

eMedNY

**New York State Department of
Health Office of Health
Insurance Programs**

**837 Dental Health Care Claim:
Supplemental Companion
Guide**

NPI EDITION

eMedNY

HIPAA V4010X097A1 837: Health Care Claim: Dental

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COMPANION GUIDE DISCLAIMER:

The New York State Department of Health (NYSDOH) has provided this Medicaid Supplemental Companion Guide for the 837 Dental Transaction, Addendum version (ASC X12N 004010X097A1) for use by Providers, Clearinghouses and all Covered Entities who are Trading Partners of NYSDOH and the New York State Medicaid Program. NYSDOH has focused primarily on the rules and policies regulating the submission of NYS Medicaid data as specified within this Supplemental Companion Guide and the NYSDOH 837 Dental Companion Guide. NYSDOH has provided this document with related information at <http://www.nyhipaadesk.com> as a resource to assist Providers and other Trading Partners in preparing HIPAA compliant electronic transactions in accordance with the program requirements of NYS Medicaid. NYSDOH does not offer individual training in the use of the ASC X12N transactions.

The information provided herein is believed to be true and correct based on the Addendum Version of the HIPAA guidelines. HIPAA regulations are continuing to evolve, therefore NYSDOH makes no guarantee, expressed or implied, as to the accuracy of the information provided herein. Furthermore, this is a living document and the information provided herein is subject to change as NYSDOH policy changes or as HIPAA legislation is updated or revised.

CG MODIFICATION TRACKING:

>V3.1

- 12/29/2008 Minor rewording of Cost Avoidance/Zero Fill section.
- 08/11/2008 Revised National Provider Identifier section of front matter and all "Provider" sections to reflect the eMedNY system requirements after NPI implementation.

>V3.0

- 09/18/2007 Removed phone system options information from NYS Medicaid Note in front matter, leaving the call center 800 number. Added note to refer to Technical Supplementary Guide.
- 08/16/2007 Added the location of the 0FILL data, in addition to the note already present, in the section on Zero Fill. Also added note on what to send when claim is not eligible for Zero Fill.
- 03/14/2007 Added information to refer to the Technical Supplementary Companion Guide in NYS Medicaid Notes in the front matter.
- 02/05/2007 Changed title to reflect new name for NYSDOH Office of Health Insurance Programs, removed "NPI Edition" from title, removed all references to "Phase II".

>V2.2

- 01/22/2007 – Significant rewording of NPI section to state that the eMedNY system will not be ready to receive the NPI as the primary provider identifier by the Compliance Date of May 23, 2007.
- 10/06/2006 – Corrected date in NPI section
- 06/13/2006 – Minor rewording of Disclaimer
- 03/23/2006 – clarified Coordination of Benefits balancing in the CAS Segment section
- 03/17/2006 – added new "National Provider Identifier (NPI)" section with critical information for sending NPI and related information prior to the Compliance Date of March 23, 2007. Removed section "Differences Between Phase I and Phase II"

>V2.1

- 10/28/2005 – updated instructions for identifying a Rendering Provider by license number
- 09/23/2005 – updated support phone numbers in front matter
- 04/20/2005 – added note about 16-digit TCN to CG Modification Tracking. Added note about using TCN in voids and adjustments; and about retrieving TCN using 276/277 to NYS Medicaid Note in front matter. Corrected out-of-state Institutional Unit phone number. Removed references to online testing and issue logging.

NYS MEDICAID NOTE:

This Supplemental Companion Guide (CG), which is provided by the New York State Department of Health (NYSDOH), outlines changes that are in conflict with the current Provider Manuals or are clearly different from the previous business process. These changes are specific to Providers who utilize the 837 Dental Healthcare Claim (837D). The document includes a listing of the various code sets that are used by the NYS Medicaid claims processing system. As an aid to developers and programmers using this CG, technical references have been added to serve as pointers to specific areas of the 837D Companion Guide (Ex. Loop-ID 2300, CL103.) NYSDOH will provide crosswalks of MMIS to HIPAA codes in this CG, for those fields/elements that require translation.

This Supplemental Companion Guide does not modify the standards; rather, it puts forth the subset of information from the Implementation Guide (IG) that will be required for processing transactions. It is important that Providers use this Companion Guide as a supplement to the 837D Companion Guide, which itself is a supplement of the IG.

SUPPORT:

Please refer to the Technical Supplementary Companion Guide for information about transaction header structures, transaction size limits, electronic communications methods, and enrollment as a trading partner. This document is available for download at nyhipaadesk.com.

For further assistance, NYSDOH and its fiscal agent, Computer Sciences Corporation (CSC), are urging providers to visit a web community, <https://www.nyhipaadesk.com>, which will provide Companion Guide updates and other pertinent information. In addition, questions may be sent to NYSDOH's Test Support Team at nyhipaadesk@csc.com.

Providers with questions may call the eMedNY Call Center at: 1-800-343-9000.

Please be advised that Unit representatives will only answer questions related to New York Medicaid HIPAA requirements.

The ASC X12N Implementation Guides and their associated addenda are available in electronic format at: www.wpc-edi.com/hipaa. Pharmacy Providers can acquire the NCPDP Implementation Guide from www.ncdp.org.

1. Submitter Name:

The first entity identified in the transaction is the Submitter, identified in the Submitter Name segment (Loop-ID 1000A, NM1 where NM101='41' and NM102='1' or '2'). NYSDOH will return the Remittance Advice (RA) to the Submitter identified by Electronic Transmitter Identification Number (ETIN, formerly referred to as TSN) at NM109. This ETIN may differ from the one reported in the ISA and GS segments. The Submitter is not a Provider in all cases. The Submitter may be an intermediary contracted for billing purposes, such as a service bureau or clearinghouse.

2. National Provider Identifier (NPI)

AS OF THE PUBLICATION DATE OF THIS DOCUMENT THE EMEDNY SYSTEM IS SCHEDULED FOR NPI IMPLEMENTATION ON SEPTEMBER 1, 2008. ALL NYS MEDICAID PROVIDERS WHO ARE HEALTH CARE PROVIDERS ARE REQUIRED TO VISIT EMEDNY.ORG TO REGISTER THEIR NPI(S) AS SOON AS POSSIBLE.

For information about the requirements for reporting NPI, refer to the NYS Medicaid Notes for the NM1 segments of each loop at levels 2310 and 2420 in the 837 Dental: Health Care Claim Companion Guide. Note that after the eMedNY system's NPI implementation the NPI must be used to identify all health care providers reported in the claim, with the sole exception of the Referring Provider, who may be identified by NYS Medicaid Provider ID or License Number, only if the NPI is not available. However, every effort should be made to use the NPI of the Referring Provider when applicable.

3. Provider(s) Identified in the 837D Dental Transaction:

Dental healthcare claims submitted on an 837D can include information about a variety of providers. To successfully submit Dental claims to NYSDOH, care must be taken to include all loops and segments required for processing NYS Medicaid claims.

Billing Provider Name:

NYSDOH requires the Billing Provider to be identified in the Billing Provider Name loop (Loop-ID 2010AA, starting with NM1 where NM101='85'). By default the Billing Provider is also processed as the Servicing Provider, unless the Rendering Provider Name loop is sent.

NYSDOH encourages providers to send the NPI in this location. During the period leading up to the eMedNY NPI implementation, the Billing Provider Name NM1 segment that starts loop 2010AA will be accepted with the following Identifiers and Qualifiers:

- NPI (NM108 will contain a Qualifier of 'XX' and NM109 will contain the Billing Provider's NPI), or
- Employer ID Number (NM108 will contain a Qualifier of '24' and NM109 will contain the Billing Provider's Employer ID Number), or
- Social Security Number (NM108 will contain a Qualifier of '34' and NM109 will contain the Billing Provider's Social Security Number).

AFTER NPI IMPLEMENTATION THE NATIONAL PROVIDER IDENTIFIER (NPI) IN THE BILLING PROVIDER NAME NM1 SEGMENT WILL BE REQUIRED,

A dental group's identifiers should not be reported in the Billing Provider Name loop. If payment is to be made to a group provider the group should be identified in the Pay-to Provider Name Loop (Loop-ID 2010AB, starting with NM1 where NM101='87').

The Billing Provider will be overridden in the claims processing system under certain circumstances, as discussed below under the Rendering Provider section. This will not affect payment, which will be made to the Pay-to Provider, but it will affect Claim Status Inquiry and claims inquiry by eMedNY Call Center staff.

Billing Provider Secondary Identification:

Prior to the eMedNY NPI implementation, NYSDOH will continue to require a valid NYS Medicaid Provider ID and Locator Code, belonging to the Billing Provider, to satisfy the business requirements for NYS Medicaid in processing a claim. Two iterations of the Billing Provider Secondary Identification REF segment must be sent with the following Identifiers and Qualifiers:

- NYS Medicaid Provider ID (REF01 will contain a Qualifier of '1D' and REF02 will contain the Billing Provider's Provider ID), and
- Locator Code (REF01 will contain a Qualifier of 'LU' and REF02 will contain the Locator Code for the service location).

AFTER NPI IMPLEMENTATION THERE MUST BE AN ITERATION OF THE BILLING PROVIDER SECONDARY IDENTIFICATION REF SEGMENT WITH:

- Employer ID Number (Qualifier 'EI' in REF01 and the EIN in REF02), or
- Social Security Number (Qualifier 'SY' in REF01 and the SSN in REF02), or
- Federal Taxpayer ID Number (Qualifier 'TJ' in REF01 and the TIN in REF02).

Note that the Qualifiers used in the REF segment are different than the ones used in NM1.

During the initial period following NPI implementation, the NYS Medicaid Provider ID and Locator Code will continue to be accepted, but will not be required, in iterations of the REF segment. This does not affect the requirement to send the EIN, SSN, or Taxpayer ID Identifier and Qualifier. Note that the value sent for these identifiers is not used for claims processing or for tax reporting purposes, since this information is maintained in the system as part of the provider enrollment and maintenance process.

Pay-to Provider Name:

NYSDOH expects to receive the Pay-to Provider loop (Loop-ID 2010AB, starting with NM1 where NM101='87') when payment is to go to a dental group rather than to the individual provider. When loop 2010AB is sent, the Pay-to Provider is processed as the Group Provider.

NYSDOH encourages providers to send the NPI in this location. During the period leading up to the eMedNY NPI implementation, the Pay-to Provider Name NM1 segment that starts loop 2010AB will be accepted with the following Identifiers and Qualifiers:

- NPI (NM108 will contain a Qualifier of 'XX' and NM109 will contain the Pay-to Provider's NPI), or
- Employer ID Number (NM108 will contain a Qualifier of '24' and NM109 will contain the Pay-to Provider's Employer ID Number).

AFTER NPI IMPLEMENTATION THE NATIONAL PROVIDER IDENTIFIER (NPI) IN THE BILLING PROVIDER NAME NM1 SEGMENT WILL BE REQUIRED,

Pay-to Provider Secondary Identification:

Prior to the eMedNY NPI implementation, NYSDOH will continue to require the NYS Medicaid Group Provider ID of the Pay-to Provider. An iteration of the Pay-to Provider Secondary Identification REF segment must be sent with:

- NYS Medicaid Provider ID (REF01 will contain a Qualifier of '1D' and REF02 will contain the Pay-to Provider's Provider ID).

AFTER NPI IMPLEMENTATION THERE MUST BE AN ITERATION OF THE PAY-TO PROVIDER SECONDARY IDENTIFICATION REF SEGMENT WITH:

- Employer ID Number (Qualifier 'EI' in REF01 and the EIN in REF02), or
- Federal Taxpayer ID Number (Qualifier 'TJ' in REF01 and the TIN in REF02).

Note that the Qualifiers used in the REF segment are different than the ones used in NM1.

During the initial period following NPI implementation, the NYS Medicaid Provider ID will continue to be accepted, but will not be required, in an iteration of the REF segment. This does not affect the requirement to send the EIN or Federal Taxpayer ID Identifier and Qualifier.

Rendering Provider Name:

By default the Rendering Provider is processed as the Servicing Provider. The Rendering Provider Name loop (Loop-ID 2310B) is indicated by use of a Qualifier in the Rendering Provider Name NM1 segment (NM101='82'). The Rendering Provider Name loop at the claim level is required by the 837 Dental Implementation Guide whenever the Pay-to Provider Name loop (Loop-ID 2010AB) is sent, in order to specify whether the Billing Provider or the Pay-to Provider rendered the services. Additionally, NYSDOH expects the Rendering Provider loop in certain cases, including claims in which the Group Provider is a dental school. NYSDOH requires the teacher in charge to be identified as the Rendering Provider for these claims.

NYSDOH encourages providers to send the NPI in this location. During the period leading up to the eMedNY NPI implementation, the Rendering Provider Name NM1 segment that starts loop 2310B will be accepted with the following Identifiers and Qualifiers:

- NPI (NM108 will contain a Qualifier of 'XX' and NM109 will contain the Rendering Provider's NPI), or
- Employer ID Number (NM108 will contain a Qualifier of '24' and NM109 will contain the Rendering Provider's Employer ID Number), or
- Social Security Number (NM108 will contain a Qualifier of '34' and NM109 will contain the Rendering Provider's Social Security Number).

AFTER NPI IMPLEMENTATION THE NATIONAL PROVIDER IDENTIFIER (NPI) IN THE RENDERING PROVIDER NAME NM1 SEGMENT WILL BE REQUIRED WHEN THE RENDERING PROVIDER IS SENT,

Rendering Provider Secondary Identification:

Prior to the eMedNY NPI implementation, if the Rendering Provider Name loop is sent, NYSDOH will continue to require in most cases (when the Rendering Provider is not the Billing Provider) a valid NYS Medicaid Provider ID or formatted License Number, belonging to the Rendering Provider, to satisfy the business requirements for NYS Medicaid in processing a claim. An iteration of the Rendering Provider Secondary Identification REF segment must be sent with the following Identifiers and Qualifiers:

- NYS Medicaid Provider ID (REF01 will contain a Qualifier of '1D' and REF02 will contain the Rendering Provider's Provider ID), or
- Formatted License Number (REF01 will contain a Qualifier of '0B' and REF02 will contain the license number, formatted as specified in the FAQ entitled "License Number - How to send a License Number as a Provider Identifier", available at the nyhpaadesk.com website under FAQs).

An additional iteration of the Rendering Provider Secondary Identification REF segment should be sent to transmit the three-digit Location Number (Locator Code), if different from the Location Number sent in the Billing Provider Name loop (loop 2010AA). A Qualifier (REF01='LU') indicates that the Location Number is being sent in REF02.

During the initial period following NPI implementation, the NYS Medicaid Provider ID and formatted License Number will continue to be accepted, but will not be required, in iterations of the REF segment.

Rendering Provider Override of the Billing Provider:

Use of the Rendering Provider loop can potentially override the Billing Provider in the receiving system. When Rendering Provider information is sent only to specify that the Billing Provider, and not the Pay-to Provider, rendered the services the Rendering Provider Secondary Identification REF segment is not necessary and should not be sent so as to avoid unintended override of the Billing Provider.

Prior to the eMedNY NPI implementation the Rendering Provider in loop 2310B overrides the Billing Provider only if all three of the following conditions are met:

- the Rendering Provider Secondary Identification REF segment is sent with a NYS Medicaid Provider ID in REF02, and
- the Pay-to Provider loop 2010AB is present with a NYS Medicaid Group Provider ID in REF02, and
- the NYS Medicaid Group Provider ID in 2010AB does not identify a dental school.

If any of the conditions for Billing Provider override described above are not met, the Rendering Provider information is used as the Servicing Provider only and the Billing Provider is not overridden.

After the eMedNY NPI implementation both the Rendering Provider and the Billing Provider are identified by their NPI. The three conditions for the Rendering Provider to override the Billing are essentially the same:

- the Rendering Provider Name NM1 segment is sent with an NPI that crosswalks in the system to a NYS Medicaid Provider ID that is valid for billing NYS Medicaid, and
- the Pay-to Provider loop 2010AB is present with an NPI in the NM1 segment that crosswalks to a NYS Medicaid Group Provider ID, and
- the NYS Medicaid Group Provider ID in the crosswalk does not identify a dental school.

Rendering Provider information can also be sent at the line level in Loop-ID 2420A. When the conditions for override of the Billing Provider information are met the override will occur at line level only.

4. Replacement/Void codes:

NYSDOH will process all values as original claims with the exception of codes '7' (Replacement) and '8' (Void). Replacement and/or Void can only be sent for previously PAID claims (Loop-ID 2300, CLM05-3).

5. Over Ninety Day Indicator:

HIPAA mandates that any claim that has passed the payers timely filing requirements must include a Delay Reason Code. The NYSDOH filing requirement is 90 days. Therefore, all claims for which more than 90 days has lapsed since the Date of Service must include one of the following HIPAA Codes in order to be considered for payment. Please note that Delay Reason Code 6 is not listed in the table because NYS Medicaid policy does not consider this a valid delay reason, and NYS Medicaid will deny any claim submitted using this code. If the delay reason is for interrupted maternity care or an IPRO denial/reversal, you may use code 11 – Other (Loop-ID 2300, CLM20).

| HIPAA Delay Reason Code | Definition |
|-------------------------|---|
| 1 | Proof of Eligibility Unknown or Unavailable |
| 2 | Litigation |
| 3 | Authorization Delays |
| 4 | Delay in Certifying Provider |
| 5 | Delay in Supplying Billing Forms |
| 7 | Third Party Processing Delay |
| 8 | Delay in Eligibility Determination |
| 9 | Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules |
| 10 | Administration Delay in the Prior Approval Process |
| 11 | Other |

6. SBR Segment:

It is important to use the correct Claim Filing Indicator Code value when reporting Medicare Part B (MB) and other TPL payers for Coordination of Benefits. Incorrect usage of this code may create pricing and/or payer coordination errors. (Loop-ID 2320, SBR09).

7. CAS Segment: Claim Level and Line Level Balancing

Claim level adjustments are reported in a CAS segment in Loop-ID 2320. An iteration of this loop should be sent for each payer whose potential involvement with the claim is being reported except where the provider has submitted under the “OFILL” Plan Name. The CAS segment is used in this loop to report prior payers’ claim level adjustments that cause the amount paid to differ from the amount originally charged. Up to five CAS segments can occur in an iteration of the loop, each reporting the adjustment associated with a single Claim Adjustment Group Code at CAS01. Only one Group Code can occur in a CAS segment. The adjustment itself is reported with a group of three values, which can occur up to six times within a single CAS segment; Adjustment Reason Code (CAS02, CAS05, CAS08, CAS11, CAS14, CAS17); Adjustment Amount (CAS03, CAS06, CAS09, CAS12, CAS15, CAS18); and Adjustment Quantity (CAS04, CAS07, CAS10, CAS13, CAS16, CAS19). These values should come from 835 transactions received for the claim. If there were no prior payer adjustments the segment is not sent.

Line level adjustments are reported in a CAS segment in Loop-ID 2430. The segment is required when the payer identified in Loop-ID 2330B made line level adjustments that cause the amount paid to differ from the amount originally charged. The data elements do not differ from a CAS at the claim level. The values reported should come from 835 transactions received for the line item. If there were no line-level prior payer adjustments for the line item the segment is not sent.

Any adjustment amount from one adjustment should be reported only once. Do not repeat a claim-level adjustment at the line level. Also do not report the total of the line-level adjustments in a claim-level CAS segment.

When amounts from distinct claim level and line level adjustments are reported balancing should be done at both the line level (line charge minus total CAS amounts equals paid) and claim level (claim total charge minus total CAS amounts from both claim and line level equals claim level paid).

8. Co-insurance and Deductibles :

The Coinsurance and Deductible amounts will now be reported as adjustment amounts in the CAS segment, in the Patient Responsibility group (claim level Loop-ID 2320, CAS01='PR'; or line level 2430, CAS01='PR').

The Coordination of Benefits Other Payer Paid Amount (i.e. Medicare Paid Amount) is reported in the AMT segment at AMT02 (claim level Loop 2320, AMT01='D').

9. Medicare Approved Amount Calculation:

When submitting claims secondary to Medicare, Providers were required to provide the Medicare Approved Amount. The HIPAA Implementation Guides do not allow this information to be required. As a result, the approved amount will be derived as a calculation of the payment and adjustment information provided in the COB sections of the claim. The sum of the Medicare Paid Amount and the amounts assigned to the Medicare Deductible and Coinsurance Claim Adjustment Reason Codes (Codes 1 & 2) will be considered the Approved Amount.

REMEMBER: It is required that all adjustments are passed into the claim exactly as received in the Remittance Advice from the Primary Payer.

10. Spend-down – Patient Participation:

The patient participation (also known as spend-down) amount will now be reported as the Patient Amount Paid for all claims. (Loop-ID 2300, AMT02 where AMT01='F5').

11. Cost Avoidance Override/Zero Fill:

"Zero Fill" is a time and cost-saving process implemented by NYSDOH to facilitate claim payment when it is known that the primary payer or any other payer prior to Medicaid, does not cover the services and so will not pay any amount towards the claim. NYSDOH permits providers to bypass submitting the claim to the prior payer(s) who would otherwise deny the claim. Providers may populate the Plan Name field of the Subscriber Information SBR segment with the value "0FILL". By doing so providers certify that they can provide documentation that the services that were billed are not covered by the prior payer(s) (Loop-ID 2000B, SBR, SBR04=0FILL). Such documentation should be kept on-file and current by billing to the prior payer(s) for the non-covered services at least once a year.

"0FILL" should also be used on claims which have been denied (the services were not covered) or were paid zero (the entire charge was adjusted, for example, applied to deductible) by any prior payer. Note however that the complete adjudication information from any prior payer who adjudicated the claim must still be included (loop 2320 and sub-loops; and/or loop 2430 and sub-loops).

When the claim is not eligible for processing under the "0FILL" plan, NYSDOH recommends submitters enter "MEDICAID" as the Plan Name (Loop-ID 2000B, SBR04=MEDICAID).