DENTAL 837D

The information contained in this document will assist Dental providers enrolled in the New York State (NYS) Medicaid Program with understanding and complying with Medicaid requirements for billing and submitting claims either in electronic or paper format.

Providers should use the information in this document along with the Dental Manual posted at **www.emedny.org**

- ✓ Select Provider Manuals from the menu
- ✓ Click on Dental
- ✓ Click on Billing Guidelines

Providers that bill electronically should refer to the 837D Companion Guide (CG) posted at **www.emedny.org.**

- ✓ Select **NYHIPAADESK** from the menu
- ✓ Click on **eMedNY Companion Guides and Sample Files**
- ✓ Look for the box labeled "837 Dental Health Care Claim Transaction" and click on **837 Dental Companion Guide and 837D Supplemental**

The NYS Medicaid Technical Supplementary Companion Guide provides technical information needed to successfully transmit and receive electronic data. The Technical Supplementary CG is available at **www.emedny.org.**

- ✓ Select **NYHIPAADESK** from the menu
- ✓ Click on **eMedNY Companion Guides and Sample Files**
- ✓ Look for the box labeled "Technical Guides" and click on the link **TECHNICAL SUPPLEMENTARY Companion Guide**

Questions about the information in this Training Matrix should be directed to the eMedNY Call Center at:

1-800-343-9000

The following is an explanation of the information contained in the matrix and instructions for use.

Column 1 eMedNY-000201 Field Number	This refers to the Field Number on the eMedNY-000201 Form.
Column 2 eMedNY-000201 Field Name	This refers to the Field Name on the eMedNY-000201 Form.
Column 3 HIPAA 837D Loop	This refers to the 837D Loop in which this data is found for electronic claims.
Column 4 HIPAA 837D Segment Information	This refers to the 837D Segment in which this data is found for electronic claims.
Column 5 NYS Medicaid Instructions	This column puts forth instructions for data use and content.

Notes:

Only Fields with Medicaid application will be explained in this document.

The source of codes used for billing is the Medicaid Dental Provider Manual.

eMedNY 000201 Field Number	eMedNY- 000201 Field Name	HIPAA 837D Loop	HIPAA 837D Segment Information	NYS Medicaid Instructions
1	PROVIDER IDENTIFICATION NUMBER	2010AA	Billing Provider Secondary Identification REF02	The Provider ID number is the eight-digit identification number assigned to providers at the time of enrollment in the Medicaid program. The provider's ID number and the provider's name and correspondence address are pre-printed in this field for all providers except dental groups.
3	GROUP ID NUMBER	2010AB	Pay to Provider Secondary Identification REF02	The Medicaid Group ID number is the eight-digit identification number assigned to the group at the time of enrollment in the Medicaid program. For a **Group Practice**, the Group ID number is pre-printed by CSC in this field. A claim should be submitted under the Group ID **only** if payment for the service(s) being claimed is to be made to the group. In such a case, the Medicaid Provider ID number of the group member that rendered the service must be entered in Field 1. For a **Shared Health Facility**, enter in this field the eight-digit identification number that was assigned to the facility by the New York State Department of Health at the time of enrollment in the Medicaid program. If the provider or the service(s) rendered is not associated with a Group Practice Shared Health Facility, leave this field blank. **Dental Schools and Orthodontic Clinics**: Leave this field blank.
4	LOCATOR CODE	2010AA	Billing Provider Secondary Identification REF02	Enter the three-digit Locator Code issued by New York State DOH. Providers need to enter an additional zero to the left of a previously issued two-digit Locater Code to comply with eMedNY billing requirements. **Note**: The provider is reminded of the obligation to notify Medicaid of all service locations as well as changes to any of them. For information on where to direct locator code updates, please refer to Information for All Providers, Inquiry Section under Provider Manuals posted at **www.emedny.org**.
5	SA EXCEPTION CODE	NA	NA	If it was necessary to provide a service covered under the Utilization Threshold program and Service Authorization (SA/UT) could not be obtained, enter the SA exception code that best describes the reason for the exception. If not applicable leave this field blank.

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Fields 6 and 6A should only be used to adjust or void a paid claim. Do not write in these fields when preparing an original claim form.				
6	CODE (A/V)	2300	Claim Information CLM05-3	**eMedNY-000201 Instructions:** If submitting an adjustment (replacement) to a previously paid claim, enter **X** or the value **7** in the A box. If submitting a void to a previously paid claim, enter **X** or the value **8** in the V box. **HIPAA Instructions**: Enter code "7" to indicate an adjustment or "8" to indicate a void.

eMedNY 000201 Field Number	eMedNY- 000201 Field Name	HIPAA 837D Loop	HIPAA 837D Segment Information	NYS Medicaid Instructions
6A	ORIGINAL CLAIM REFERENCE NUMBER	2300	Original Reference Number REF02	If submitting an adjustment or a void, enter the appropriate **Transaction Control Number (TCN)** in this field. A TCN is a 16-digit identifier that is assigned to each claim document or electronic record regardless of the number of individual claim lines (service date/procedure combinations) submitted in the document or record. For example, a document/record containing a single service date/procedure combination will be assigned a unique, single TCN; a document/record containing five service date/procedure combinations will be assigned a unique, single TCN, which will be shared by all the individual claim lines submitted under that document/record. **Adjustment** An adjustment may be submitted to accomplish any of the following purposes: • To change information contained in one or more claims submitted on a previously paid TCN • To cancel one or more claim lines submitted on a previously paid TCN (except if the TCN contained one single claim line or if all the claim lines contained in TCN are to be voided) ***Adjustment to Change Information*** If an adjustment is submitted to correct information on one or more claim lines sharing the same TCN, follow the instructions below: • The Provider ID number, the Group ID number, and the Patient's Medicaid ID number must not be adjusted. • The adjustment must be submitted in a new claim form (copy of the original form is unacceptable). • The adjustment must contain all claim lines originally submitted in the same document/record (all claim lines with the same TCN), and all applicable fields must be completed with the necessary changes. The adjustment will cause the correction of the adjusted information in the TCN history records as well as the cancellation of the original TCN payment and the re-pricing of the TCN based on the adjusted information. **Void** A void is submitted to nullify **all** individual claim lines originally submitted on the same document/record and sharing the same TCN. When submitting a void, please follow the instructions below: • The void must be submitted on a new claim form (copy of the original form is unacceptable). • The void must contain all the claim lines to be cancelled and all applicable fields must be completed. Voids cause the cancellation of the original TCN history records and payment.

eMedNY 000201 Field Number	eMedNY- 000201 Field Name	HIPAA 837D Loop	HIPAA 837D Segment Information	NYS Medicaid Instructions
Fields 7 - 9A require information obtained from the Client's (Recipient's) Medicaid Common Benefit Identification Card.				
7	RECIPIENT ID NUMBER	2010BA	Subscriber Name NM109	Enter the recipient's ID number (Client ID Number) as it appears on the Common Benefit Identification Card. Medicaid Client ID numbers are assigned by the State of New York and are composed of eight characters in the format AANNNNNA, where A = alpha character and N = numeric character.
8	DATE OF BIRTH	2010BA	Subscriber Demographic Information DMG02	Enter the recipient's birth date indicated on the Common Benefit ID Card. **eMedNY-000201 Instructions**: The format entered must be MMDDYYYY. **HIPAA Instructions**: The format of the date must be CCYYMMDD.
8A	PATIENT'S SEX	2010BA	Subscriber Demographic Information DMG03	**eMedNY-000201 Instructions:** Place an X in the appropriate box to indicate the recipient's sex. **HIPAA Instructions**: Enter an M or F.
9	RECIPIENT NAME – FIRST	2010BA	Subscriber Name NM104	Enter the recipient's first name as it appears on the Common Benefit Identification Card.
9A	RECIPIENT NAME – LAST	2010BA	Subscriber Name NM103 NM104	Enter the recipient's last name as it appears on the Common Benefit Identification Card.
10	PATIENT'S ACCOUNT NUMBER	2300	Claim Information CLM01	**eMedNY-000201 Instructions**: For record-keeping purposes, the provider may choose to identify a patient by using an Office Account Number. This field can accommodate up to 20 alphanumeric characters and is reported on the remittance statement. **HIPAA Instructions**: Required data and is reported on the HIPAA 835 electronic remittance.
13	EMERGENCY RELATED			Enter an X in the Yes box only when the condition being treated is related to an emergency (the patient requires immediate intervention as a result of severe, life-threatening, or potentially disabling condition); otherwise leave this field blank. **Note for dental claims**: No emergency indicator exists in the HIPAA 837D for dental services. There is a list of procedure codes that are allowed for recipients eligible for emergency services only.

eMedNY 000201 Field Number	eMedNY- 000201 Field Name	HIPAA 837D Loop	HIPAA 837D Segment Information	NYS Medicaid Instructions
14	ACCIDENT CODE	2300	Claim Information CLM11	**eMedNY-000201 Instructions**: If applicable, enter the appropriate code from the Code Sets, to indicate whether the service rendered to the recipient was for a condition resulting from an accident or a crime. **Code Description:** 0/Blank Not Applicable 1 Auto Accident 2 Employment 3 Another Party Responsible 4 Other Accident **HIPAA Instructions**: See Companion Guide.
15	PATIENT STATUS CODE	N/A	N/A	Leave this field blank
19	PRIOR APPROVAL NUMBER	2300	Prior Authorization or Referral Number REF02	If the provider is billing for a service that requires Prior Approval/Prior Authorization, enter in this field the 11-digit prior approval number assigned for this service by the appropriate agency of the New York State Department of Health. If several service dates and/or procedures need to be claimed and they are covered by different prior approvals, a separate claim form has to be submitted for each prior approval. **Notes:** • For information regarding how to obtain Prior Approval/Prior Authorization for specific services, please refer to the Information for All Providers, Inquiry section under Provider Manuals posted at www.emedny.org. • For information on how to complete the prior approval form, please refer to the Prior Approval Guidelines in the Dental Provider Manual. • For information regarding procedures that require prior approval, please consult the Procedure Codes and Fee Schedules in the Dental Provider Manual.
20	PLACE	2300	Claim Information CLM05-1	Enter the **two**-digit place of service where the service was rendered. Please note that the Place of Service Code is different from the locator code. **Dental Schools**: Enter 99 (Other) in this field and complete field 20A.

eMedNY 000201 Field Number	eMedNY- 000201 Field Name	HIPAA 837D Loop	HIPAA 837D Segment Information	NYS Medicaid Instructions
20A	PLACE OF SERVICE ADDRESS			**Dental Schools**: Enter the exact address of the location where the service was performed.
21	SERVICE PROVIDER IDENTIFICATION NUMBER	2310B	Rendering Provider Secondary Information REF02	If applicable, enter the Service Provider's Medicaid ID Number in this field. If he/she is not enrolled in Medicaid, enter his/her license number in this field. If a license number is used, it must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license. **Dental School**: Enter the Medicaid ID number or license number of the supervising dentist. **Orthodontic Clinic**: Enter the Medicaid ID number or the license number of the dentist who rendered the service. If more than one dentist rendered the service, enter the Medicaid ID number or the license number of the principal dentist. **Dental Practitioners**: Leave this field blank.
21A	PROF CD	2310B	Rendering Provider Secondary Information REF02	**Orthodontic Clinics and Dental Schools** If a license number is indicated in Field 21, the Profession Code that identifies the service provider's profession must be entered in this field. Profession Codes are listed at www.emedny.org. ✓ Select **NYHIPAADESK** from the menu ✓ Click on **Crosswalks** ✓ Look for the box labeled "Using License Number " and click on **Provider License Type to Profession Code Mapping** **Dental Practitioners**: Leave this field blank. **HIPAA Instructions**: The Profession Code is reported before the license number.

eMedNY 000201 Field Number	eMedNY- 000201 Field Name	HIPAA 837D Loop	HIPAA 837D Segment Information	NYS Medicaid Instructions
21B	Name (SERVICE PROVIDER)	2310B	Rendering Provider Name NM1	**Orthodontic Clinics and Dental Schools Only**: If a license number was entered in field 21, enter the service provider's name in 21B.
Fields 23, 23A, and 23B must be completed when the recipient has been referred by another provider.				
23	ORDERING/ REFERRING PROVIDER ID/LICENSE NUMBER	2310A	Referring Provider Secondary Information REF02	If the patient was referred for treatment by another provider, enter the Ordering/Referring Provider's Medicaid ID Number in this field. If the referring dentist is not enrolled in Medicaid, enter his/her license number. If a license number is used, it must be preceded by two zeroes (00) if it is a NY State license or by the standard Post Office abbreviation of the state of origin if it is an out-of-state license If no referral was involved, leave this field blank. If the patient is restricted to another dental provider, the dentist rendering services must enter the **Medicaid ID** number of the patient's primary dental provider in this field. **The license number of the primary dental provider is not acceptable in this case.**
23A	PROF CD	2310A	Referring Provider Secondary Information REF02	If a license number is indicated in Field 23, the Profession Code that identifies the referring provider's profession must be entered in this field. Profession Codes are listed at www.emedny.org. ✓ Select **NYHIPAADESK** from the menu ✓ Click on **Crosswalks** ✓ Look for the box labeled "Using License Number" and click on **Provider License Type to Profession Code Mapping** **HIPAA Instructions:** The Profession Code is reported before the license number.
23B	Name (ORDERING / REFERRING PROVIDER)	2310A	Referring Provider Name NM103	If the patient was referred by another provider, enter the referring provider's name in this field.

eMedNY 000201 Field Number	eMedNY- 000201 Field Name	HIPAA 837D Loop	HIPAA 837D Segment Information	NYS Medicaid Instructions
The claim form can accommodate up to nine encounters with a single patient if all the information in the Header Section of the claim (Fields 1–24B) applies to all the encounters.				
25	DATE OF SERVICE	2300/ 2400	Date-Service Date DTP03	Enter the date on which the service was rendered in the format MM/DD/YY **HIPAA Instructions:** The format of the date must be CCYYMMDD. **Orthodontists and Orthodontic Clinics:** enter only the last date of service in the quarter for which you are billing.
26	PROCEDURE CODE	2400	Dental Service SV301-2	This code identifies the type of service that was rendered to the recipient. Enter the appropriate 5-character procedure code. **Note:** Procedure codes, definitions, prior approval requirements (if applicable), fees, etc. can be found under the Procedure Codes and Fee Schedule section of the Dental Provider Manual**.**
27	TIMES PERFORMED	2400	Dental Service SV306	If a procedure was performed more than one time on the same date of service, enter the number of times in this field. If the procedure was performed only one time or the procedure code requires completion of Fields 28 and 29, this field may be left blank.
28	ORAL CAVITY	2400	Dental Services SV304-1, SV304-2 SV304-3, SV304-4	If applicable, enter the appropriate oral cavity code. Procedures requiring an entry in this field are marked accordingly in the Procedure Code and Fee Schedule of the Dental Provider Manual.
29	TOOTH	2400	Tooth Information TOO02	If applicable, enter the number(s) or letter(s) that identify the tooth on which the procedure was performed. **Notes:** • A permanent tooth is identified by a two-digit number. For example: 01 • A primary tooth is identified by a capital letter. For example: F
29A	SURFACE	2400	Tooth Information TOO03-1, TOO03-2 TOO03-3, TOO03-4 TOO03-5	If applicable, enter the code that indicates the tooth surface being restored. Please **write the letter code** in the appropriate column; **do not enter an X**. An entry in this field requires a Tooth Code in Field 29. Procedures requiring an entry in this field are marked accordingly in the Procedure Code and Fee Schedule of the Dental Provider Manual.

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30	AMOUNT CHARGED	2400	Dental Service SV302	Enter the total amount charged for each service rendered. The amount may not exceed the provider's usual charge.
Fields 31, 31A, 31B, and 31C are only applicable if the recipient is also a Medicare beneficiary.				
31	MEDICARE CO INSURANCE	2320 2430	Claim Adjustment CAS03, 6, 9,12, 15,18	If applicable, enter the Medicare co-insurance amount for the specific procedure.
31A	MEDICARE DEDUCTIBLE	2320 2430	Claim Adjustment CAS03, 6, 9,12, 15,18	If applicable, enter the Medicare deductible amount for the specific procedure.
31B	MEDICARE CO PAY	N/A	N/A	If applicable, enter the Medicare co-pay amount for the specific procedure.
31C	MEDICARE PAID	2320 2430	COB Payer Paid Amount AMT02 Line Adjudication Information SVD02	If applicable, enter the amount actually paid by Medicare for the specific procedure. If Medicare denies payment, enter 0.00.

eMedNY 000201 Field Number	eMedNY- 000201 Field Name	HIPAA 837D Loop	HIPAA 837D Segment Information	NYS Medicaid Instructions
32	OTHER INSURANCE PAID	2320 2430 2300	Coordination of Benefits Payer Paid Amount AMT02 Line Adjudication Information SVD02 Patient Paid Amount AMT02 (Spend down)	This field must be completed if the patient is covered by insurance other than Medicare. Leave this field blank if the recipient has no other insurance coverage. **Note:** It is the responsibility of the provider to determine whether the patient is covered by other insurance and whether the insurance carrier covers the service being billed for. If the service is covered or if the provider does not know if the service is covered, the provider must submit a claim to the other insurance carrier prior to billing Medicaid, as Medicaid is the payer of last resort. If applicable, enter the amount actually paid by the other insurance carrier in this field. If the other insurance carrier denied payment, enter 0.00 in this field. Proof of denial of payment must be maintained in the patient's billing record. **HIPAA Instructions:** If applicable, enter the other insurance paid amount or zeros for non-payment in loop 2320, AMT02 / 2430, SVD02. Enter spend down (patient participation) amount in 2300, AMT02.
37	CERTIFICATION	2300	Claim Information CLM06	The provider or an authorized representative of a dental school must sign the claim form. Rubber stamp signatures are not acceptable. Please note that the certification statement is on the back of the form. If billing electronically, the provider must have a Certification Statement on file.
37A	COUNTY OF SUBMITTAL	N/A	N/A	Enter the name of the county wherein the claim form is signed. The County may be left blank only when the provider's address, as preprinted in the upper left corner of the claim form, is within the county wherein the claim form is signed.
38	DATE SIGNED	N/A	N/A	Enter the date on which the provider or an authorized representative of the dental provider signed the claim form. The date should be in the format MM/DD/YY. **Note:** In accordance with New York State regulations, claims must be submitted within 90 days of the Date of Service unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days or two years from the Date of Service, refer to Information for All Providers, General Billing section, under Provider Manuals posted at **www.eMedNY.org**.