemented the contingency plan for NPI and will continue to use the Florida Medicaid Provider Number until May 23, 2008.

   Prior to May 23, 2008, if the Medicaid Provider Number is received in the 2010AA Billing Provider loop within the REF segment where REF01 equals 1D and the 2010AA NM1 segment where NM108 equals XX is not received, the claim will process correctly. If applicable the REF02, where REF01=1D can also be used within the 2010AB Pay-to-Provider, 2310A Referring Provider, 2310B Rendering Provider, 2310C Service Facility Provider and/or 2420A Rendering Provider loops.

   Beginning May 23, 2008 for all health care providers, the Provider NPI, Taxonomy Code and Zip Code + 4 postal code must be received in the appropriate loops. The NPI will be sent in the NM109, where NM108 equals XX. The Taxonomy Code will be sent in the PRV03 and the Zip Code + 4 postal code will be sent in the N403 and N404.

   For all non-healthcare providers where an NPI is not assigned, the claim must contain the Medicaid Provider Number within the appropriate loops within the REF segment where REF01 equals 1D.

   Note: This information overrides the information documented in Section 3 for NM1 and REF segment provider number identification information.

3. **Logical File Structure:**

   There can be only one interchange (ISE/IEA) per logical file. The interchange can contain multiple functional groups (GS/GE) however; the functional groups must be the same type.

4. **Submitter:**

   Submissions by non-approved trading partners will be rejected.

5. **Claims and Encounters:**

   Claims and encounters must be submitted in separate ISA/IEA envelopes.

6. **Response/997 Functional Acknowledgement:**

   A response transaction will be returned to the trading partner that is present within the ISA06 data element.

   The Agency for Health Care Administration will provide a 997 Functional Acknowledgment for all transactions that are received.

   You will receive this acknowledgment within 48 hours unless there are unforeseen technical difficulties. If the transaction submitted was translated without errors for a request type transaction, i.e. 270 or 276, you will receive the appropriate response transaction generated from the request. If the transaction submitted was a claim transaction, i.e. 837, you will receive either the 835 or the unsolicited 277.

   Note: The 835 and unsolicited are only provided weekly.

7. **When NM108 = 24 or REF01=EI:**

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If the NM108 equals 24 (Employer Identification Number (EIN)) or the REF01 equals EI (EIN) within any loop, the value in the corresponding NM109 or REF02 must be in the format of XX-XXXXXXX.

Note: This format include the hyphen (-).

8. **Claims Allowed per Transaction (ST/SE envelope):**

   The HIPAA implementation guide states on the CLM (Claim Information) segment that the developers recommend that trading partners limit the size of the transaction (ST/SE) envelope to a maximum of 5,000 CLM segments.

   The Agency for Health Care Administration does not have a maximum for the number of claims per transaction (ST/SE envelope).

9. **Document Level:**

   The Agency for Health Care Administration processes files at the claim level. It is possible based on where the error(s) occur within the hierarchical structure that some claims may pass compliance and others will fail compliance. Those claims that pass compliance will be processed within the Florida Medicaid Management Information System (FMMIS). Those claims that fail compliance will be reported on the 997.

10. **Dependent Loop:**

    For the Agency for Health Care Administration, the subscriber is always the same as the patient (dependent). Claims containing data in the Patient Hierarchical Level (2000C loop) may not process correctly.

11. **Compliance Checking:**

    Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. In addition to Level 4, Level 7 patient (dependent) level will occur if 2000C patient loop is received. All other levels will be validated within the FMMIS.

12. **Identification of TPL:**

    For each claim at the header level, if loop 2320 (Other Subscriber Information) is present and SBR09 (Claim Filing Indicator) is not equal to MB (Medicare), 16 (HMO Medicare Risk), HM (HMO) or MC (Medicaid), the COB Payer Paid Amounts (AMT01=D) received in the 2320 loop(s) will be summed together for the Payer Paid Amount.

    Note: The 2320 loop can repeat multiple times per claim

2 TRANSMISSION AND DATA RETRIEVAL METHODS

EDS supports several types of data transport depending upon the trading partner's need. Providers and their representatives can submit and receive data via: Web portal, Remote Access Server (RAS), and Value Added Network (VAN)/Switch Vendors for interactive transactions.

1. Web portal: Transaction files are uploaded/downloaded in the Trade Files menu on the secure Web portal.

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2. Remote Access Server (RAS): This option is available to trading partners who do not have an existing Internet connection. The RAS server typically supports those who need a dial-up option. Once the RAS connection is established, transaction files are uploaded/downloaded in the Trade Files menu on the secure Web portal.
3. Value Added Networks (VANs) or Switch Vendors: VANs or Switch Vendors typically support interactive transactions through a dedicated connection to the fiscal agent. VANs sign a contract with the State and have unique, VAN specific communication arrangements with the fiscal agent. A list of approved vendors is listed on the fiscal agent Web site.

Detailed information to assist with EDI related processes are available on the Provider Public Web site at: http://www.mymedicaid-florida.com

Information available includes:

1. Remote Access Server connectivity instructions for submitters without an existing Internet connection;
2. Trading Partner Testing Procedures (Ramp Manager) for all new trading partners, or trading partners adding a new transaction; and
3. Web Upload/Download instructions for submitters uploading/downloading via the secure Web portal.

File/System Specifications

EDI will only accept Windows\PC\DOS formatted files.

EDI will allow upload and download of zipped or compressed files.

Note: Only one X12 transaction file is permitted in each “zipped” file.

EDI does not require any specific file extensions. This includes acceptance of files without an extension.

The Web portal is designed to support the following Internet browsers:

1. Internet Explorer, version 6 or later;
2. Firefox, version 1.5 or later; and
3. Opera, version 8.5 or later.

3 TRANSMISSION RESPONSES

For every transaction received, there is an expected response. The available responses are an Interchange Acknowledgement (TA1), a Functional Acknowledgement (997), and an Unsolicited Claim Status (277U).

Once a transaction is received, it will go through a ‘front end’ compliance check called a TA1. The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1

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segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Once the transaction has passed the 'front end' compliance check it then goes through a syntax compliance edit. This edit is to verify the compliance within the ANSI X12 syntax according to the HIPAA Implementation Guides. The transaction will receive a Functional Acknowledgement (997) to provide feedback on the transaction. The 997 functional acknowledgement contains accepted or rejected information. If the transaction contains any syntactical errors, the segments and elements in which the error occurred will be reported in a rejected acknowledgement. If the transaction contains no syntactical errors, a positive 997 response will be generated and the transaction is passed on for processing.

4 EDI SUPPORT

The EDS EDI Unit is available to support trading partners and providers that exchange transactions electronically. Support functions include:

1. Enrollment processing for trading partners requesting to submit transactions electronically;
2. Installation assistance and submission support for Provider Electronic Solutions (PES) software;
3. Provide assistance to billing agents, clearinghouses and software vendors;
4. Identifying and troubleshooting technical issues; and
5. Data Exchange help.

EDI staff is available Monday through Friday 8:00 a.m. to 5:00 p.m., EST by choosing option 3 when dialing:

1. Inside Florida: 1-800-289-7799;
2. Outside Florida: 1-800-955-7799; and
3. Local calls from Tallahassee area: 850-xxx-xxxx.

5 CONTROL SEGMENT DEFINITIONS FOR FLORIDA MEDICAID 837 DENTAL TRANSACTION

X12N EDI Control Segments
ISA – Interchange Control Header Segment
IEA – Interchange Control Trailer Segment
GS – Functional Group Header Segment
GE – Functional Group Trailer Segment
ST – Transaction Set Header
SE – Transaction Set Trailer

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X12N EDI Control Segments
TA1 – Interchange Acknowledgement

5.1 ISA - Interchange Control Header Segment

Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

837 Dental Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.3	N/A	ISA	ISA01 - Authorization Information Qualifier	'00' – No Authorization Information Present
B.3	N/A	ISA	ISA02 - Authorization Information	[space fill]
B.4	N/A	ISA	ISA03 - Security Information Qualifier	'00' – No Security Information Present
B.4	N/A	ISA	ISA04 - Security Information	[space fill]
B.4	N/A	ISA	ISA05 - Interchange ID Qualifier	'ZZ' – Mutually Defined
B.4	N/A	ISA	ISA06 - Interchange Sender ID	Trading Partner Supplied by Florida Medicaid, left justified space filled.
B.4	N/A	ISA	ISA07 - Interchange ID Qualifier	'ZZ' – Mutually Defined
B.5	N/A	ISA	ISA08 - Interchange Receiver ID	‘77027’ left justified and space filled. Florida Medicaid Sender ID
B.5	N/A	ISA	ISA09 - Interchange Date	The date format is YYMMDD.
B.5	N/A	ISA	ISA10 - Interchange Time	The time format is HHMM
B.5	N/A	ISA	ISA11 - Interchange Control Standards Identifier	‘U’ – Interchange Control Standards Identifier

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837 Dental Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.5	N/A	ISA	ISA12 - Interchange Control Version Number	'00401' – Control Version Number
B.5	N/A	ISA	ISA13 - Interchange Control Number	Interchange Unique Control Number – Must be identical to the interchange trailer IEA02
B.6	N/A	ISA	ISA14 - Acknowledgment Request	'0' – No Acknowledgement Requested '1' – Acknowledgement Requested
B.6	N/A	ISA	ISA15 - Usage Indicator	'T' - Test Data 'P' - Production Data
B.6	N/A	ISA	ISA16 - Component Element Separator	':' – Component Element Separator

5.2 IEA - Interchange Control Trailer

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

837 Dental Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.7	N/A	IEA	IEA01 - Number of included Functional Groups	Number of included Functional Groups
B.7	N/A	IEA	IEA02 - Interchange Control Number	Must be identical to the value in ISA13

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5.3 GS – Functional Group Header

Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

837 Dental Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.8	N/A	GS	GS01 - Functional ID Code	‘HC’ – Health Care Claim (837)
B.8	N/A	GS	GS02 - Application Sender’s Code	Trading Partner Supplied by Florida Medicaid, left justified, do not space fill.
B.8	N/A	GS	GS03 - Application Receiver’s Code	‘77027’ left justified do not space fill. Florida Medicaid Receiver ID
B.8	N/A	GS	GS04 - Date	The date format is CCYYMMDD
B.8	N/A	GS	GS05 - Time	The time format is HHMM
B.9	N/A	GS	GS06 - Group Control Number	Group Control Number
B.9	N/A	GS	GS07 - Responsible Agency Code	‘X’ – Responsible Agency Code
B.9	N/A	GS	GS08 - Version/ Release/ Industry ID Code	'004010X097A1' – Version / Release / Industry Identifier Code

5.4 GE – Functional Group Trailer

Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

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837 Dental Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.10	N/A	GE	GE01 – Number of Transaction Sets Included	Number of included Transaction Sets
B.10	N/A	GE	GE02 – Group Control Number	Must be identical to the value in GS06

5.5 ST – Transaction Set Header

Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

837 Dental Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
53	N/A	ST	ST01 – Transaction Set Identifier Code	‘837’ – Health Care Claim
53	N/A	ST	ST02 – Transaction Set Control Number	Transaction Control Number

5.6 SE – Transaction Set Trailer

Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

837 Dental Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
313	N/A	SE	SE01 – Number of Included Segments	Total Number of Segments included in Transaction Set including ST and SE.
313	N/A	SE	SE02 – Transaction Set	Must be identical to the

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			Control Number	value in ST02

5.7 TA1 – Interchange Acknowledgement

The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

837 Dental Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
B.11	N/A	TA1	TA101 - Interchange Control Number	Interchange control number of the original interchange received (ISA/IEA)
B.11	N/A	TA1	TA102 - Interchange Date	The date format is YYMMDD Date within the original interchange received (ISA/IEA)
B.11	N/A	TA1	TA103 - Interchange Time	The time format is HHMM Time within the original interchange received (ISA/IEA)
B.12	N/A	TA1	TA104 - Interchange Acknowledgement Code	'A' – Transmitted interchange control structure header/trailer received without errors. 'E' – Transmitted interchange control structure header/trailer received and accepted, errors are noted. 'R' – Transmitted interchange control structure header/trailer rejected due to errors.
B.12	N/A	TA1	TA105 - Interchange Note	See the 837D

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837 Dental Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
			Code	Implementation Guide for valid values.

5.8 Valid Delimiters

The following delimiters must be used for the 837D for Florida Medicaid otherwise the transaction may not process correctly.

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	~	126	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

6 COMPANION GUIDE FOR THE 837D TRANSACTION

This section specifies X12 837D fields for which Florida Medicaid has specific requirements.

837 Dental Health Care Claim and Encounter Claims				
Page	**Loop**	**Segment**	**Data Element**	**Comments**
Header				
55	N/A	BHT	BHT02 - Transaction Set Purpose Code	‘00’ – Original
56	N/A	BHT	BHT06 - Transaction Type Code	‘CH’ – Chargeable (Use with Dental Health Care Claim) ‘RP’ – Reporting (Use with Dental Health Care Encounter)
Submitter Name				
61	1000A	NM1	NM109 - Identification Code	Florida EDI Trading Partner ID

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Receiver Name				
67	1000B	NM1	NM103 – Name Last or Organization Name	'STATE OF FLORIDA MEDICAID'
67	1000B	NM1	NM109 - Identification Code	'77027' - Florida Medicaid Payer ID
Billing Provider Name				
71	2000A	PRV	PRV01 - Provider Code	'BI' – Billing Provider 'PT' – Pay-to-Provider
72	2000A	PRV	PRV02 - Reference Identification Qualifier	'ZZ' – Health Care Provider Taxonomy
72	2000A	PRV	PRV03 - Provider Specialty Code	Provider Taxonomy Code
78	2010AA	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
78	2010AA	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
82	2010AA	N4	N403 - Zip Code	Billing Provider Zip Code + 4 postal code (excluding punctuation and blanks)
84	2010AA	REF	REF01 - Reference Identification Qualifier	'EI' – EIN or 'SY' – SSN Healthcare providers must send NPI in the associated NM109 and the REF01='1D' should not be used. 'EI' or 'SY' must be used when

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				NM108='XX'. Non-healthcare providers must send this REF segment where REF01='1D'. NM108 must equal '24' or '34' when REF01='1D'
84	2010AA	REF	REF02 - Reference Identification	If REF01='EI' (EIN) If REF01='SY' (SSN) If REF01='1D' (Florida Medicaid Provider ID) See comments on associated REF01
Pay-to-Provider Name Used if Different than the Billing Provider				
89	2010AB	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
89	2010AB	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
93	2010AB	N4	N403 - Zip Code	Billing Provider Zip Code + 4 postal code (excluding punctuation and blanks)
95	2010AB	REF	REF01 - Reference Identification Qualifier	'EI' – EIN or 'SY' – SSN Healthcare providers must send NPI in the associated NM109 and the REF01='1D' should not be used. 'EI' or 'SY' must be used when NM108='XX'. Non-healthcare providers

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				must send this REF segment where REF01=‘1D’. NM108 must equal ’24’ or ‘34’ when REF01=‘1D’
95	2010AB	REF	REF02 - Reference Identification	If REF01=‘EI’ (EIN) If REF01=‘SY’ (SSN) If REF01=‘1D’ (Florida Medicaid Provider ID) See comments on associated REF01.
Subscriber Level Note: For Florida Medicaid, the insured and the patient are always the same person. Use this HL segment to identify the recipient and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop may not process correctly.				
97	2000B	HL	HL04 - Hierarchical Child Code	‘0’ – No Subordinate HL Segment in this Hierarchical Structure
99	2000B	SBR	SBR01 - Payer Responsibility Sequence Number Code	Refer to Implementation Guide for Valid Values
101	2000B	SBR	SBR09 - Claim Filing Indicator Code	‘MC’ - Medicaid
Subscriber Name				
104	2010BA	NM1	NM102 - Entity Type Qualifier	‘1’ – Person
105	2010BA	NM1	NM108 - Identification Code Qualifier	‘MI’ – Member Identification Number
106	2010BA	NM1	NM109 - Identification Code	Florida Recipient 10-digit Medicaid ID’
Payer Name				
118	2010BB	NM1	NM103 - Name Last or Organization Name	‘STATE OF FLORIDA MEDICAID’
118	2010BB	NM1	NM108 - Identification Code Qualifier	‘PI’ – Payer Identification
118	2010BB	NM1	NM109 - Identification Code	‘77027’ - Florida Medicaid Payer ID

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Claim Information				
150	2300	CLM	CLM01 - Claim Submitter's Identifier	Patient Control Number Value received will be returned on the '835' Remittance Advice
151-152	2300	CLM	CLM05-1 – Facility Type Code	Enter the 2-digit Place of Service Code. Valid values used by Florida Medicaid can be found in the Medicaid Provider Reimbursement Handbook
151-152	2300	CLM	CLM05-3 - Claim Frequency Type Code	Value indicates whether the current claim is an original claim, a void, or an adjustment. Valid values are as follows: 1 = Original Claim 7 = Adjustment (Replacement of Paid Claim) 8 = Void (Credit only). The ICN to Credit should be placed in the REF02, where REF01='F8'. Providers must use the most recently paid ICN when voiding or adjusting. Consult your appropriate Reimbursement Handbook for additional guidelines for filing voids and adjustments.
164	2300	DTP	DTP01 – Date Time Qualifier	'472' – Service This DTP Segment is Required if all of the services on the claim /encounter were

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				performed. (i.e. If 2300-CLM19='PB' is not present)
164-165	2300	DTP	DTP02 – Date Time Period Format Qualifier	'D8' - CCYYMMDD 'RD8' - CCYYMMDD-CCYYMMDD (including dash)
165	2300	DTP	DTP03 – Service Date	Service Date
180	2300	REF	REF01 – Reference Identification Qualifier	'F8' – Original Reference Number
180	2300	REF	REF02 - Reference Identification	Enter the 13-digit ICN or 17-digit TCN assigned to the original claim submission. (ICN/TCN to be credit/voided).
IG 182/ October 2002 Addenda 17	2300	REF	REF01 - Reference Identification Qualifier	'G1' – Prior Authorization Number
IG 182/ October 2002 Addenda 17	2300	REF	REF02 - Reference Identification	Enter the 10-digit Prior Authorization Number only if the services rendered required and received approved Prior Authorization from AHCA. This number must be entered with the qualifier 'G1' (Prior Authorization Number).
186	2300	NTE	NTE01 - Note Reference Code	'ADD' – Additional Information
186	2300	NTE	NTE02 - Description	MCO Receipt Date – Format CCYYMMDD Required for MCO Encounters
Referring Provider Name				
189	2310A	NM1	NM108 - Identification	'XX' – Health Care

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			Code Qualifier	Financing Administration National Provider Identifier (NPI) for Healthcare Providers ‘24’ – Employer’s Identification Number OR ‘34’ – Social Security Number for non-healthcare provider
189	2310A	NM1	NM109 - Identification Code	If NM108=‘XX’ (NPI) If NM108=‘24’ (EIN) If NM108=‘34’ (SSN)
199	2310A	PRV	PRV03 - Provider Specialty Code	Referring Provider Taxonomy Code (used for claims submitted with NPI)
193-194	2310A	REF	REF01 - Reference Identification Qualifier	‘1D’ – Medicaid Provider Number Beginning May 23, 2008 Healthcare providers were required to send NPI in the associated NM109 data element and the REF01=1D should not be used. Non-healthcare providers must send this REF segment where REF01=‘1D’
194	2310A	REF	REF02 - Reference Identification	If REF01=‘1D’ (Florida Medicaid Provider ID) See comments on associated REF01
Rendering Provider Name				
197	2310B	NM1	NM108 - Identification Code Qualifier	‘XX’ – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers

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				'24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
197	2310B	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
199	2310B	PRV	PRV03 - Reference Identification	Rendering Provider Taxonomy Code (used for claims submitted with NPI)
201-202	2310B	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number Beginning May 23, 2008 Healthcare providers were required to send NPI in the associated NM109 data element and the REF01='1D' should not be used. Non-healthcare providers must send this REF segment where REF01='1D'
202	2310B	REF	REF02 - Reference Identification	If REF01='1D' (Florida Medicaid Provider ID) See comments on associated REF01.
Other Subscriber Information				
213-219	2320	CAS	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 – Adjustment Reason Code	All external code source values from code source 139 are allowed.
220	2320	AMT	AMT01 - Amount Qualifier Code	'D' – Payer Amount Paid
220	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Amount Paid (TPL or MCO) Used for Fee-for-Service

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				and Encounters
222	2320	AMT	AMT01 - Amount Qualifier Code	'B6' – Payer Allowed Amount
222	2320	AMT	AMT02 - Payer Paid Amount	Other Payer Allowed Amount Paid (TPL or MCO) Used for Fee-for-Service and Encounters
Other Payer Name				
241	2330B	NM1	NM109 – Identification Code	This number must be identical to at least once occurrence of the 2430-SVD01 to identify the other payer. Florida Medicaid captures third party payment amount(s) from the service line(s) in 2430-SVD02. Note: The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail.
246	2330B	DTP	DTP01 - Date Claim Paid	'573' - Other Payer or MCO Claim Adjudication Date
246	2330B	DTP	DTP02 – Date Time Period Format Qualifier	'D8' – Date Format (CCYYMMDD)
246	2330B	DTP	DTP03 – Date Time Period	TPL or MCO Adjudication Date (CCYYMMDD)
Line Counter				
265	2400	LX	LX01 – Line Counter	Florida Medicaid will accept up to the HIPAA allowed 50 detail lines per claim.
268-269	2400	SV3	SV304-1 - Oral Cavity Designation	Enter the appropriate Mouth Quadrant code

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				for each procedure. Only the first value listed for each procedure will be used to process the claim. Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both. See Section 7 – Program Specific Required Information for Florida Medicaid Claims Processing
272	2400	TOO	TOO02 - Industry Code	Enter the appropriate 2-digit Tooth Number on the line item for each procedure. Each line should contain only one Tooth Number (for permanent teeth) or Tooth Character (for primary teeth). Refer to the National Standards Tooth Numbering System for the appropriate Tooth Number or Tooth Letter for the procedure. Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both.
272	2400	TOO	TOO03-1 - Tooth Surface Code	Enter the appropriate Tooth Surface code for each procedure. Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both.

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273	2400	DTP	DTP01 – Date Time Qualifier	'472' – Service This DTP Segment is Required if Dates of Service are different than those submitted within the 2300-DTP03, where DTP01=472.
273	2300	DTP	DTP02 – Date Time Period Format Qualifier	'D8' - CCYYMMDD
274	2300	DTP	DTP03 – Service Date	Service Date
Detail Line Rendering Provider Name Note: Required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is different than the Billing/Pay-to Provider (2010AA\AB).				
291	2420A	NM1	NM108 - Identification Code Qualifier	'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers '24' – Employer's Identification Number OR '34' – Social Security Number for non-healthcare provider
291	2420A	NM1	NM109 - Identification Code	If NM108='XX' (NPI) If NM108='24' (EIN) If NM108='34' (SSN)
293	2420A	PRV	PRV03 - Reference Identification	Detail Level Rendering Provider Taxonomy Code Used for claims submitted with NPI
295-296	2420A	REF	REF01 - Reference Identification Qualifier	'1D' – Medicaid Provider Number Beginning May 23, 2008 Healthcare providers were required to send NPI in the associated

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				NM109 data element and the REF01='1D' should not be used. Non-healthcare providers must send this REF segment where REF01='1D'
296	2420A	REF	REF02 - Reference Identification	If REF01='1D' (Florida Medicaid Provider ID) See comments on associated REF01/
Line Adjudication Information				
302	2430	SVD	SVD01 – Identification Code	This number must match one occurrence of the 2330B-NM109 identifying Other Payer
302	2430	SVD	SVD02 – Service Line Paid Amount	Enter the Third Party Payment Amount (TPL) at the line item level only.
Line Adjustment				
305-311	2430	CAS	CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 – Adjustment Reason Code	All external code source values from code source 139 are allowed.
305-311	2430	CAS	CAS03, CAS06, CAS09, CAS12, CAS15, CAS18 – Adjustment Amount	Adjustment Amount

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7 PROGRAM SPECIFIC REQUIRED INFORMATION FOR FLORIDA MEDICAID CLAIMS PROCESSING

The values listed here are used in Loop 2400 – SV304-1.

DDE Value	FL Description	FL Value	X12 Value
Lower Left	Lower Left Quadrant	LL	30
Upper Left	Upper Left Quadrant	UL	20
Lower Right	Lower Right Quadrant	LR	40
Upper Right	Upper Right Quadrant	UR	10
Maxillary Area	Upper Arch	UA	01
Mandibular Area	Lower Arch	LA	02

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